Successful transfemoral percutaneous coronary intervention after failed transradial intervention in patient with tortuous and angulated lesion

Operator: Hun Sik Park
Presenter: Won Suk Choi, MD
Kyungpook National University Hospital, Daegu, Korea
CASE

- Male/62
- C/C: chest pain for 2 months
- Per/Hx: smoking (+), 20 Pack-years
  alcohol (-)
- Past Hx: Hypertension (+), 10 years ago
  Diabetes melitus (+), 6 years ago
  Prior PCI (+), 16 months ago
  mid and distal RCA (Taxus #2)
  proximal and distal LCX (Taxus #2)
ECG at admission
Chest X-ray
2D-UCG
CAG – LCA (TRI)

No significant stenosis at LAD

No ISR of previous stent in LCX
CAG – RCA (TRI)

Diffuse, irregular, heavily calcified, and angulated lesions in proximal and mid portion of RCA.
PCI – dRCA (TRI)

Deep engagement of AL1 and the balloon (2.0x20mm) backup at proximal RCA

Guiding catheter: 6Fr AL1
Guid wire: Run through
Balloon: 2.0×20 mm
PCI – dRCA (TRI)

Guiding catheter: 6Fr IR1.5
Guid wire: Fielder FC
Run through

1.5x20mm balloon could not be delivered across the lesion
1.5x20mm balloon catheter was passed the lesion in conjunction with double guide wire
PCI – dRCA (TRI)

2.0x20mm balloon could not be delivered across the lesion
CAG – RCA (TFI)

Coronary angiogram still showed significant stenosis of distal RCA
PCI – dRCA (TFI)

Guiding catheter: 7Fr JR 4.0
Guid wire: Run through
PCI – dRCA (TFI)

Stent: 2.75x12 mm Promus element
PCI – dRCA (TFI)
Discussion point

- Backup support of a guiding catheter is important for successful percutaneous coronary intervention in difficult coronary anatomy.
- The methods of increased backup support were deep engagement technique, double wire technique and anchor balloon technique.
- Sometimes, exchange of an access route could be a good option for PCI in patients with difficult coronary anatomy.