C030

PCI for CTO after TAVR with a Self-expandable Bioprosthesis

The 76 year-old lady has medical history of ESRD under CAPD, CAD 2VD s/p POBAS to LAD and RCA in Nov. 2015 and severe aortic stenosis s/p TAVR (CoreValve 31mm) in Jan. 2016. This time, she suffered from effort angina and thallium scan revealed RPD over infero-lateral wall. Diagnostic angiography revealed good condition in left coronary with collaterals to distal RCA. There was a total occlusion in the 2nd portion of RCA. Due to the stent frame, the RCA could only be engage by JR guide catheter, of which the support is not ideal for a CTO lesion. We advance the Corsair catheter was introduced with the assistance of a Sion Blue wire. And a Gaia first wire was used to cross the CTO lesion but a 1.0mm ballon could not cross the lesion. We then used a Guidezilla catheter to increase supportability and balloon catheter successfully cross the lesion and further POBA and POBAS were performed smoothly. We'd like to share the tip of using guide cathter extension system to handle with PCI when coronary ostium could be partially engaged due to the self-expandable arotic prosthetic. As we move the indication of TAVR to lower-risk, younger patients, there would be 5% of patients needing an unplanned PCI. We should be well-prepared for this kind of challenge in the future.