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Impact of efficacy on conus branch anchoring technique in proximal RCA-CTO PCI

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A woman in her 80s, with a history of congestive heart failure, presented with a progressively worsening exertional chest pain. She was transferred to our hospital to have a detailed cardiac examination. Her coronary angiography showed severe triple- vessel disease. First, she underwent PCI for stenosis of both LAD and LCx. Next, we tried to perform RCA-CTO PCI. We selected a 6 Fr Judkins right 4 cm (JR4) curve guiding catheter through her right femoral artery. At the beginning of the PCI, we could not get a good co-axial position of the guiding catheter and handle it well in that her ascending aorta was too narrow against a JR4 curve. Therefore, we decided to perform a side branch anchoring technique. A 0.014&quot floppy-tipped guide wire was advanced into the conus branch and a 1.5 mm semi-compliant balloon was dilated at 6 atmospheres pressure. The CTO lesion was successfully wired with a Gaia 1st wire through a Corsair catheter because of the increment in buck-up force of the guiding catheter. Moreover, the anchoring balloon played a role as sealing the branch. Continuing to inflating the balloon, we successfully delivered a 3.0 mm by 15mm non-compliant balloon to the CTO site. Subsequently, a 3.0 mm by 22 mm Resolute Integrity zotarolimus-eluting stent was deployed. We occasionally face difficulties to complete revascularization for RCA-CTO due to weakness in back-up force of guiding catheter. Side branch anchoring technique could be an efficient and useful maneuver in such a difficult situation.