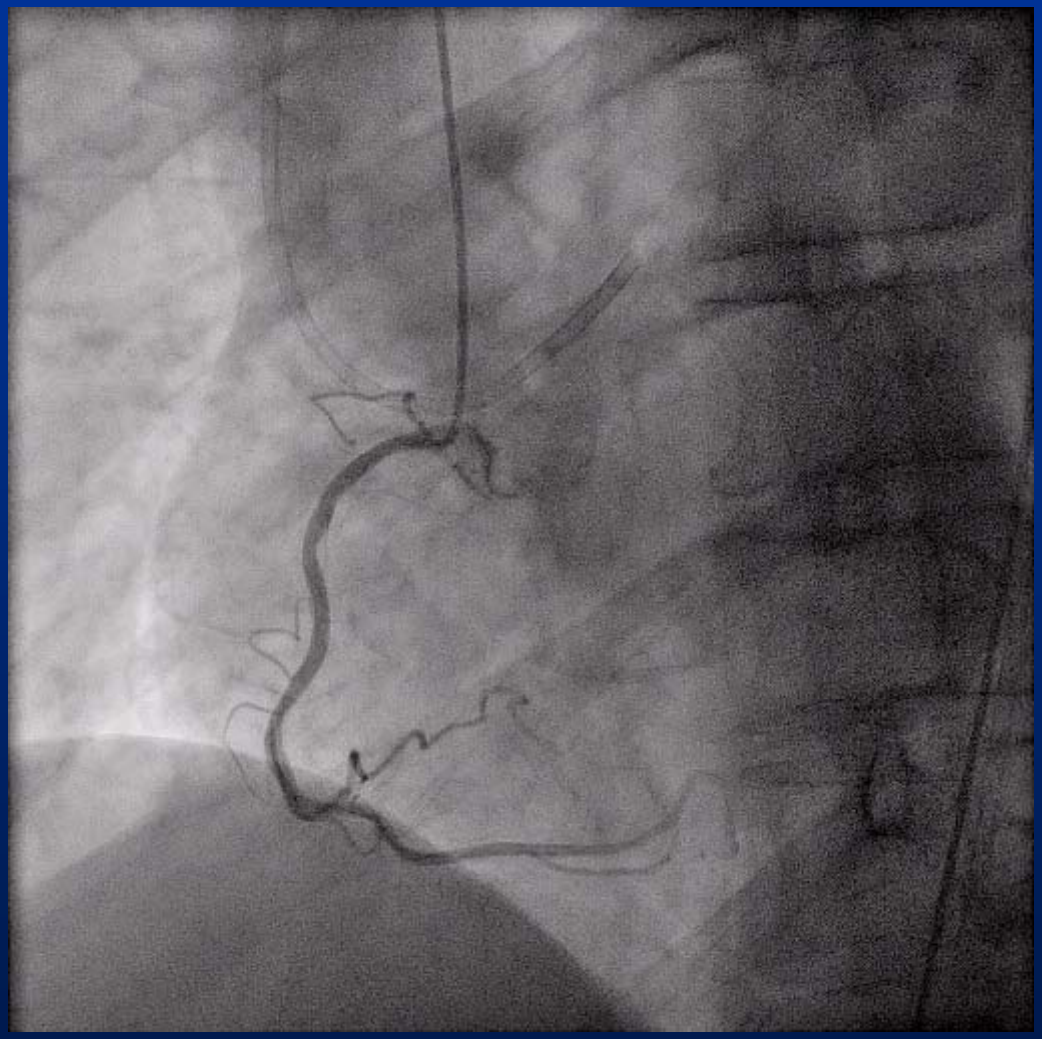
CTO LAD

Male, 54 years, CCS 2, GFR 118ml/min

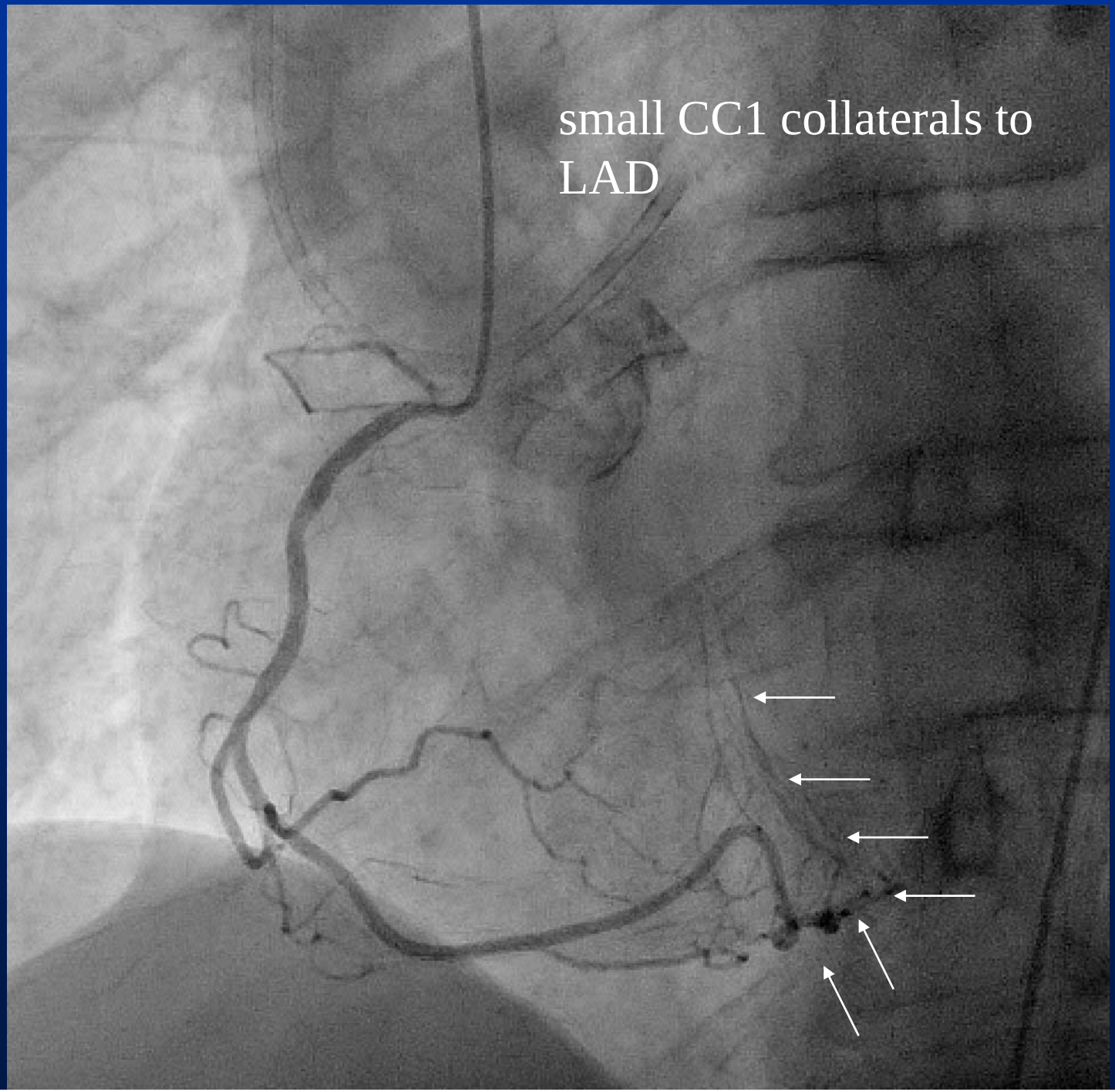
no prior infarction – LVEF 62%

Anterior and apical ischemia – large territory

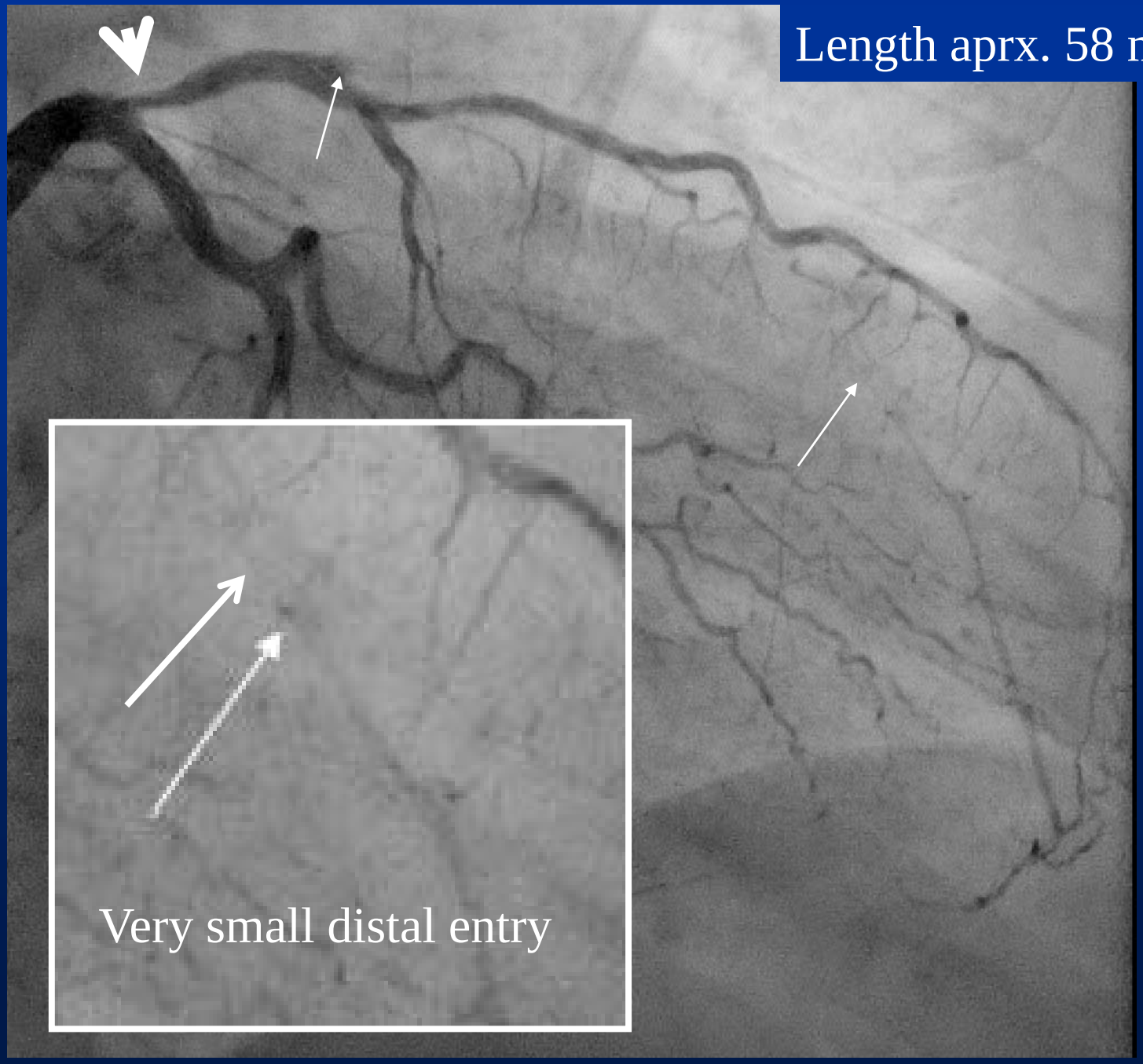
2 failures to open LAD antegradely

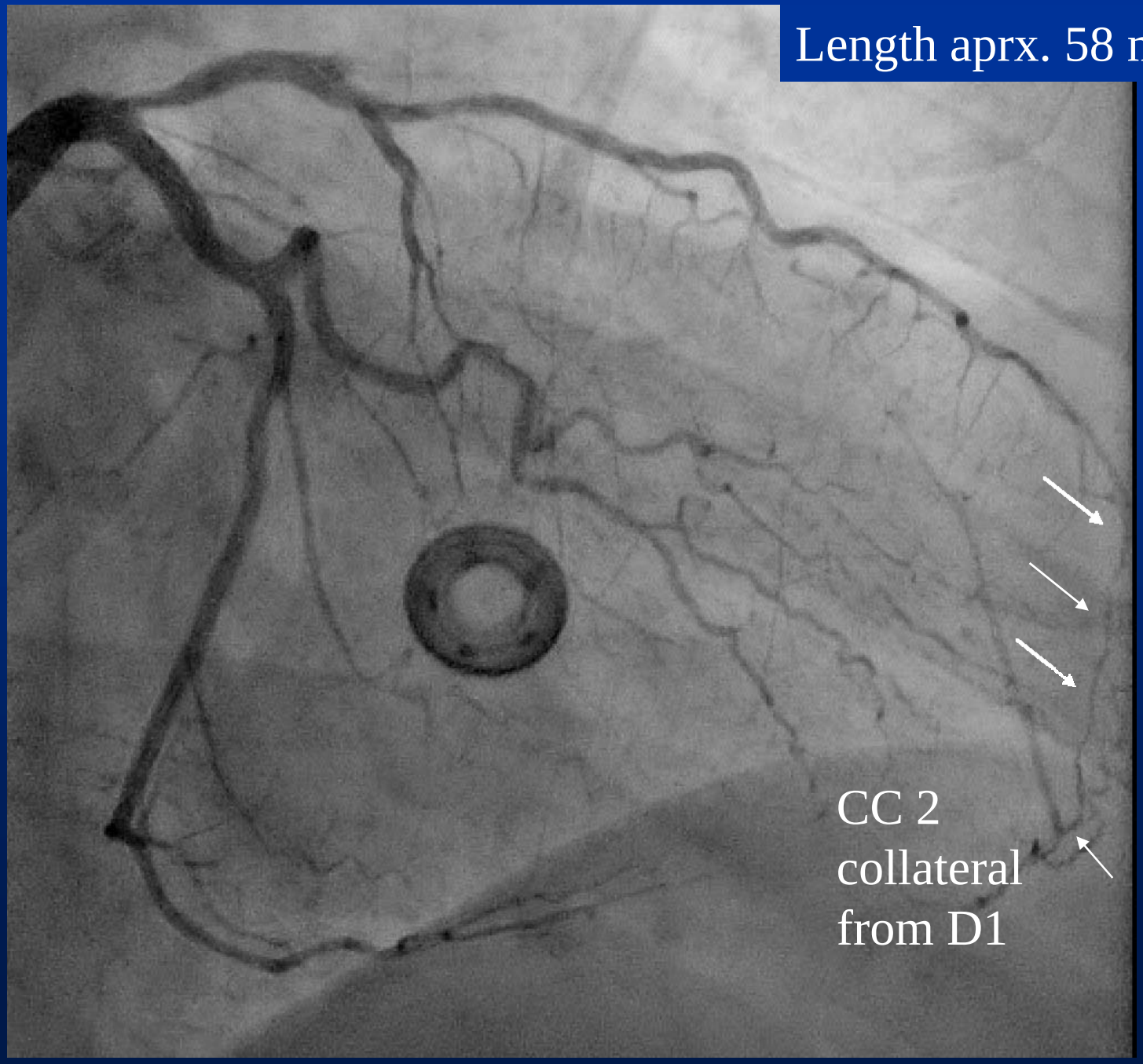


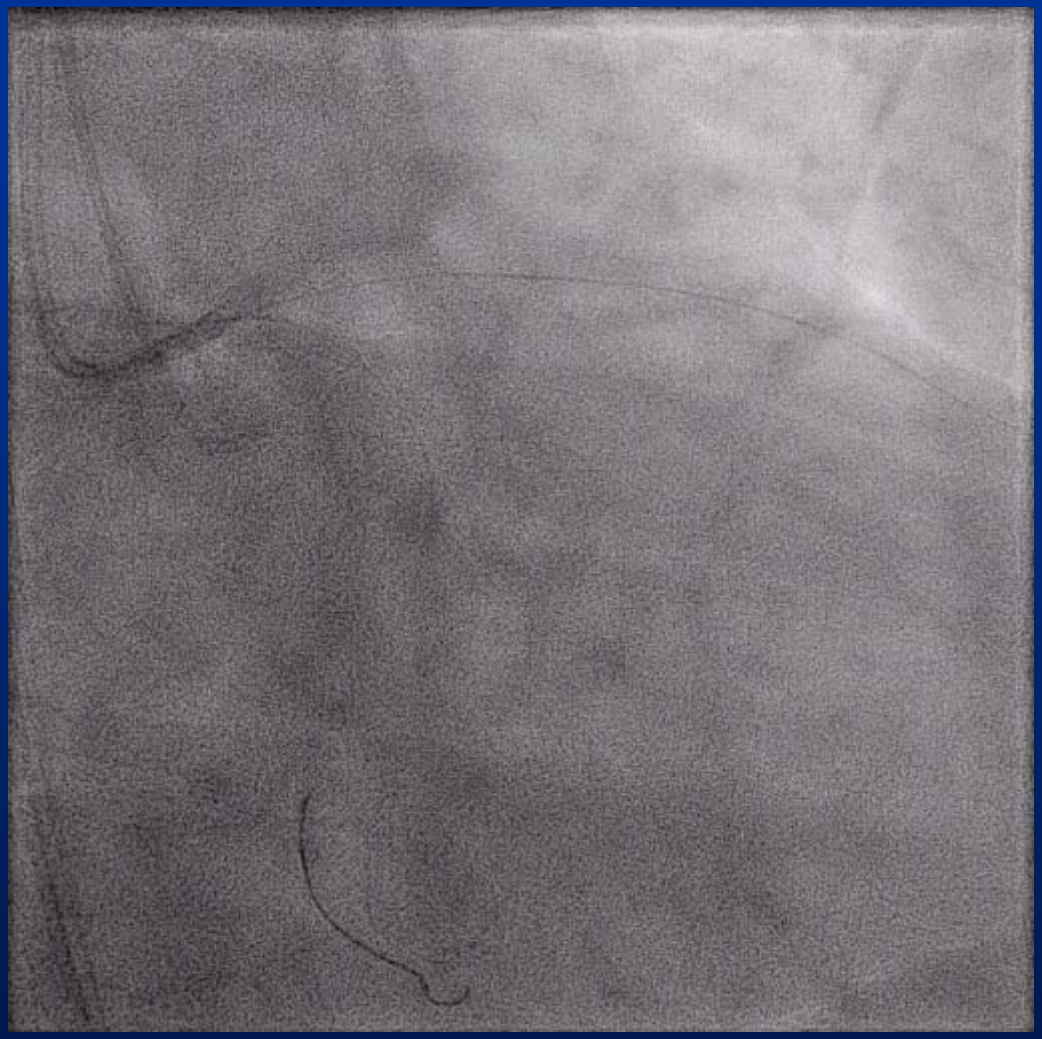
RCA ostial 30%


small CC1 collaterals to LAD

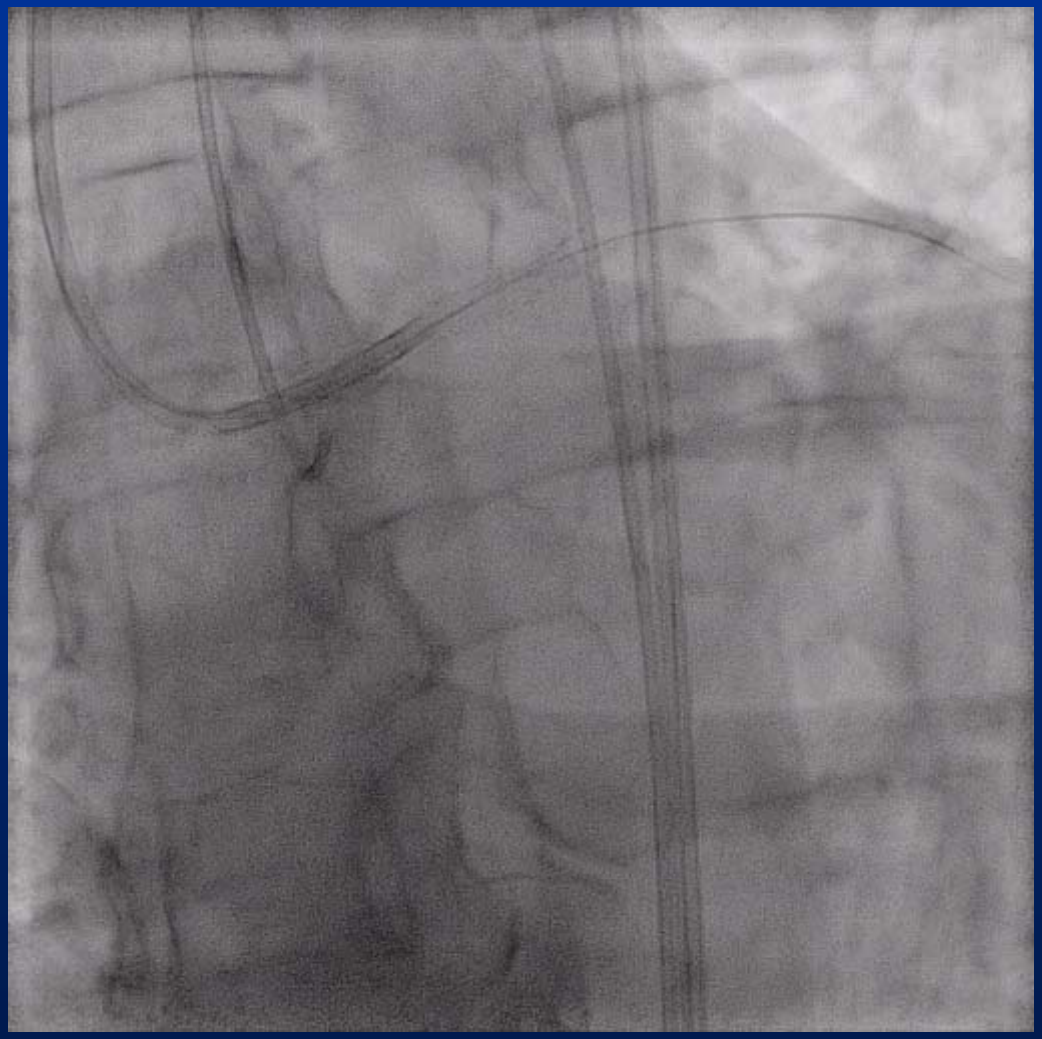
Lad ostial 70%, proximal + mid LAD occlusion, collateral from D1 to LAD


Length aprx. 58 mm
Very small distal entry

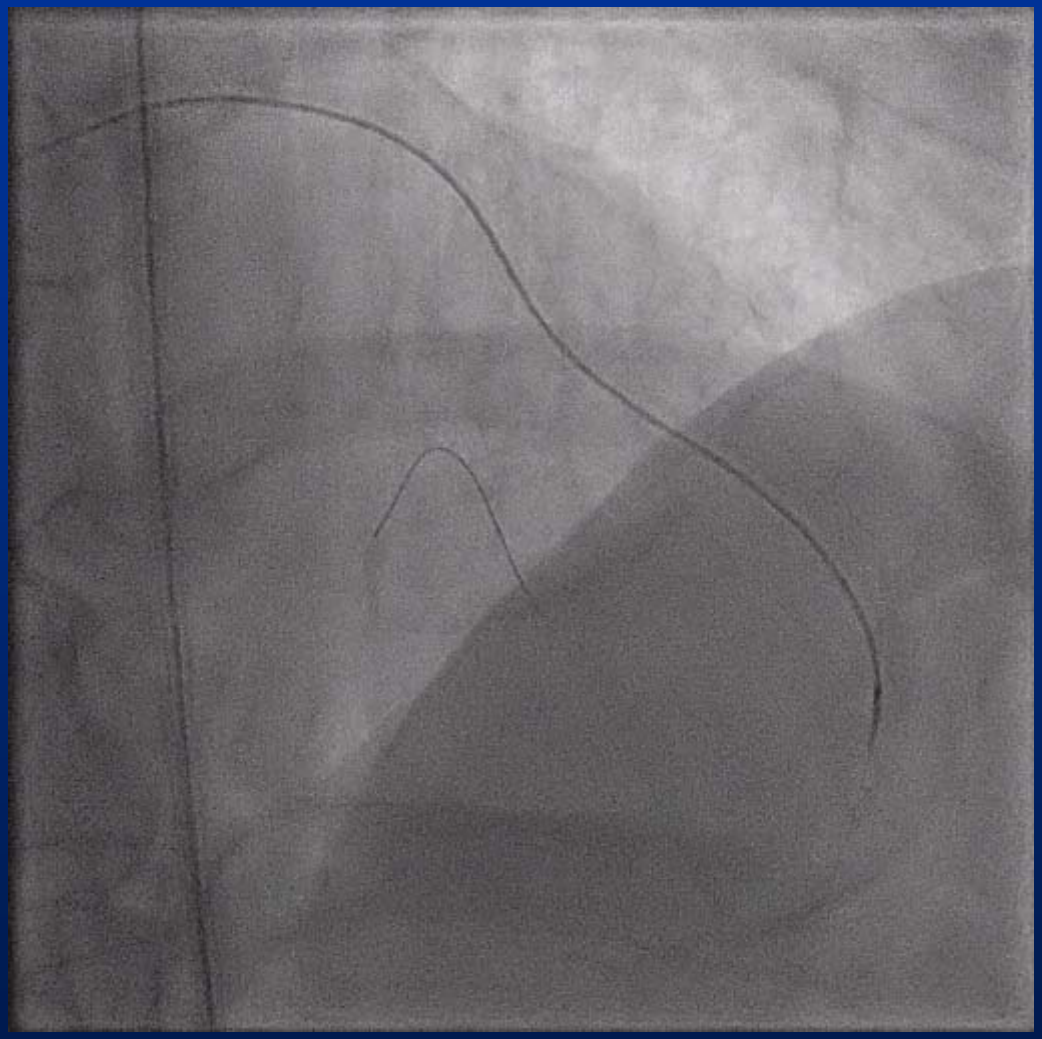

Length aprx. 58 mm
CC 2
collateral
from D1



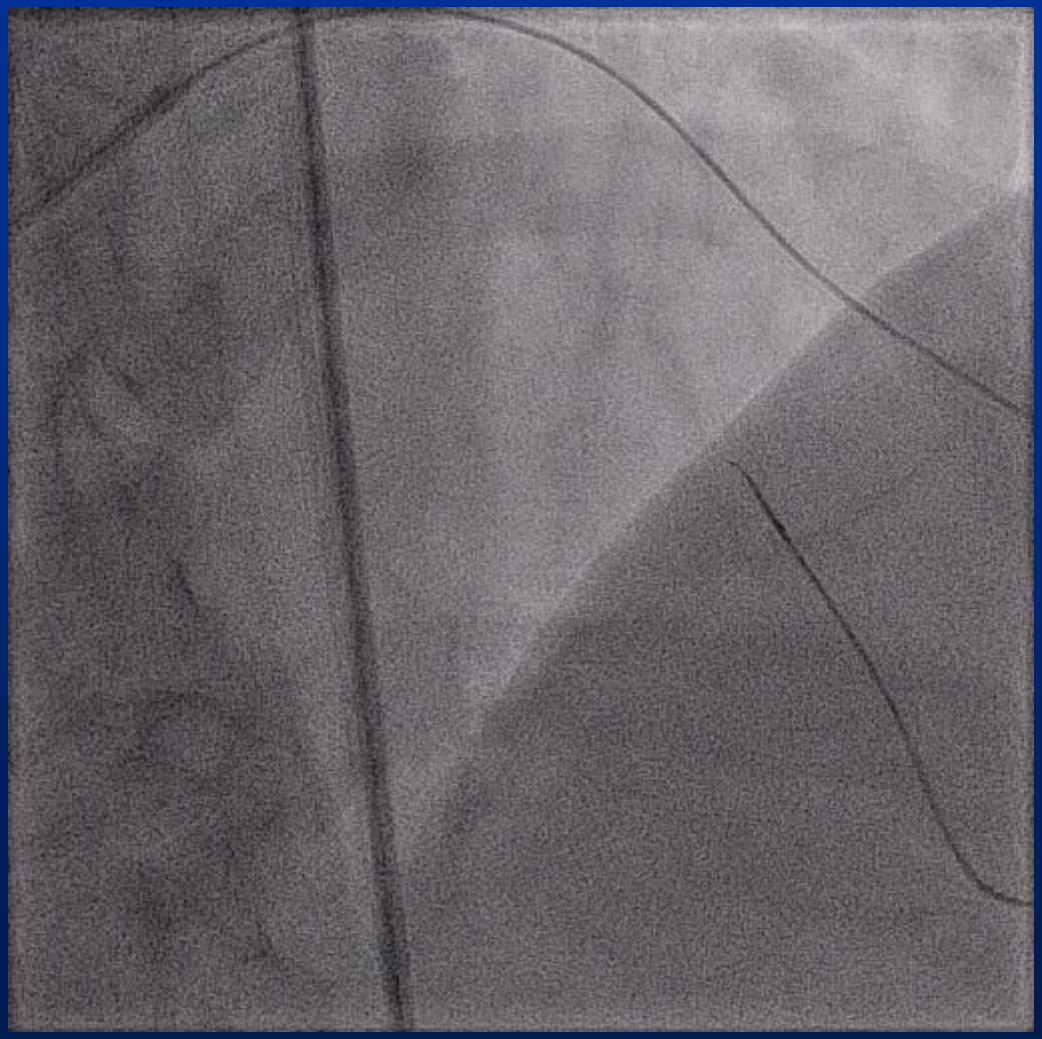
Guide: 7 F and 5 F; PW wires in CX and LAD-D1, dilate LM-ostial LAD with DES, then retrograde aproach for CTO



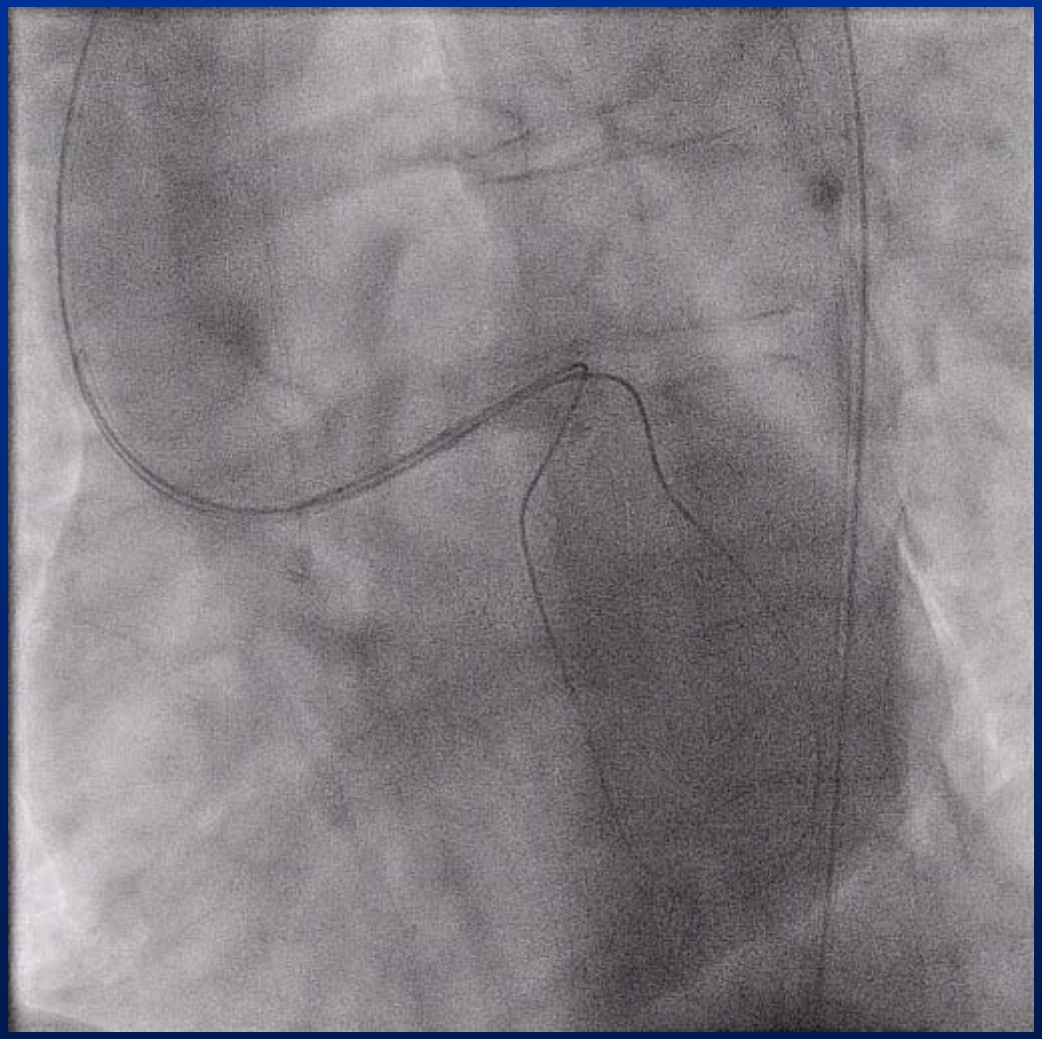
Nobori 3.5 x 24 mm



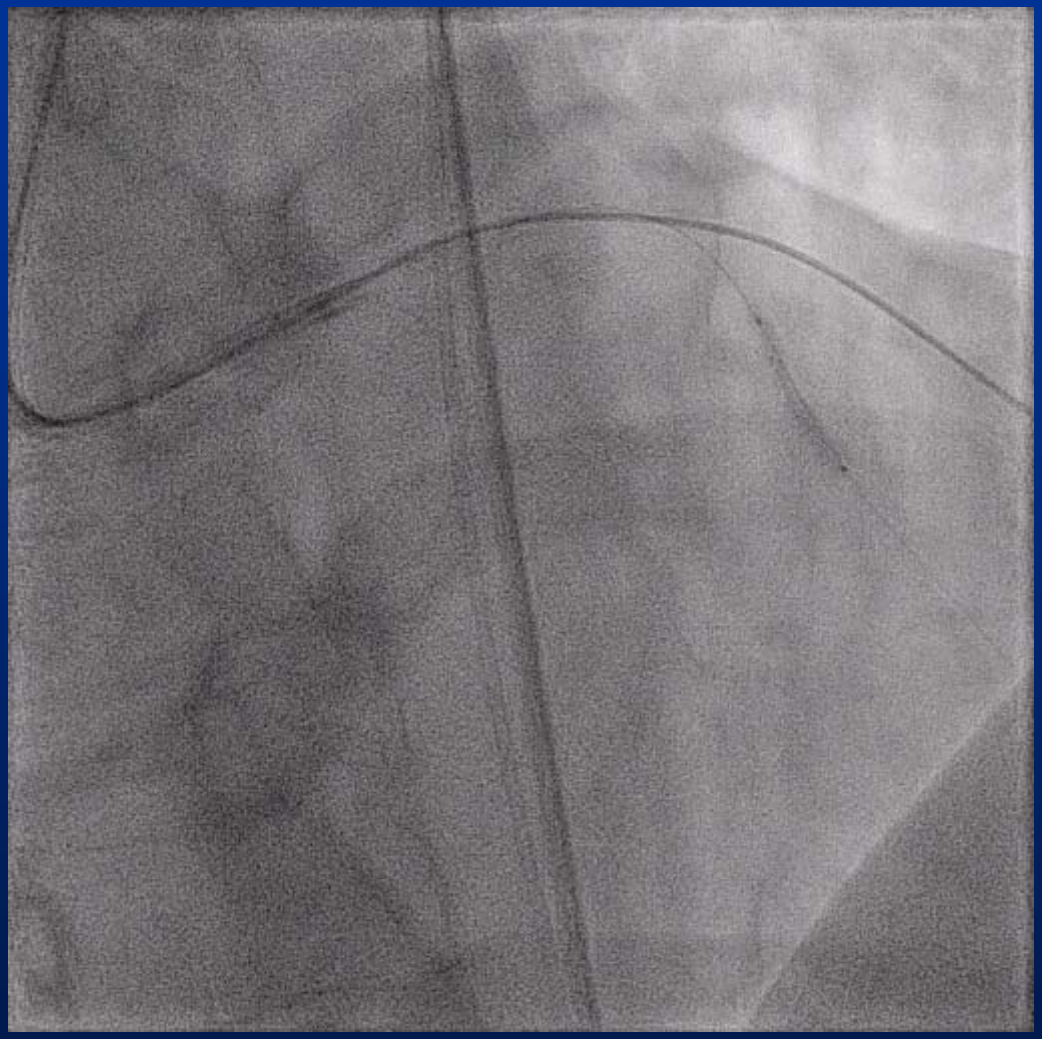
Entering epicardial CC2 collateral D1 – LAD with Whisper LS and Corsair



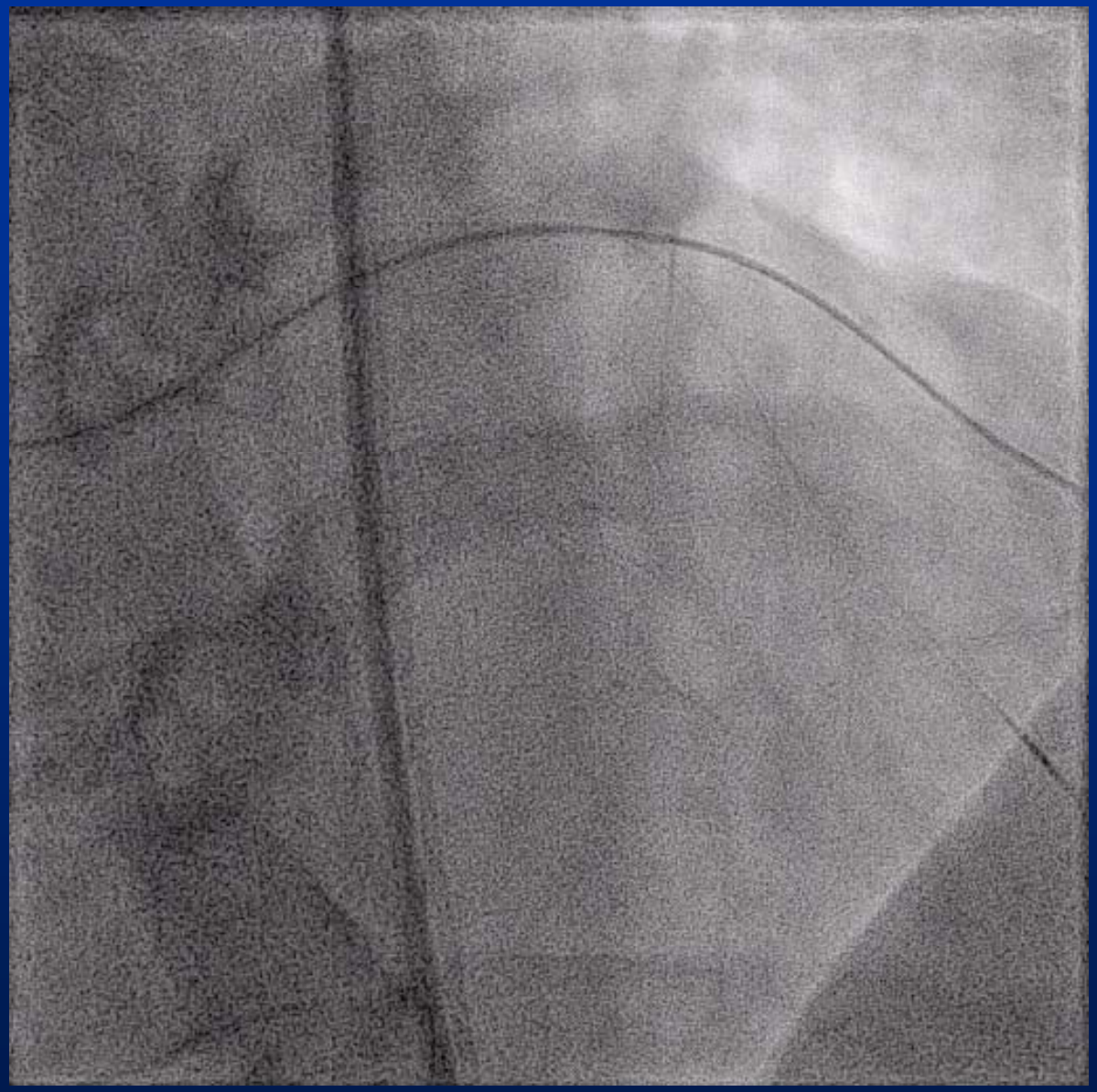
Corsair & Ultimate 3g



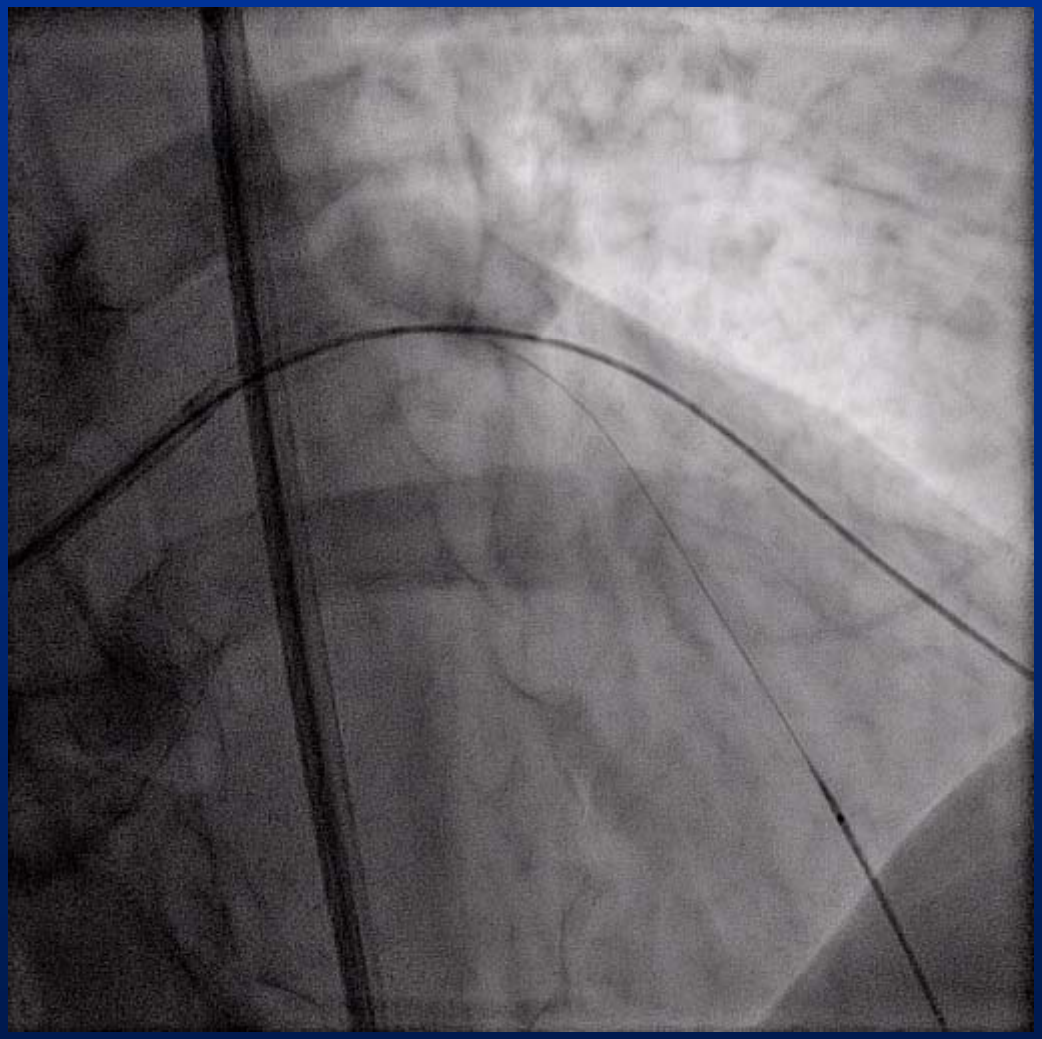
Externalisation with Corsair and RG3



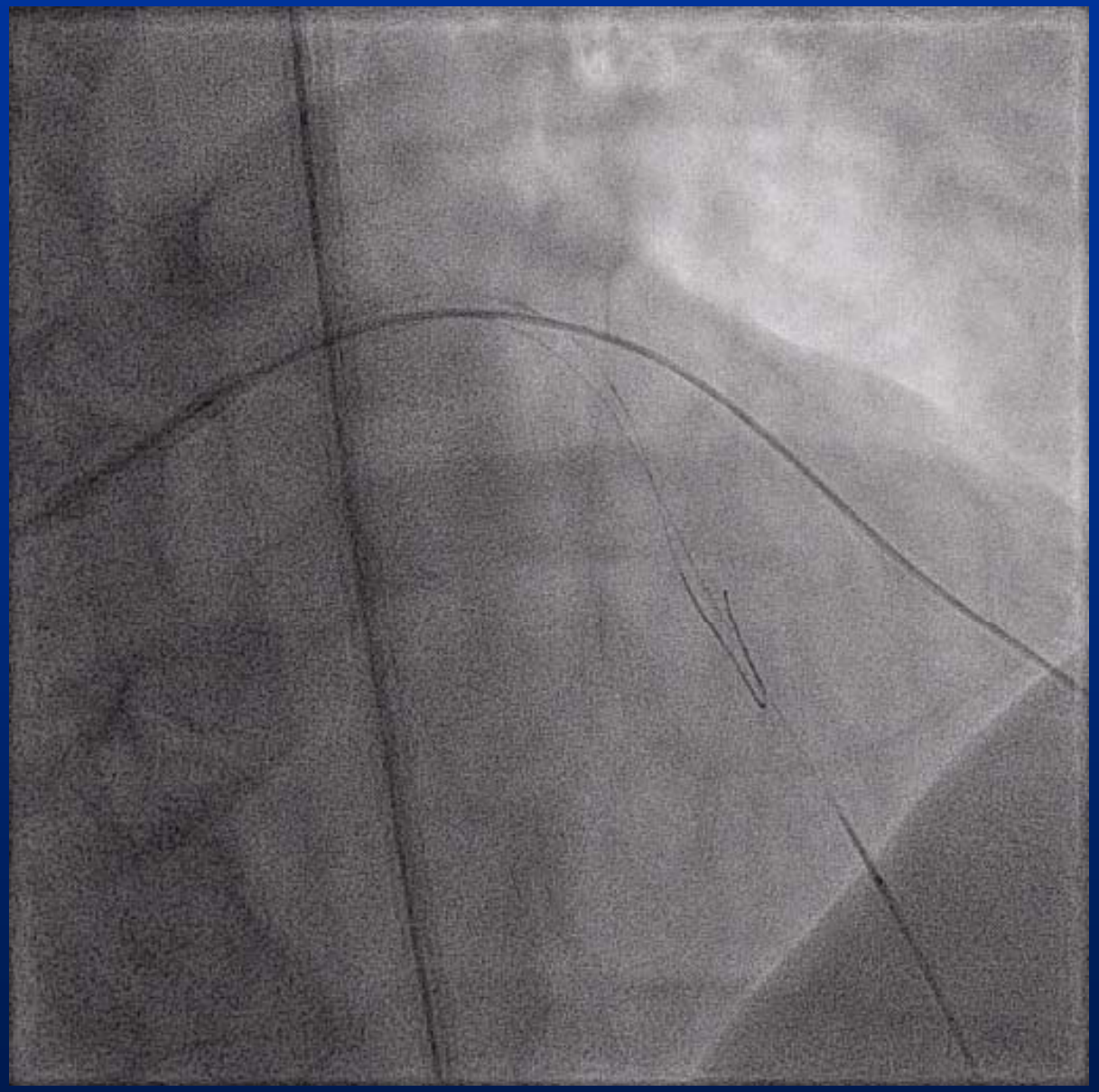
Antegrade Balloon 2.5 x 30 mm



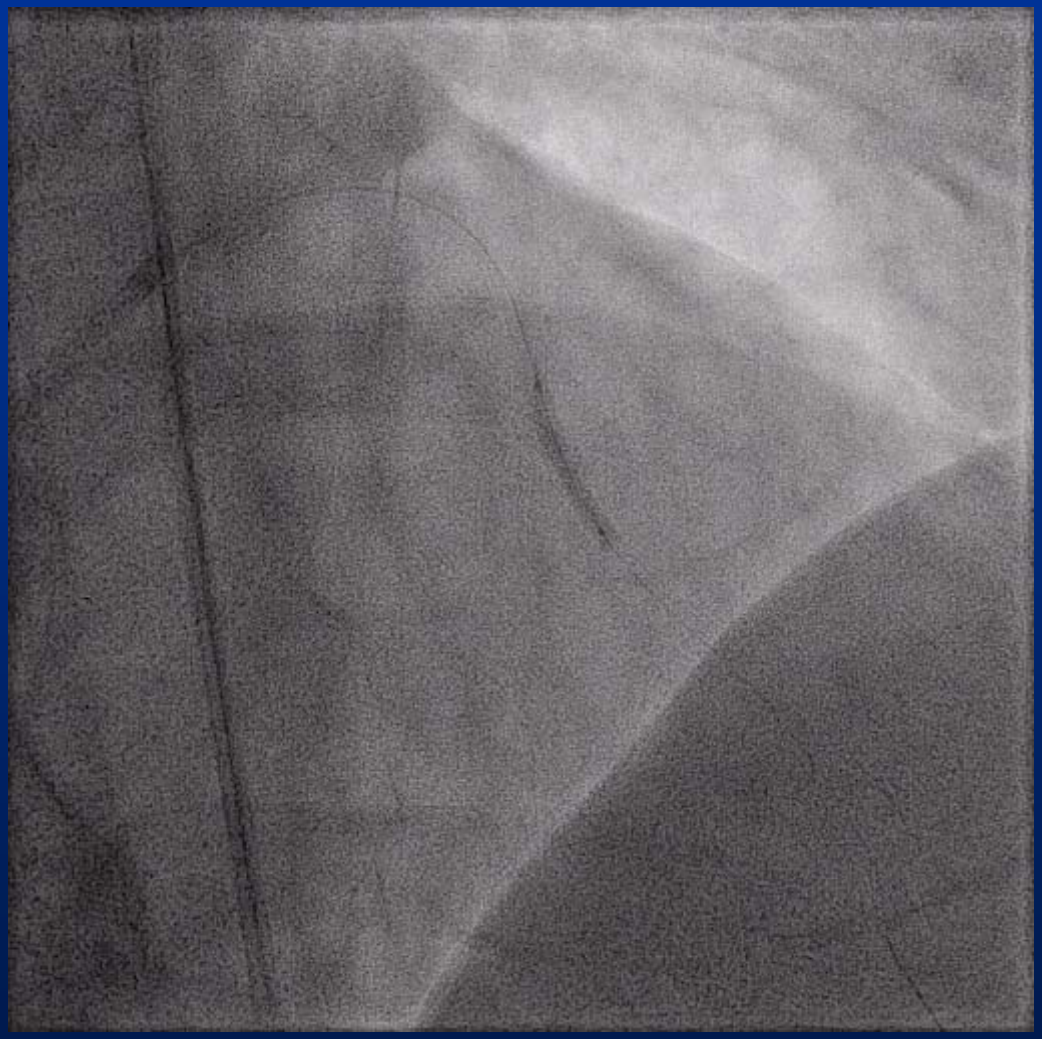
Due to friction guide and RG3 escaped ostium and RG3 kinked upon reentering the guide



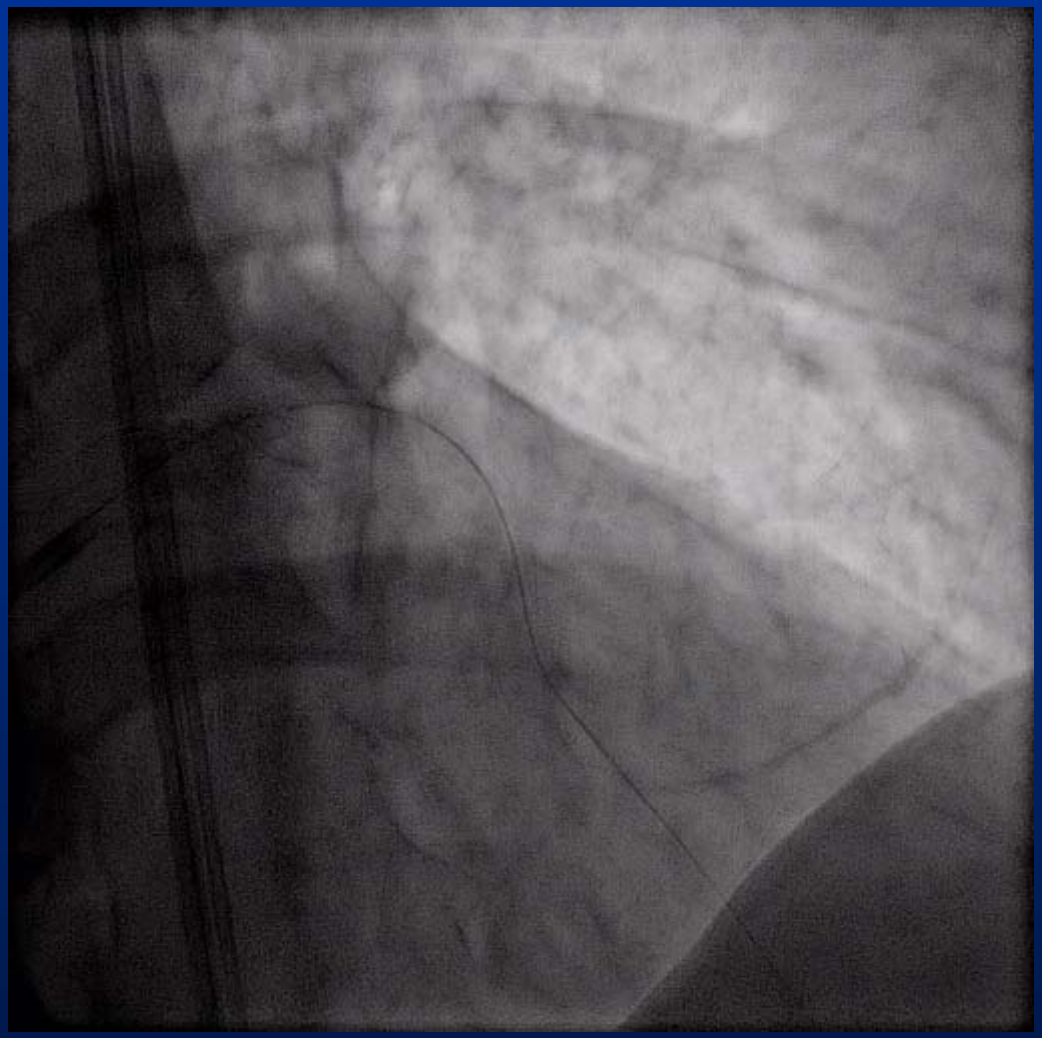
…but the result was ok for stenting.



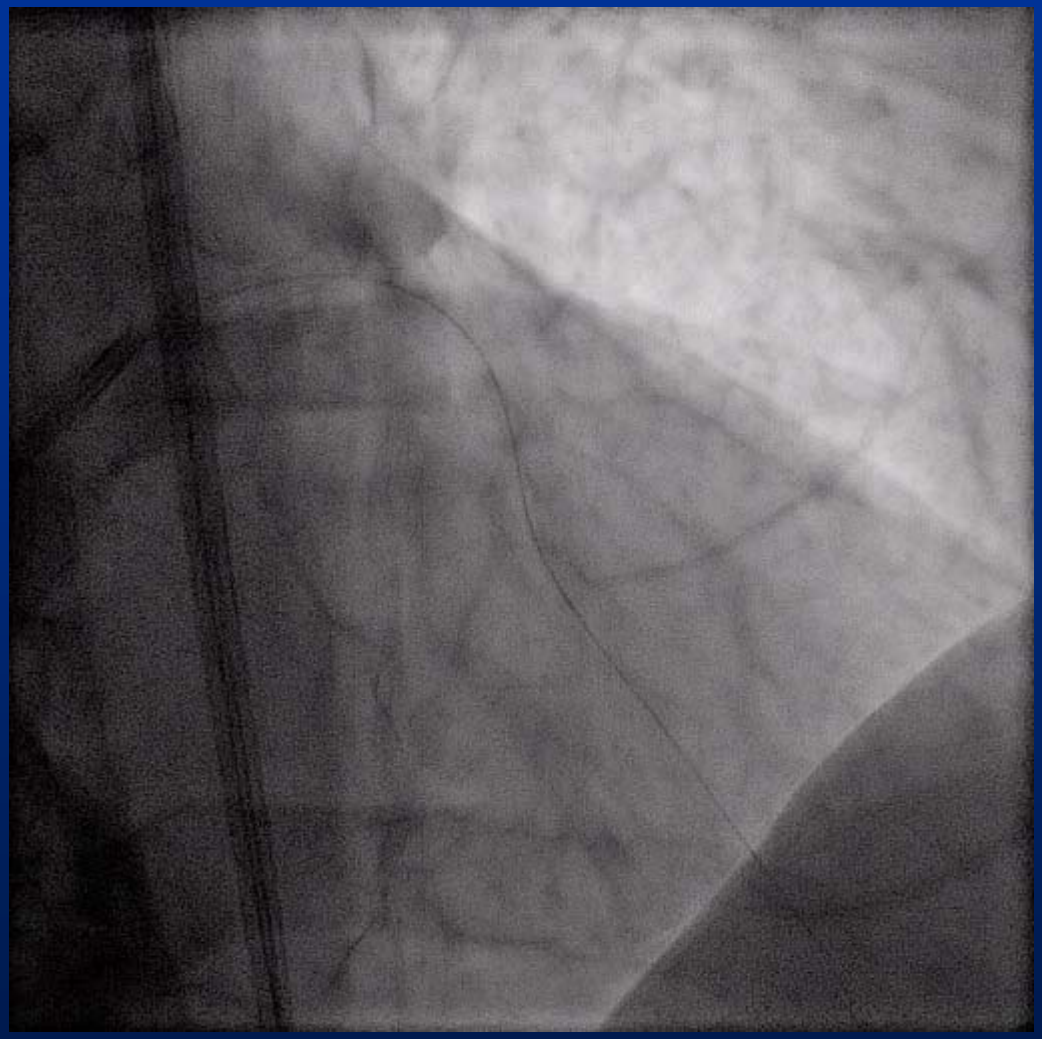
So I decided to reenter my Whisper wire, pulll the RG3 and finish over the antegrade wire



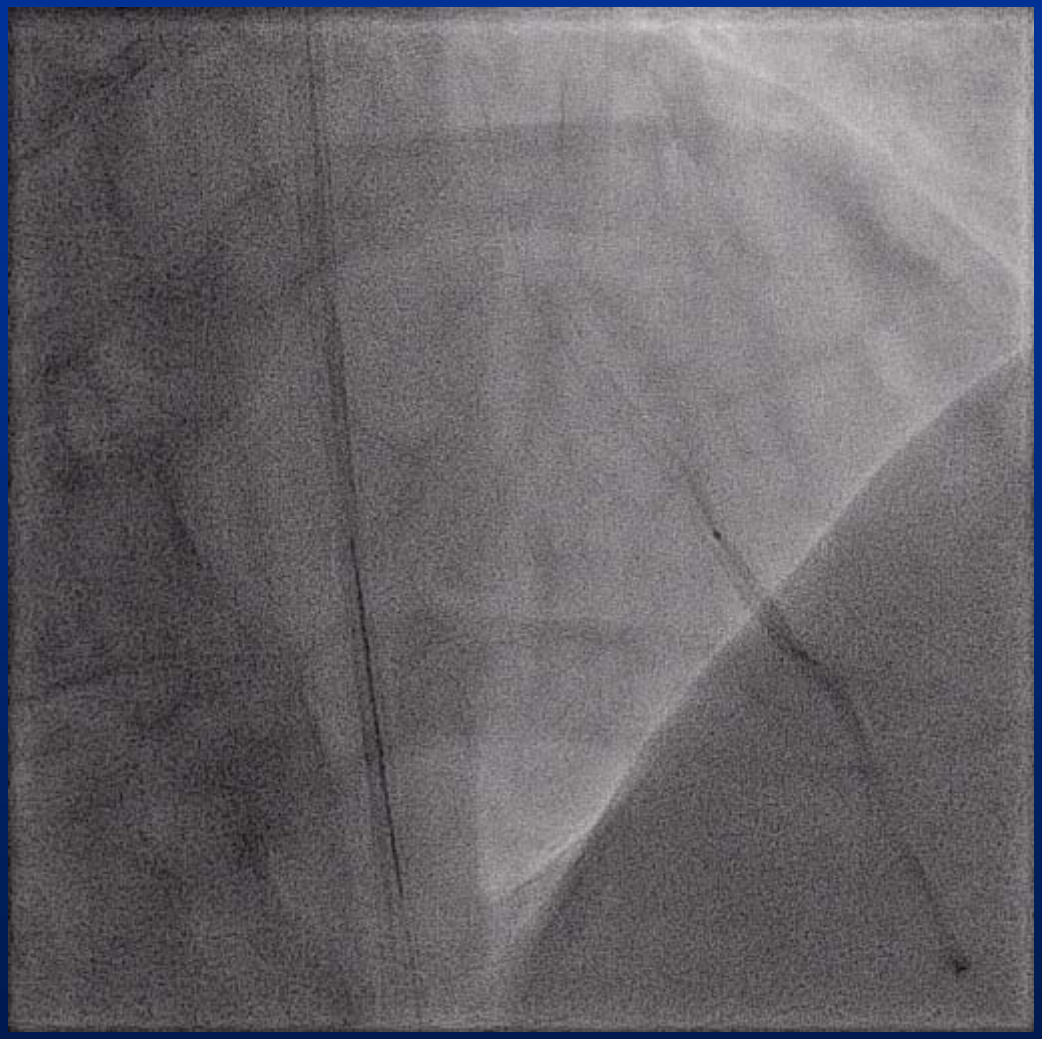
To ensure easy stenting somer touch-up with the balloon 2.5 x 30 again



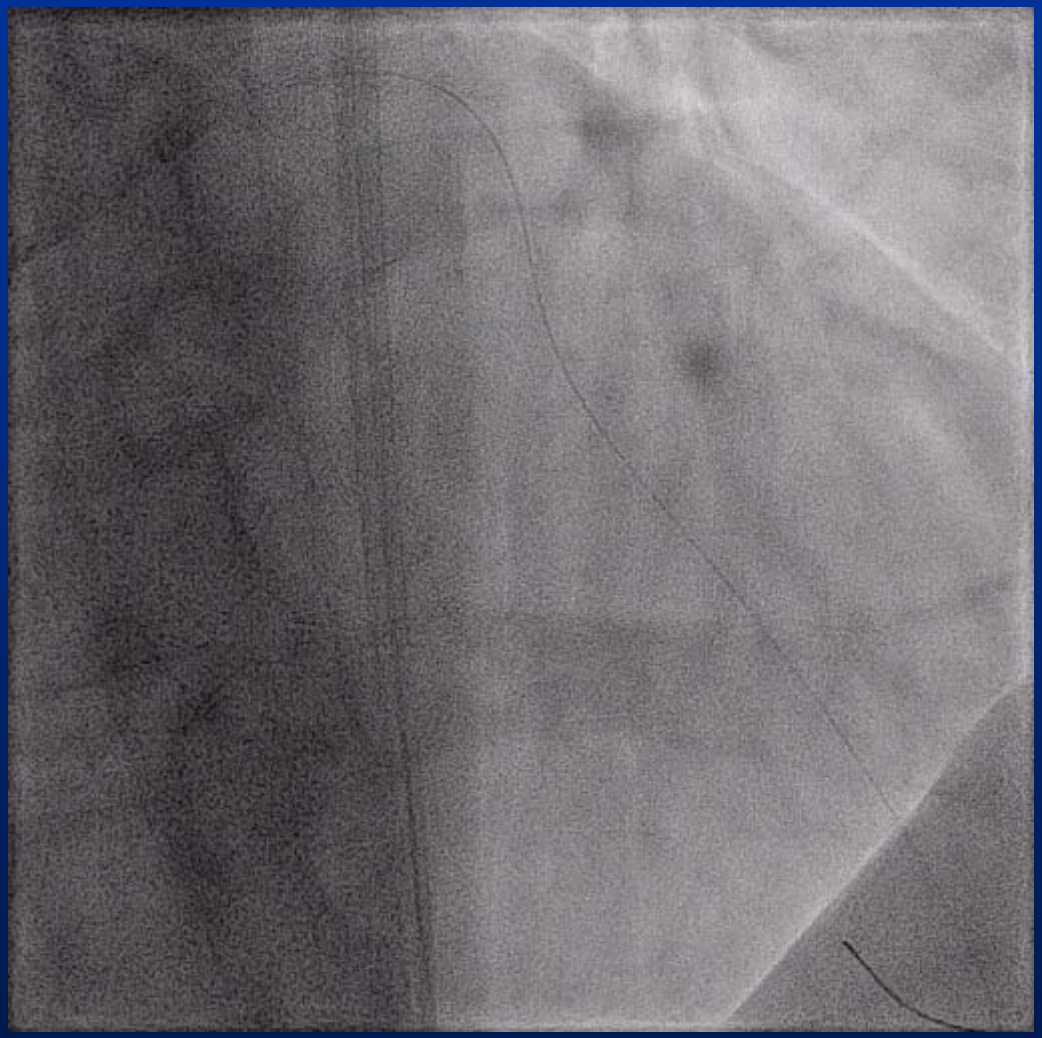
??? Occlusive dissection in mid LAD? ACT was 280



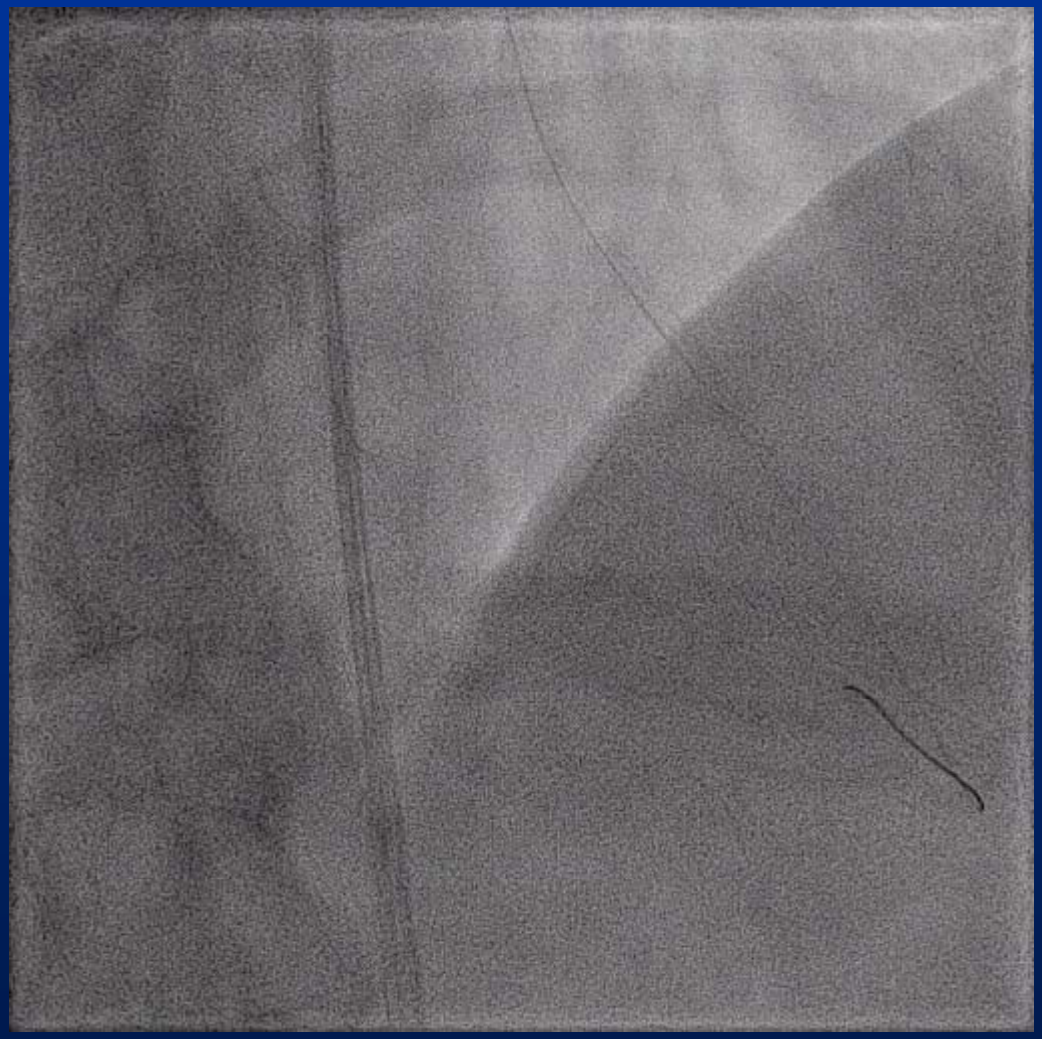
Extend of Dissection ??? IVUS? Tip - injection ?



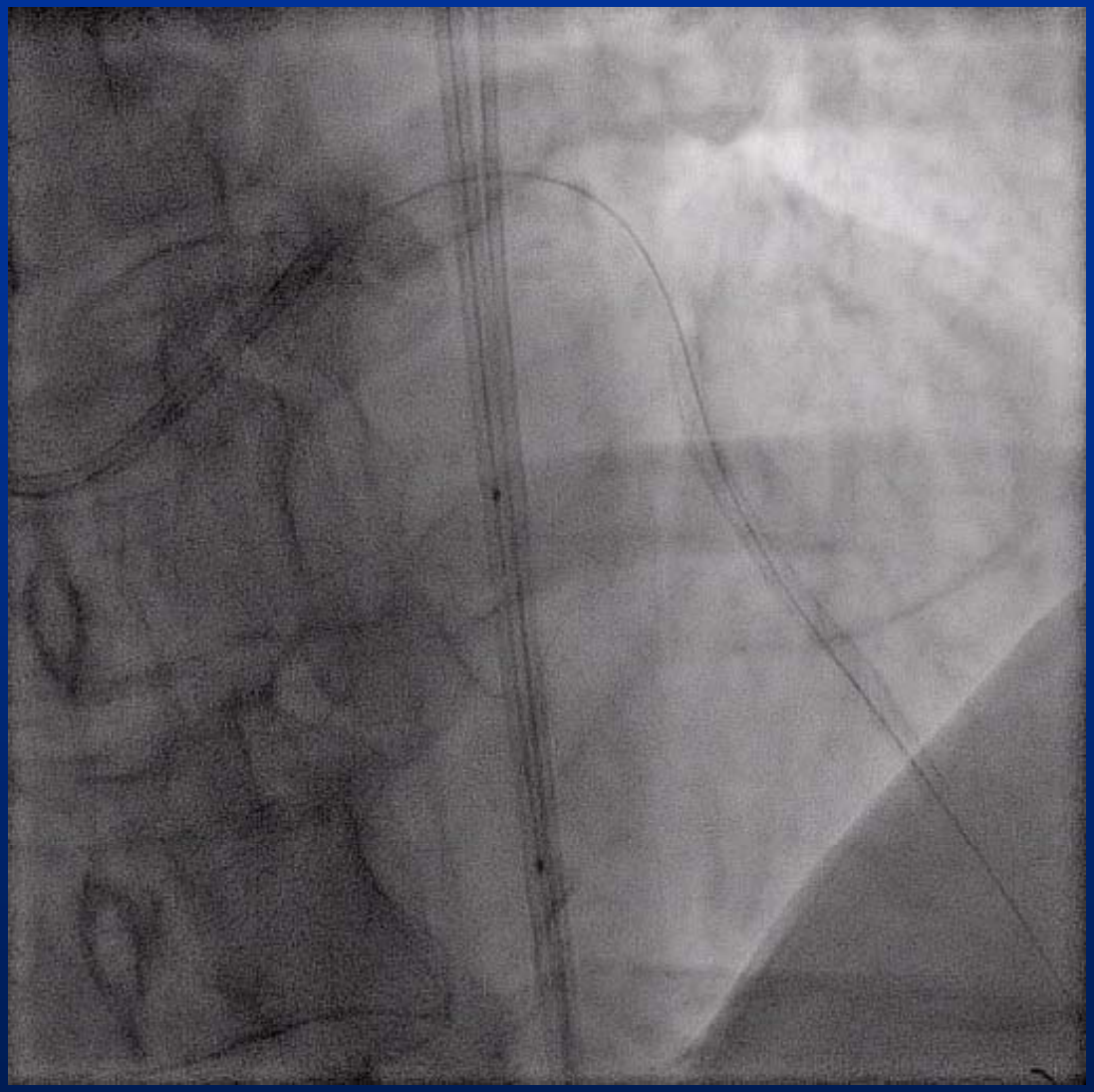
Finecross selective dye injection to define end of dissection



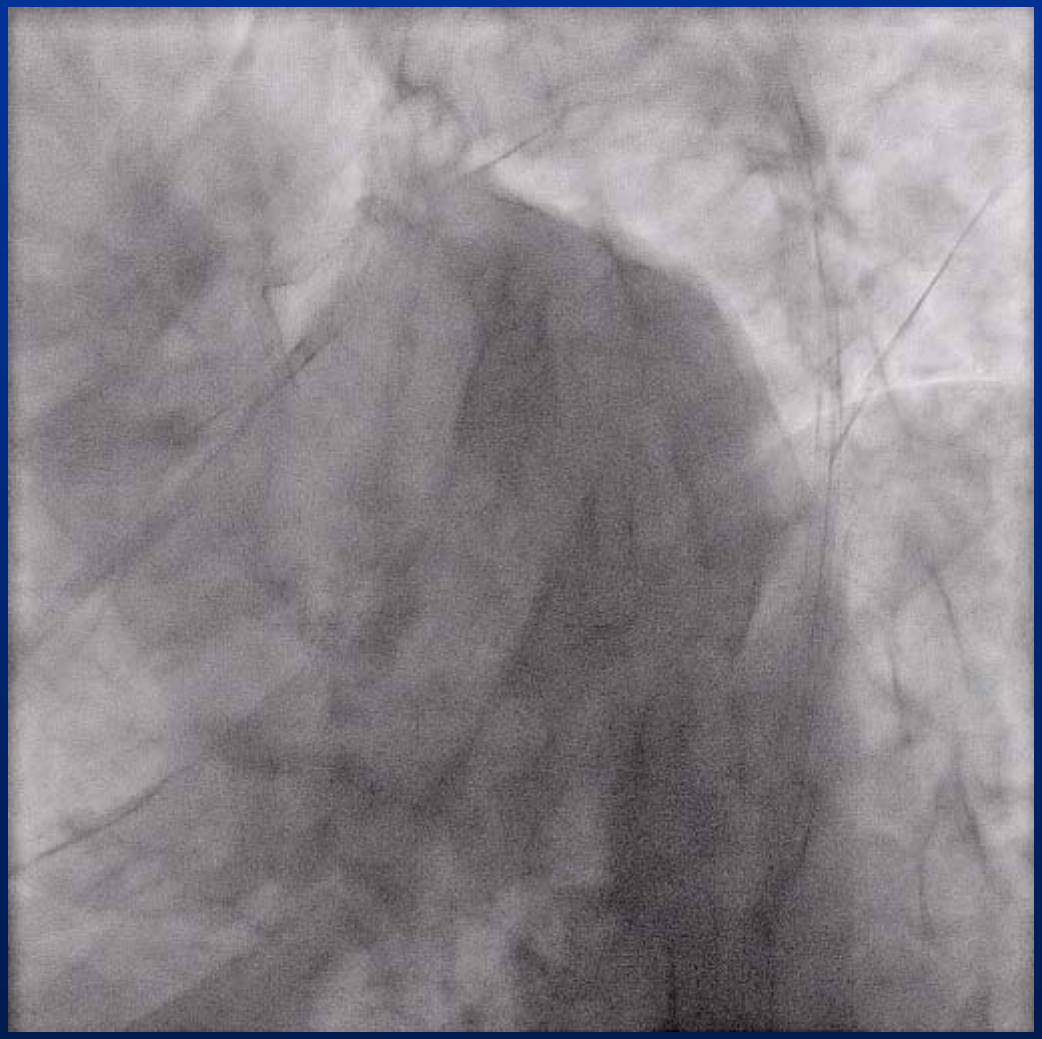
Start stenting beyond „ end of dissection“



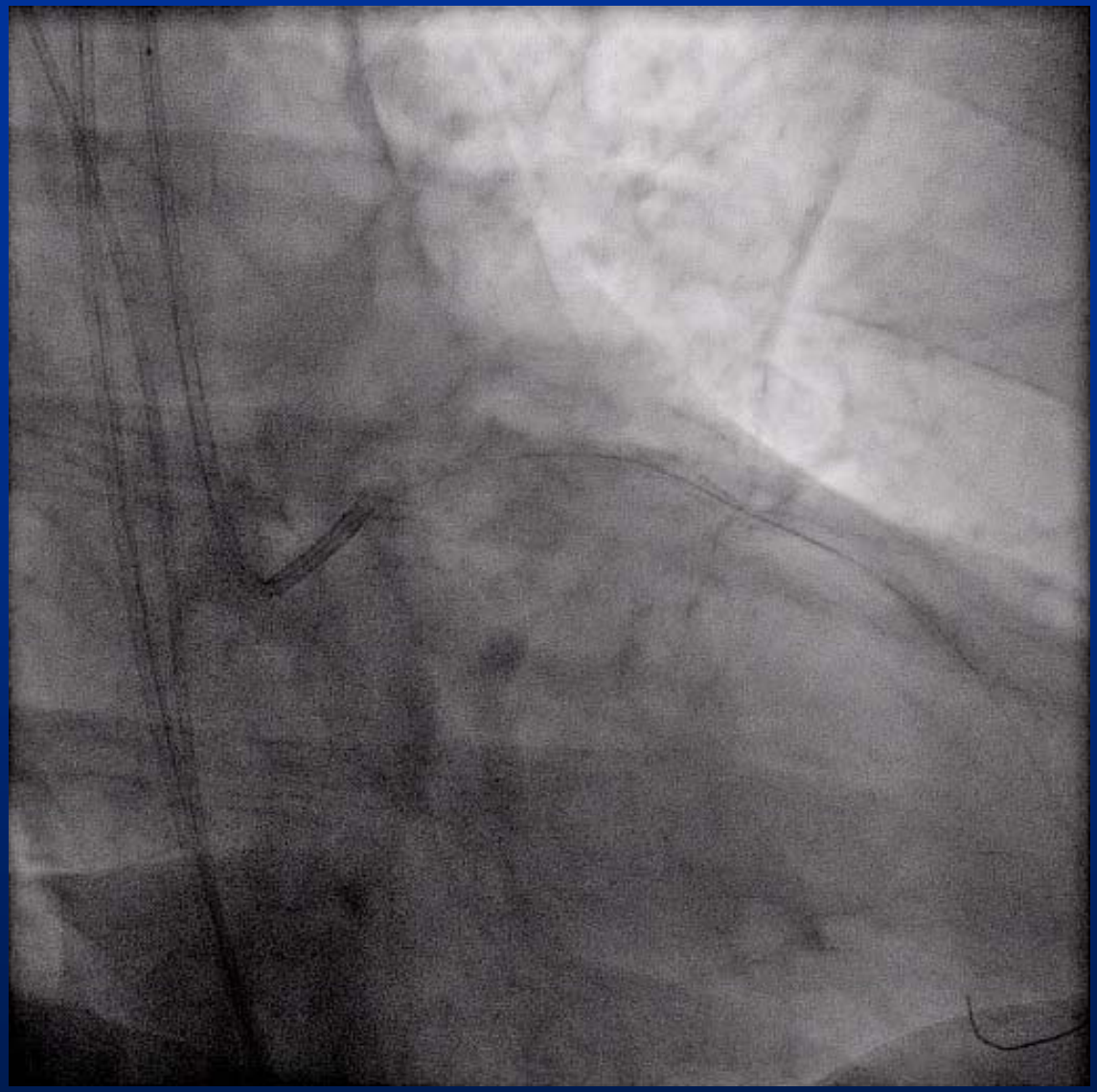
2nd Nobori 3.0 x 28 mm



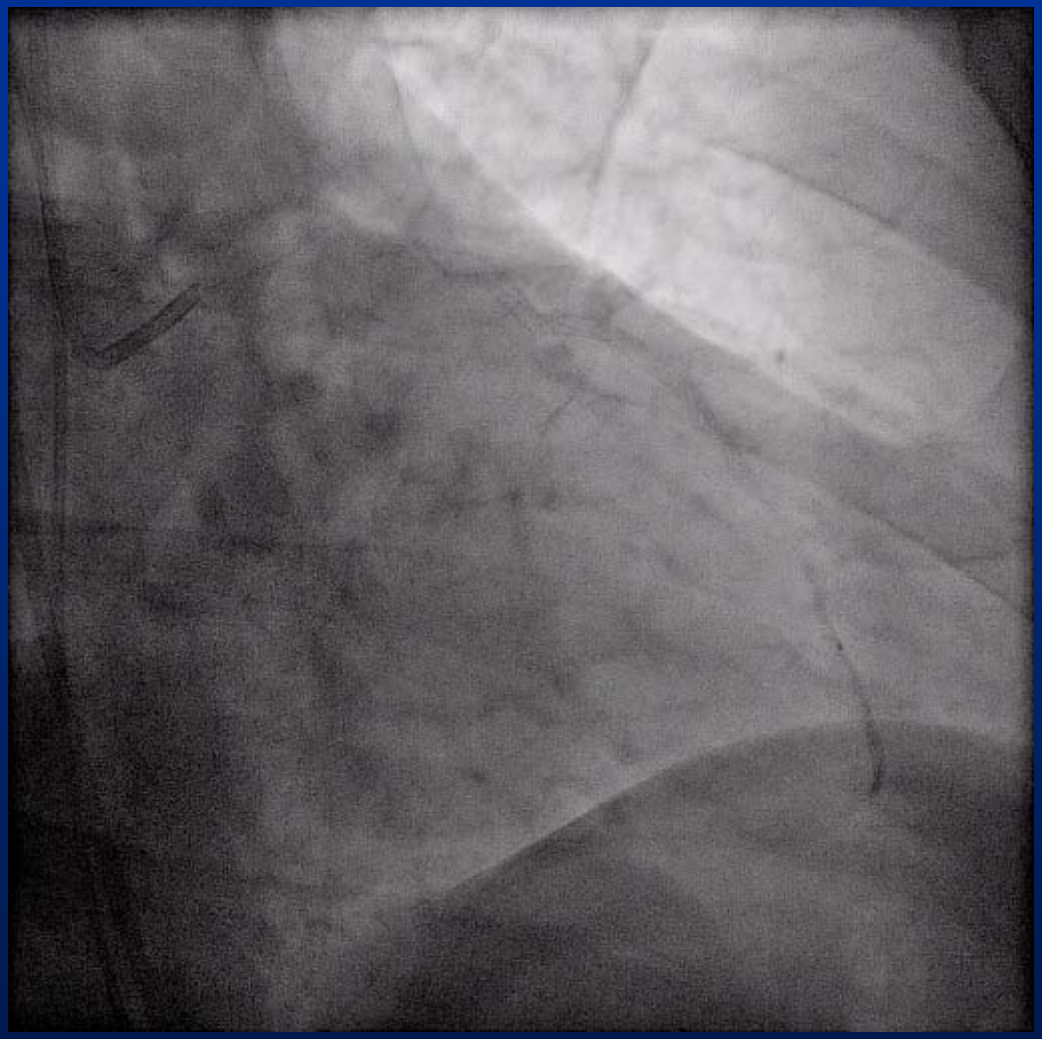
Flow-stop proximal to „ dissection-end“
a) Dissection is longer or b) occlusive dissection proximal



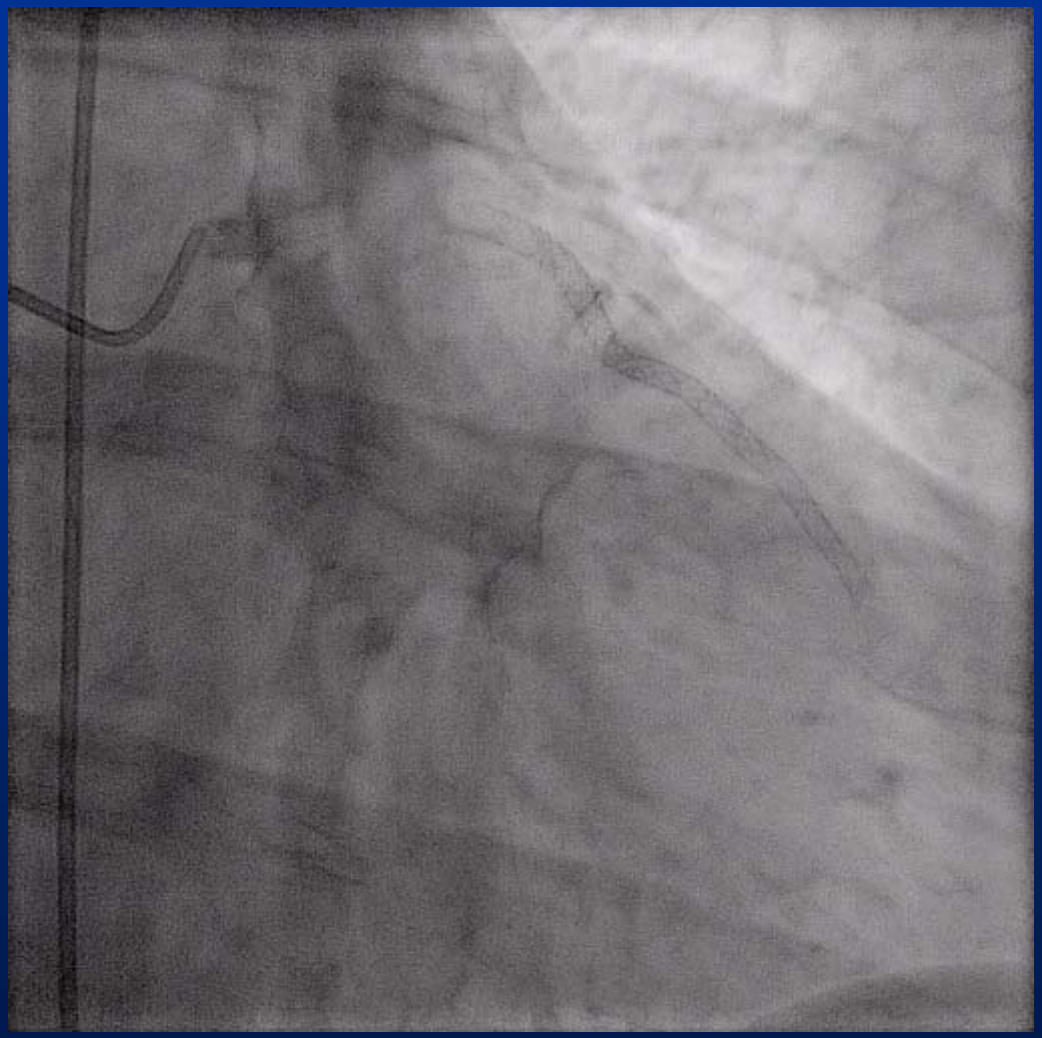
Still confused…



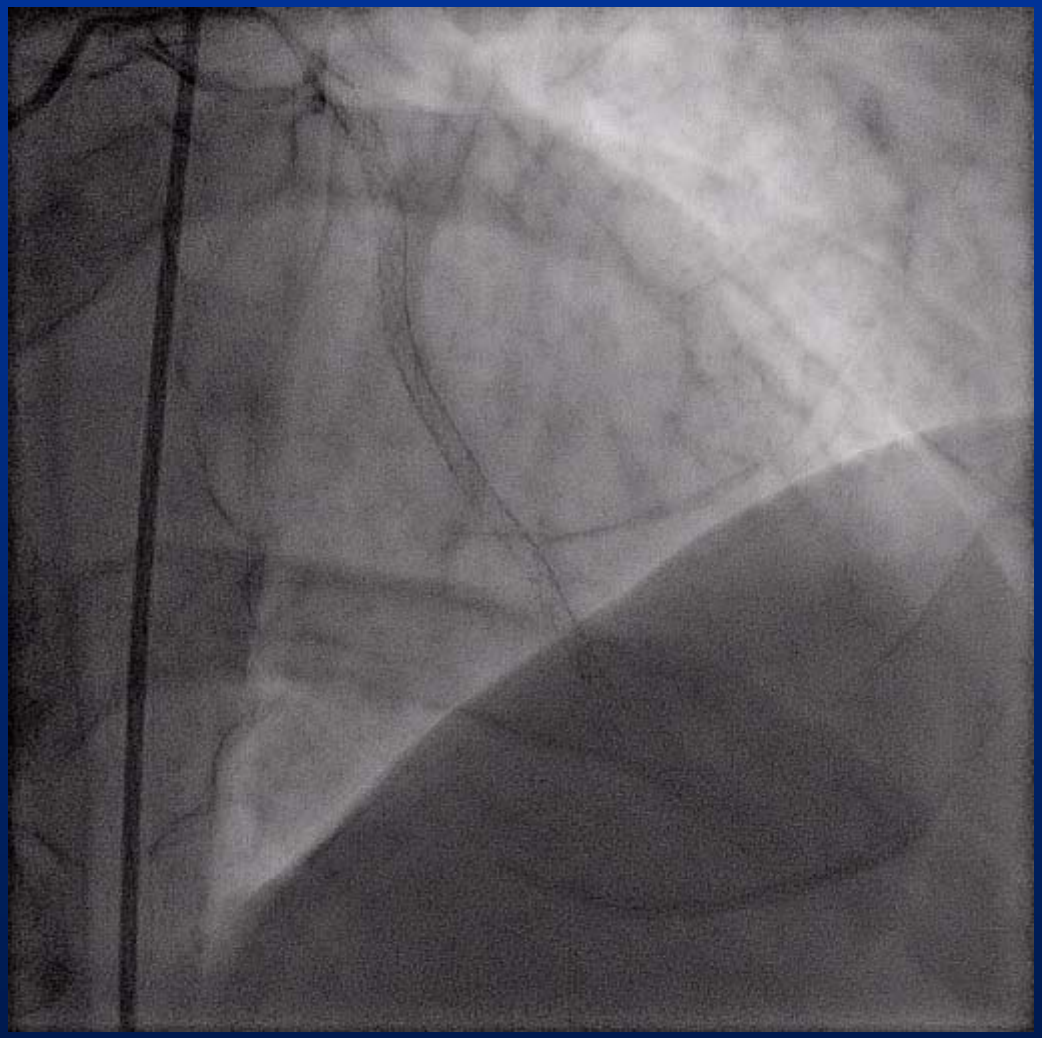
Maybe proximal occlusive dissection

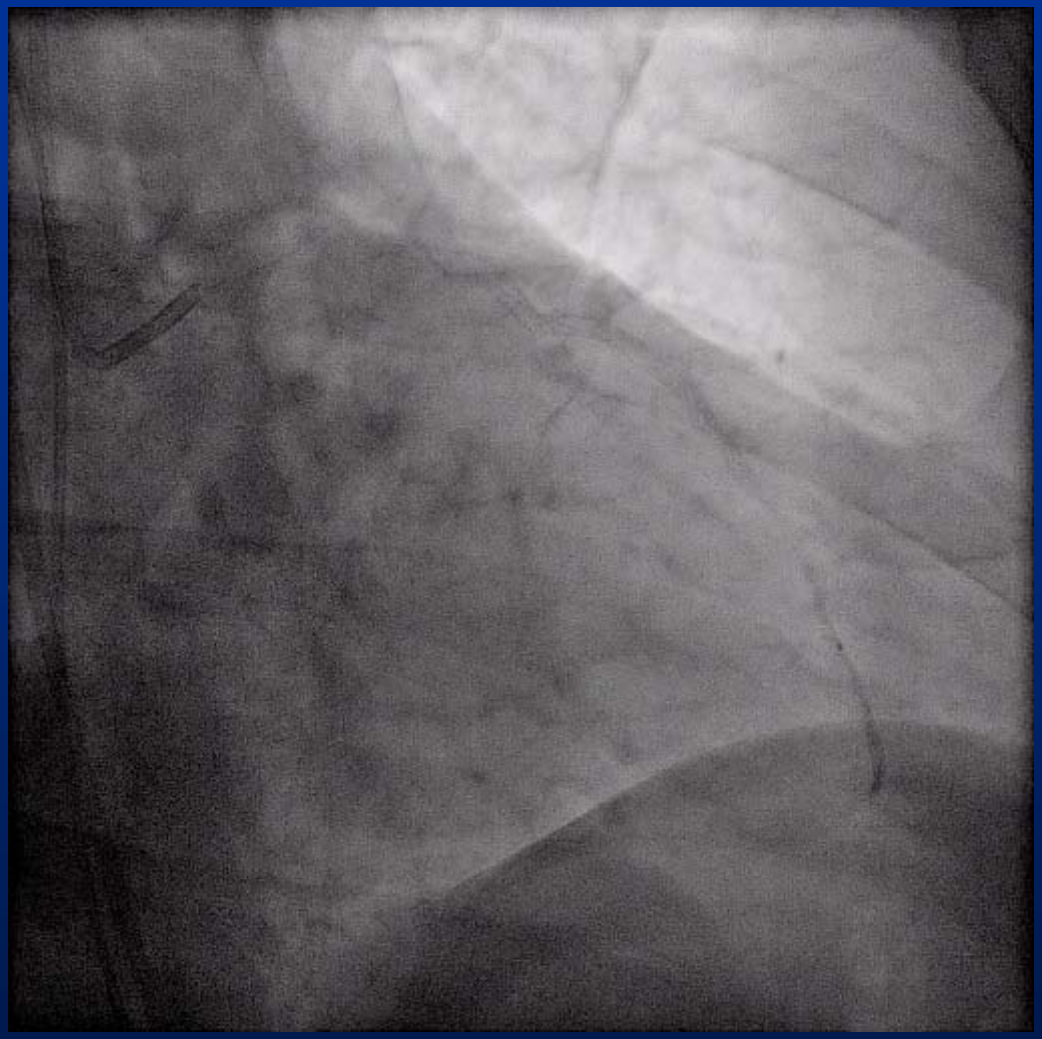


Confirm my guess with tip – injection – yes definitely no distal obstruction

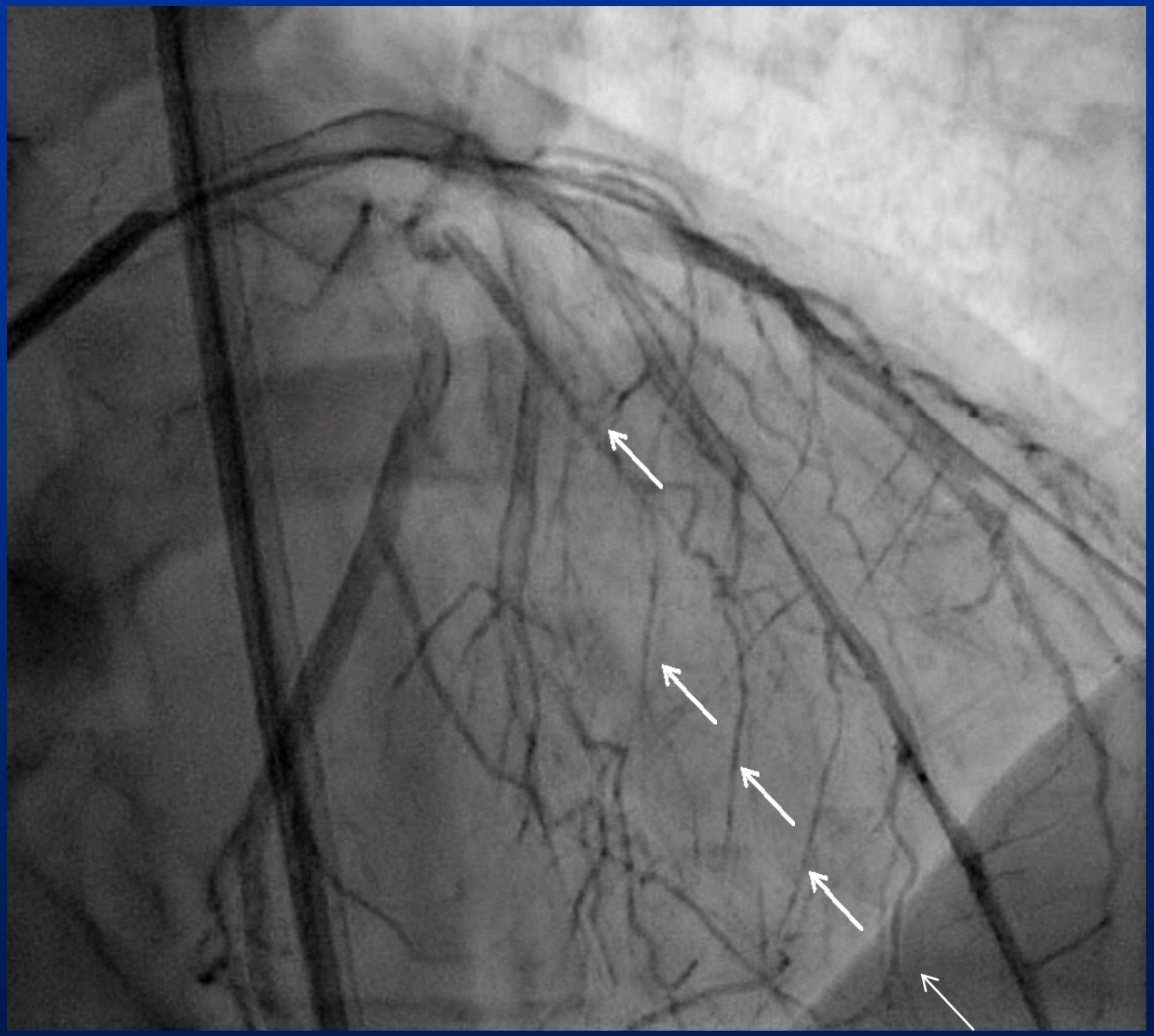


After 3rd stent, Nobori 3.0 x 15 proximal

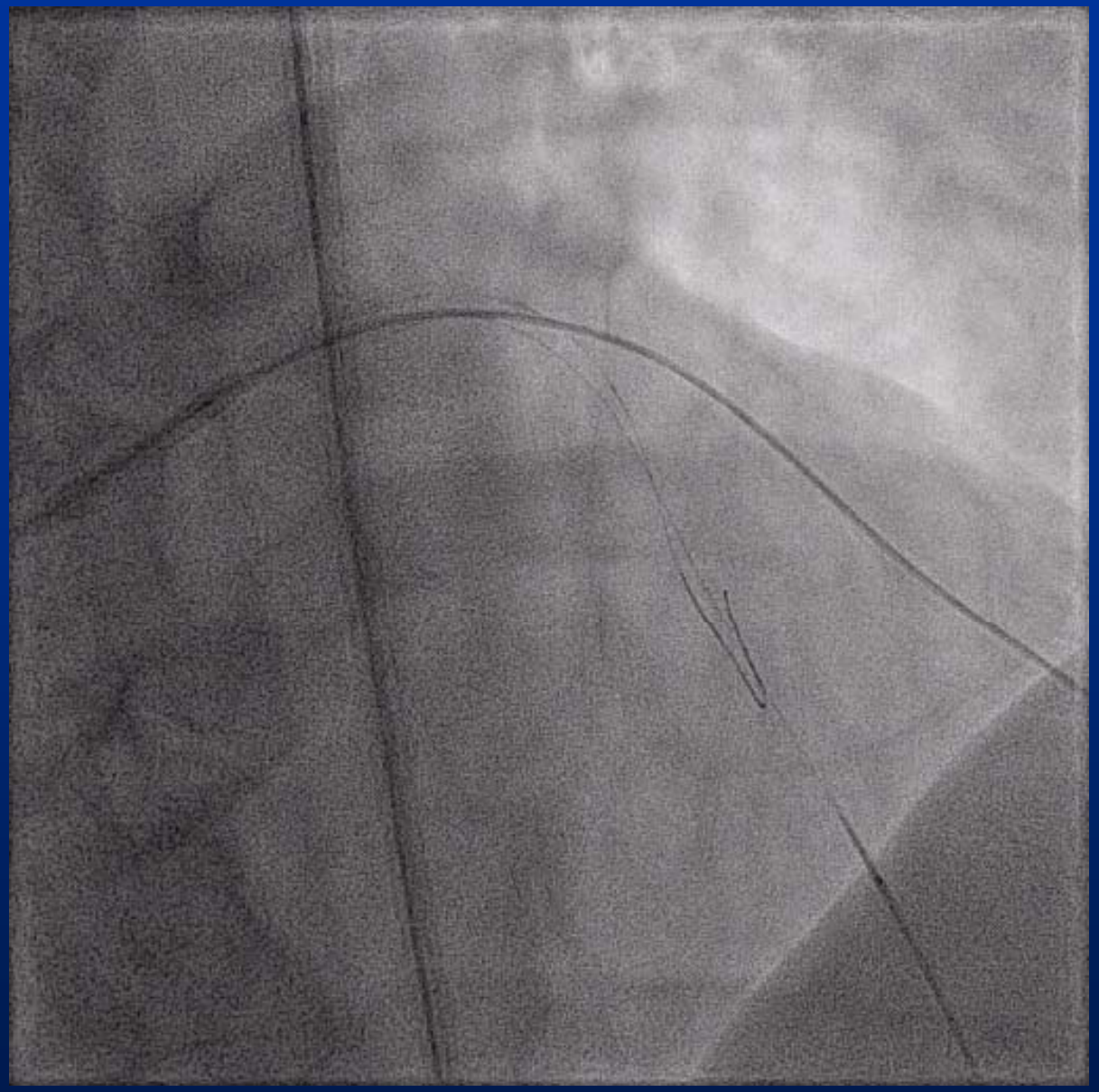




And review of last tip – injection: I stented the wrong channel: no SB left !



Review of the run after first ballooning



And that was the moment when it happened: STAR-like enterig of a predilated artery with a polimer wire…

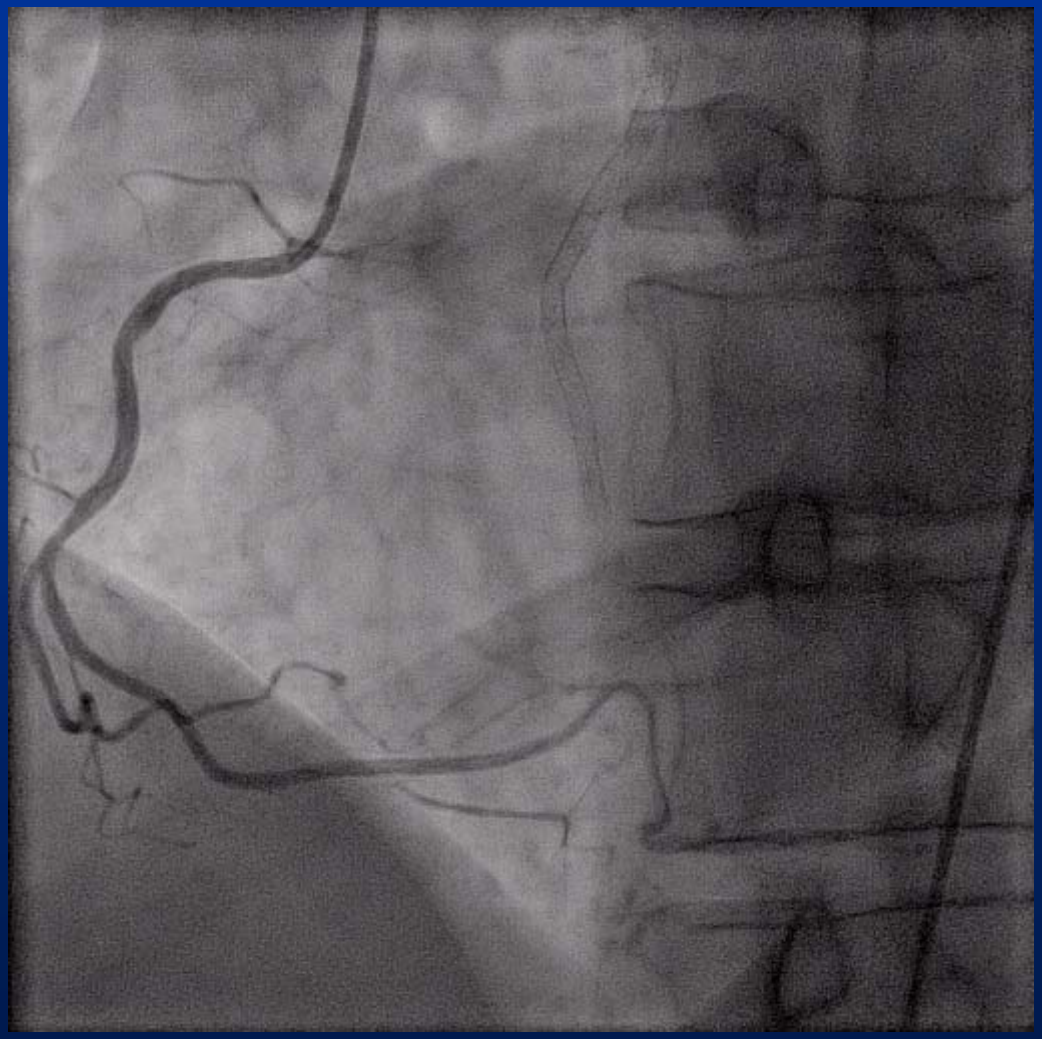
What now?

- No angina or ECG-changes
- The retrograde wire was pulled, the D1 collateral had disappeared, the vessel was torn
- The distal LAD no more an ideal target for CABG with this CCS 2 SVD patient

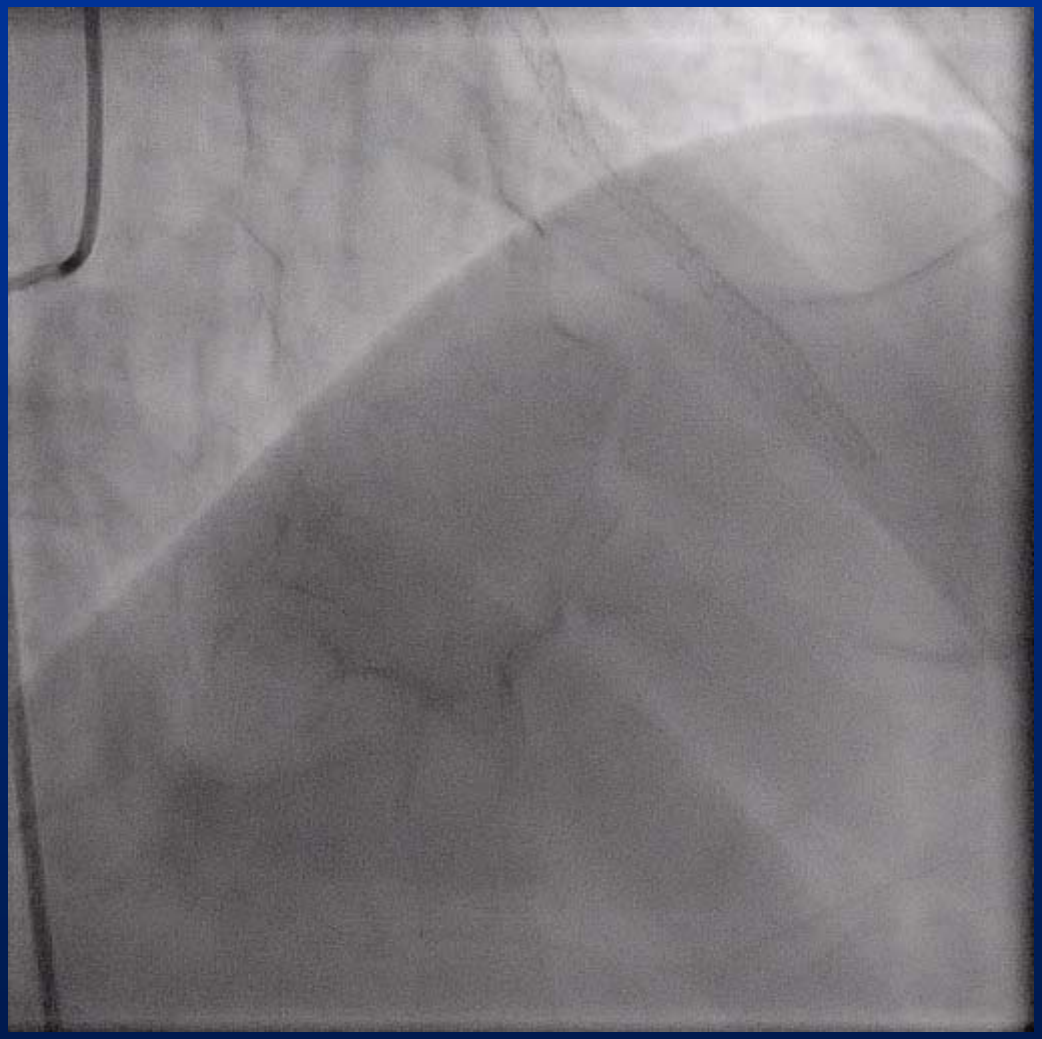
What now?

Reschedule in 6 weeks for an other retrograde attempt

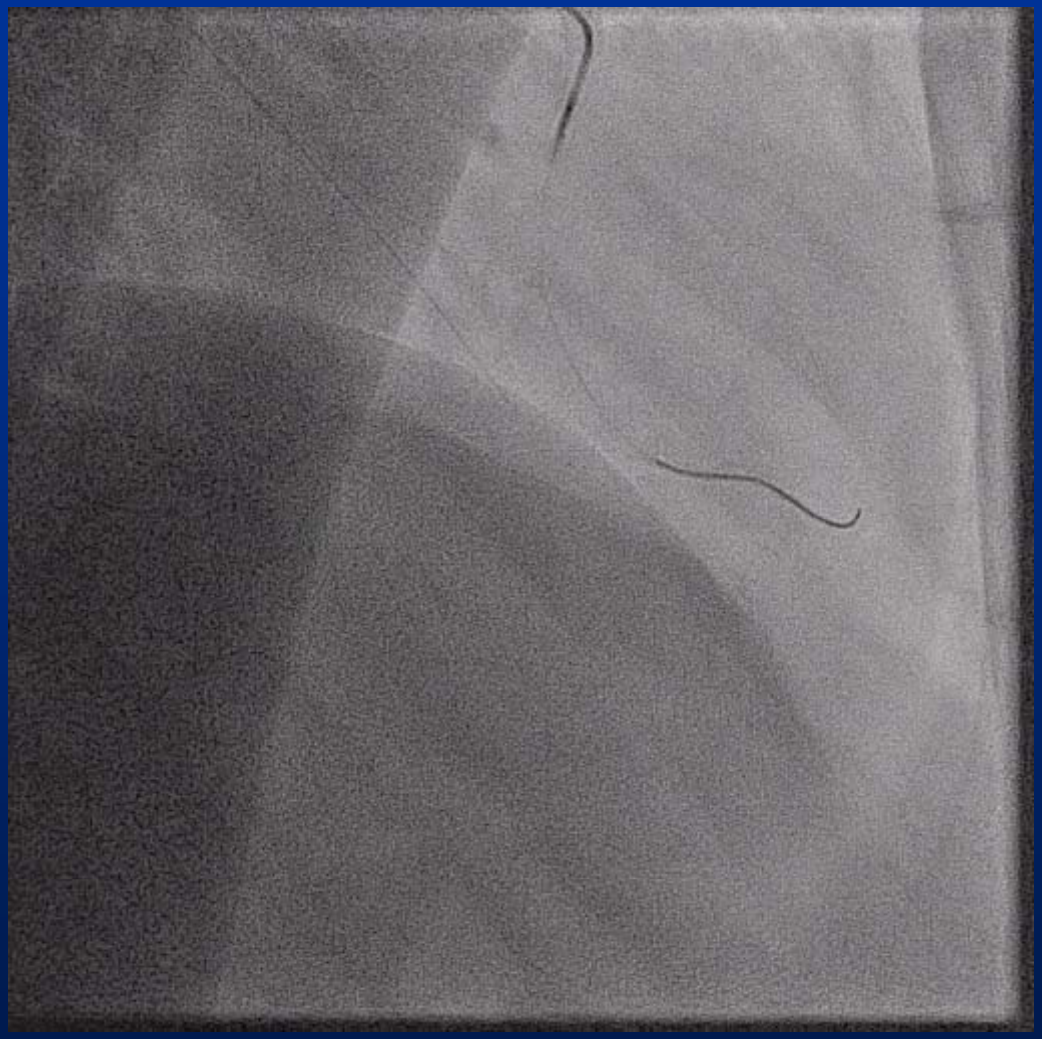
FU 24 hrs: cTnT +, no CK-rise



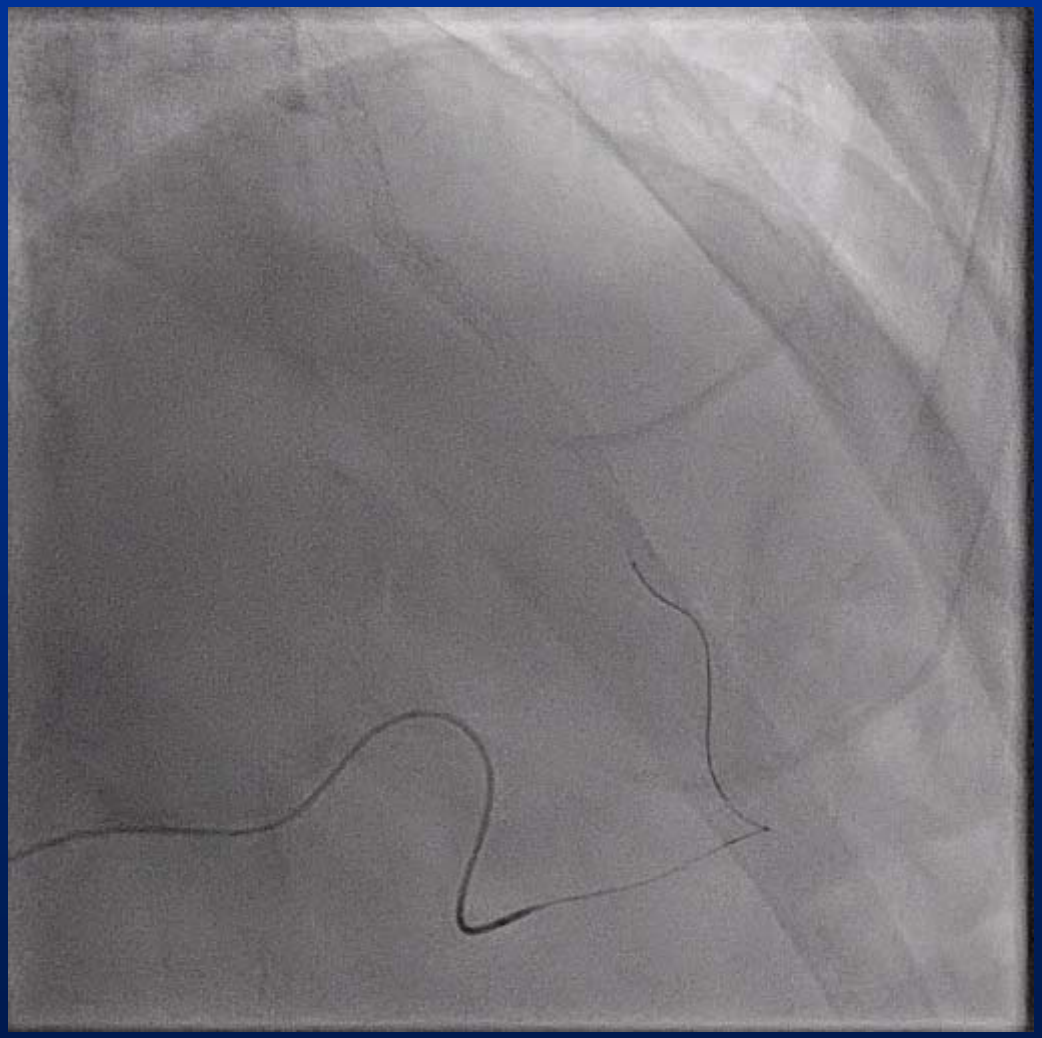
6 weeks later; still CCS 2



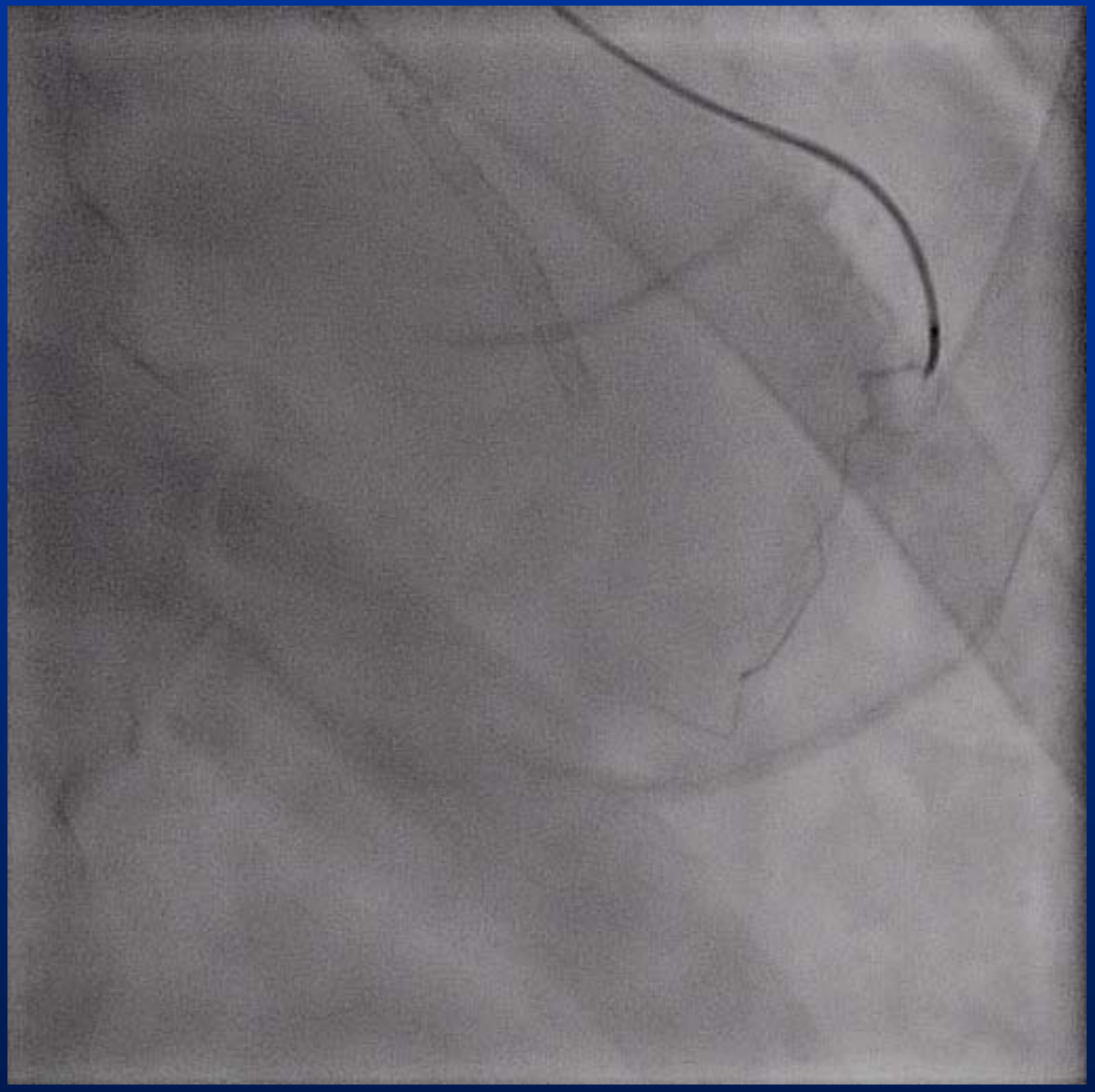
Collaterals from RCA increassed from CC1 to CC2



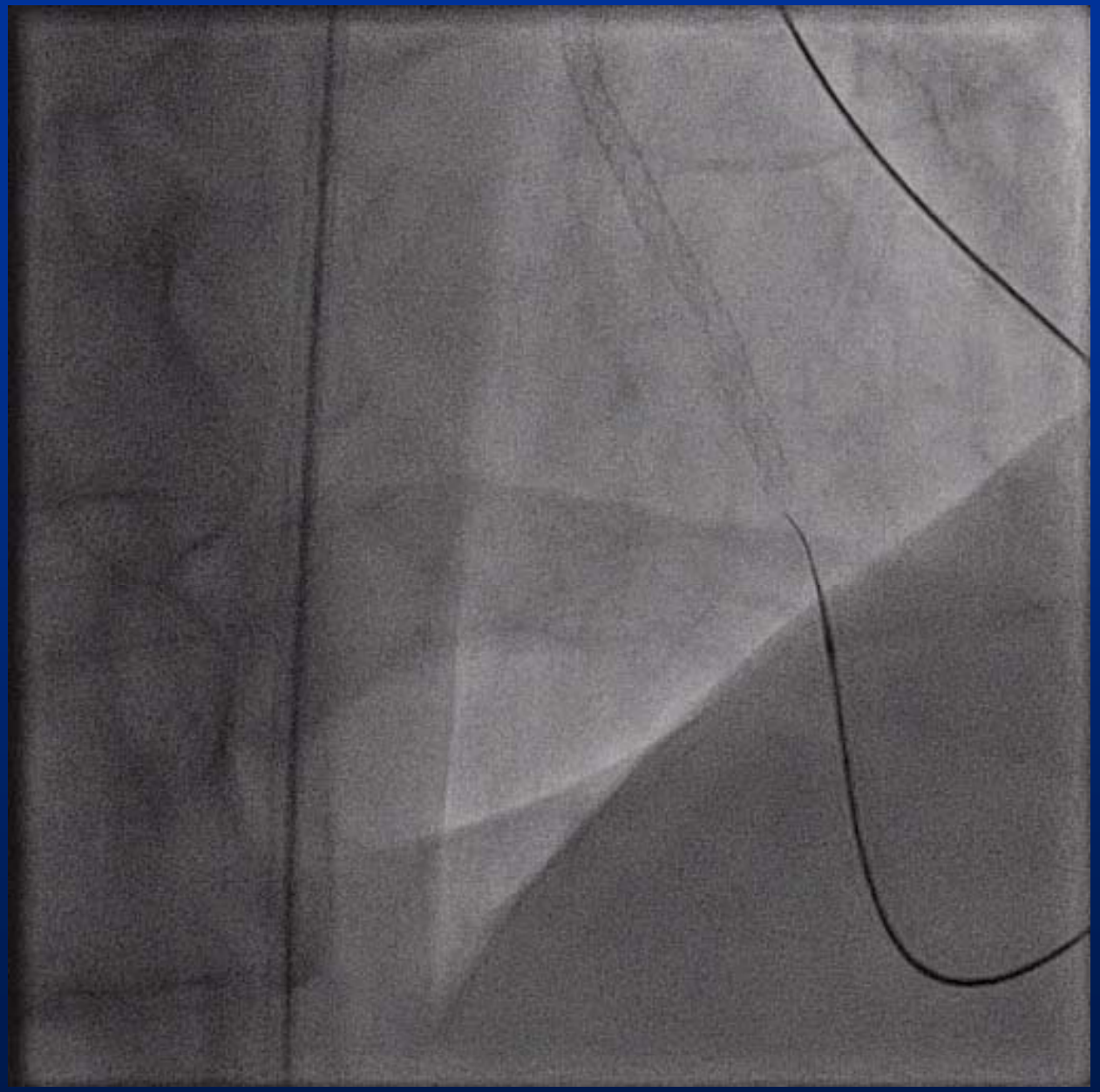
Collateral stems from RV branch



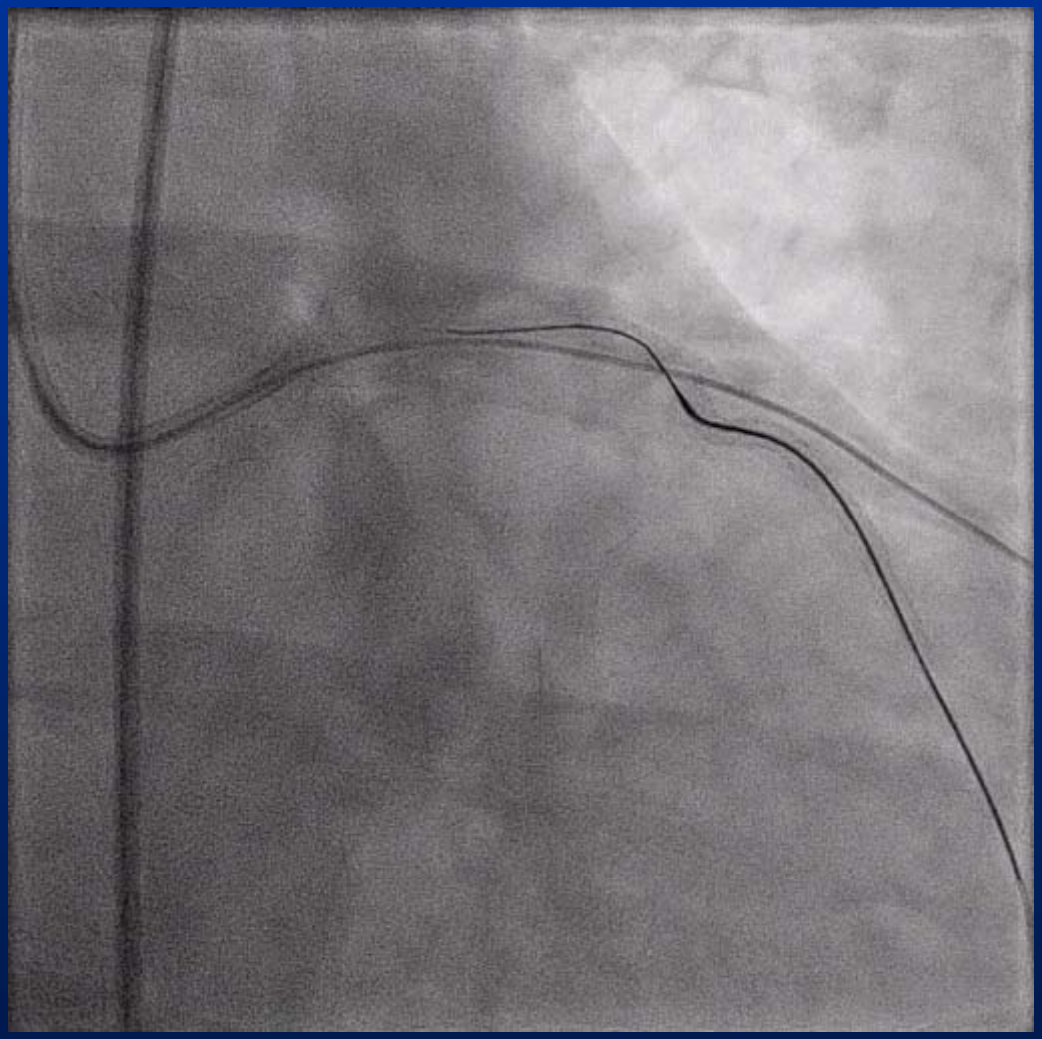
Cannot be crossed with Corsair



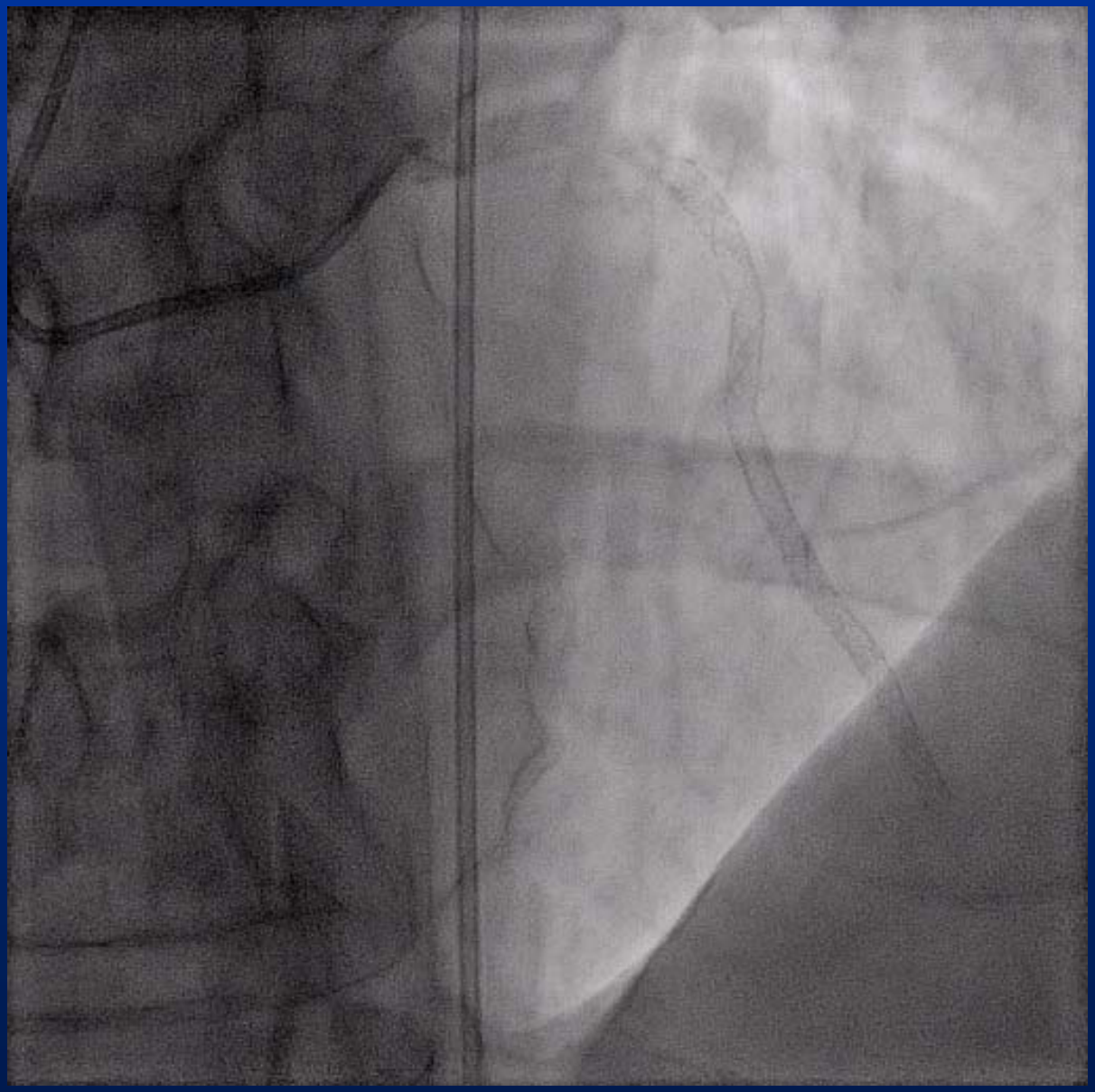
D1-LAD collateral had disappeared but was visible upon tip-injection



Selected with Whisper/Corsair and then punctured with Confianza 12



Entering prox LAD/LM/guide with Ultimate



Final result after dilation + adding a 3.0 x 15 distal to stents

6 messages to keep in mind

1. Polimer wires are a bad choice to reenter freshly dilated coronary arteries
2. A nice vessel upon selective injection may be a nice false channel – watch out for SB
3. Dont stent the false channel from top to bottom – by no means
4. Consider retrograde repuncture to correct the mistake
5. A collateral that „disappears“ is still present and suitable for retrograde aproach

6. Seeing is believing

But can you always believe what you see ?