

Retrograde Approach in CTO : Septal Channel Use

Hakujikai Memorial Hospital
Yasushi Asakura M.D.

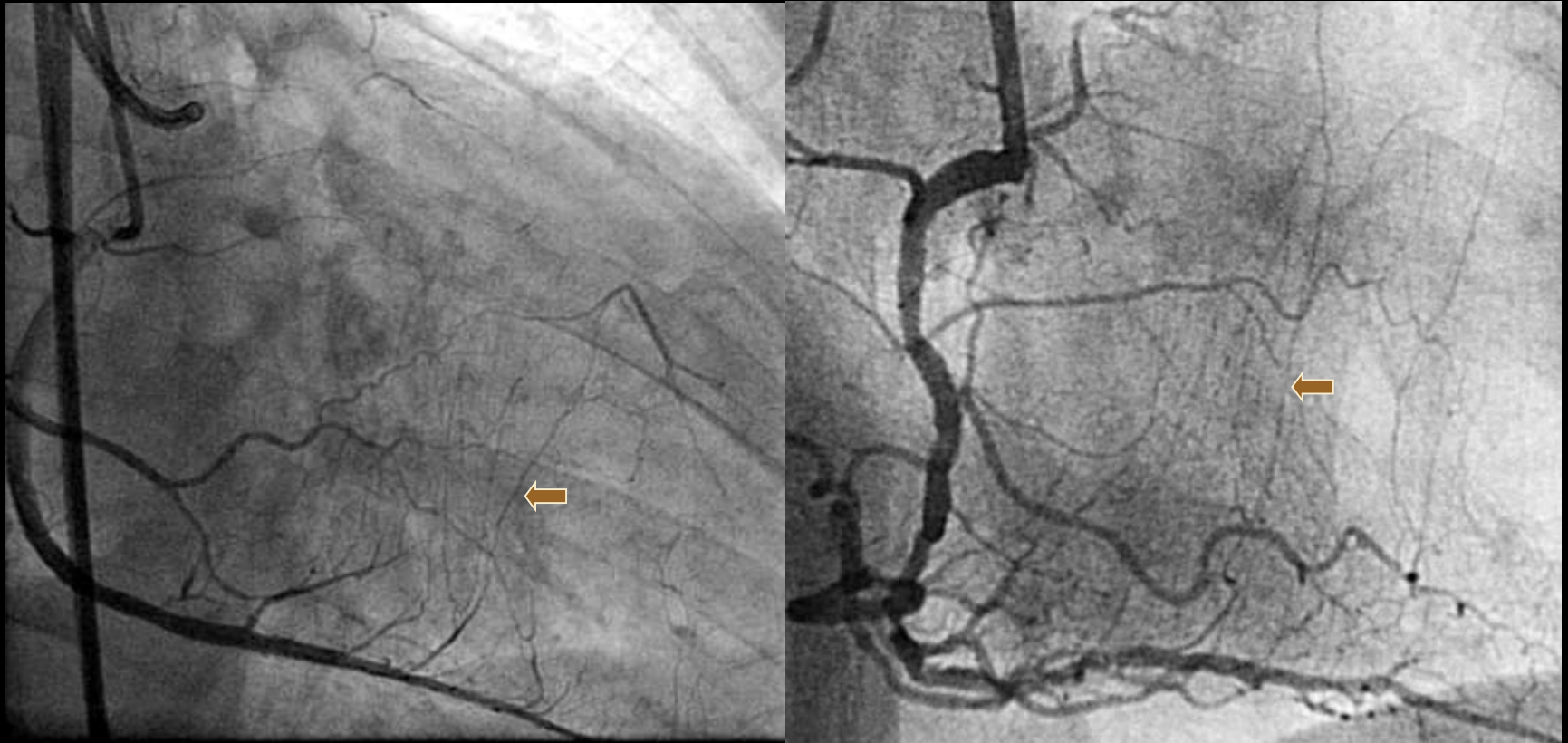




CC grade Aspect

Septal collateral with CC 1

Septal collateral with CC 2



Continuous connection: grade CC1 and CC2

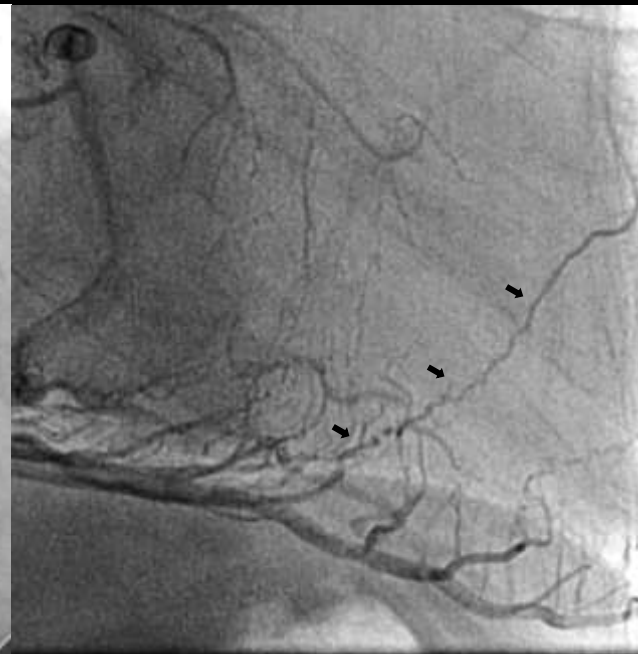
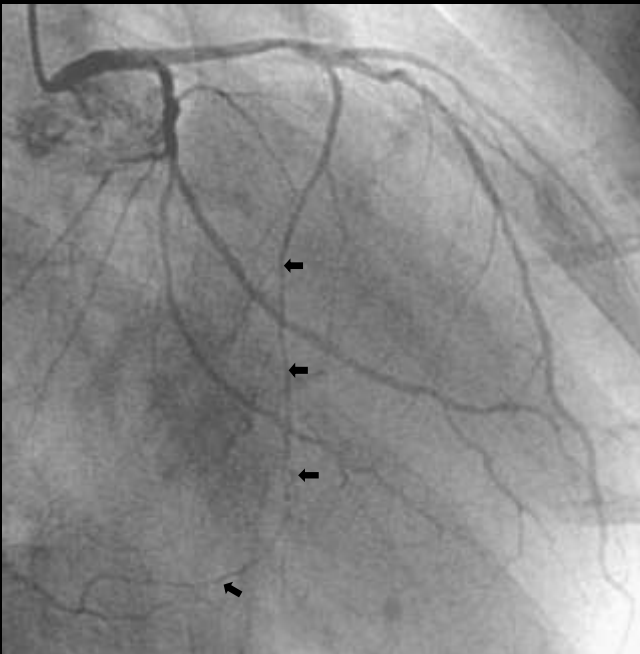


Tortuosity Aspect

Mild

moderate

severe

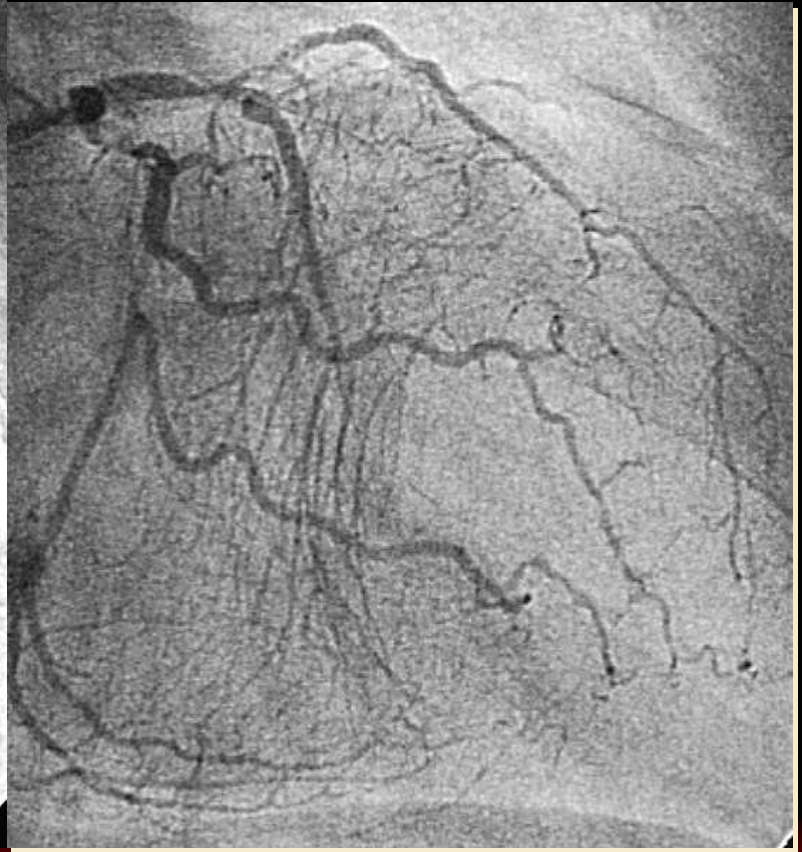
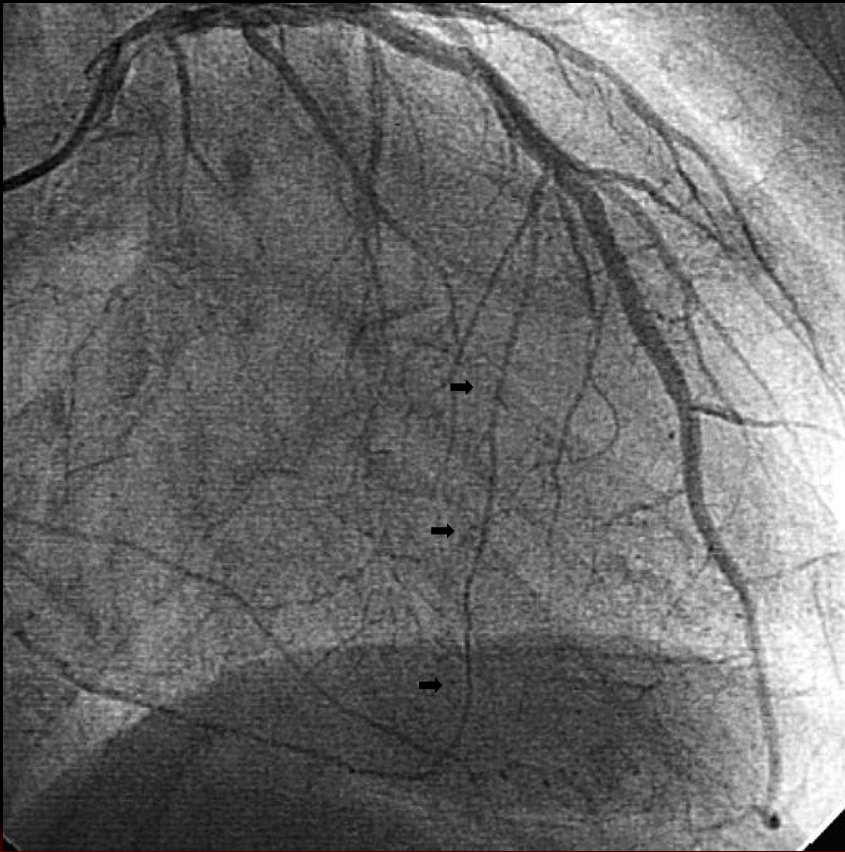




Branch Aspect

Non-branch

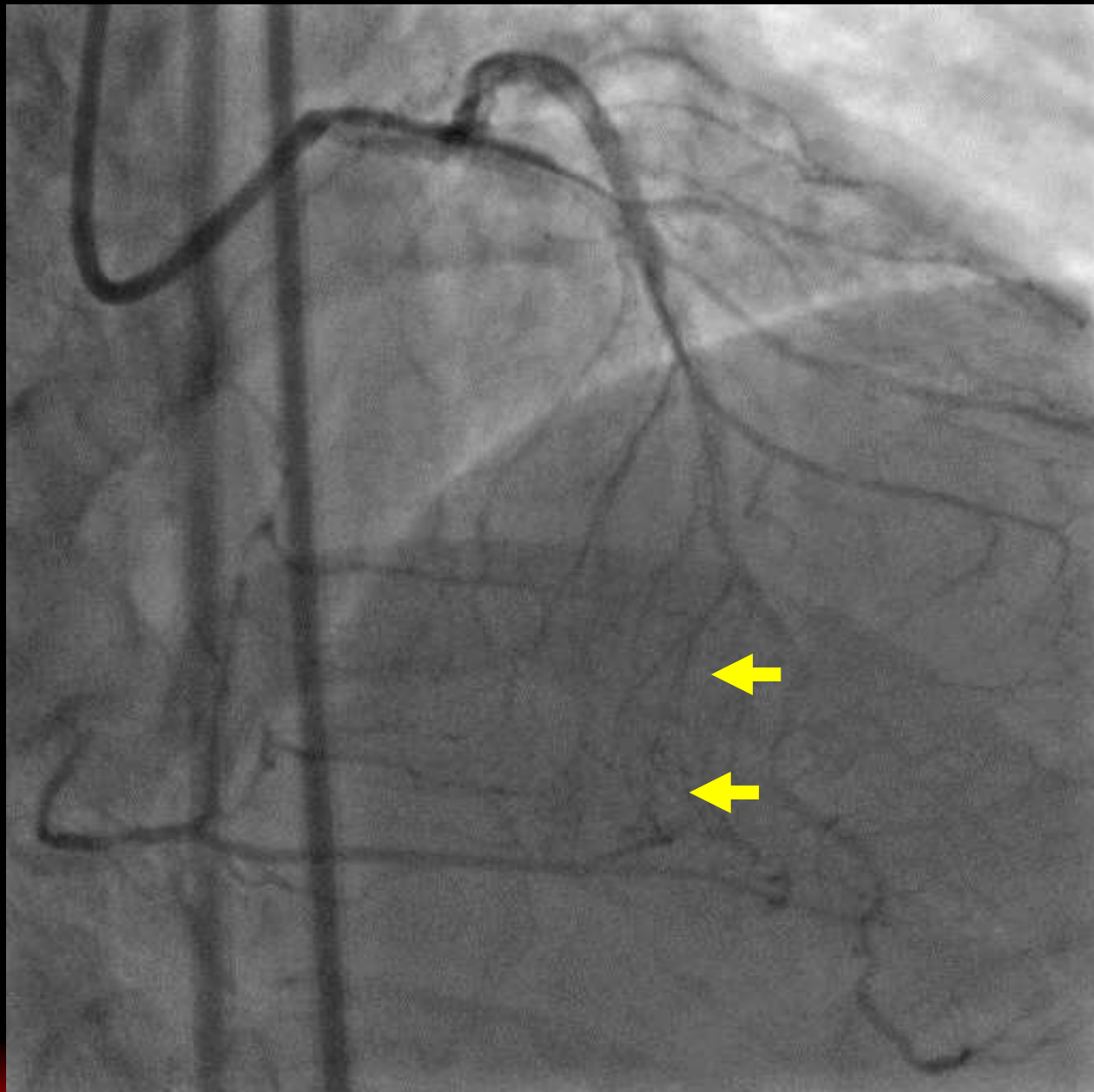
branch





Case Septal

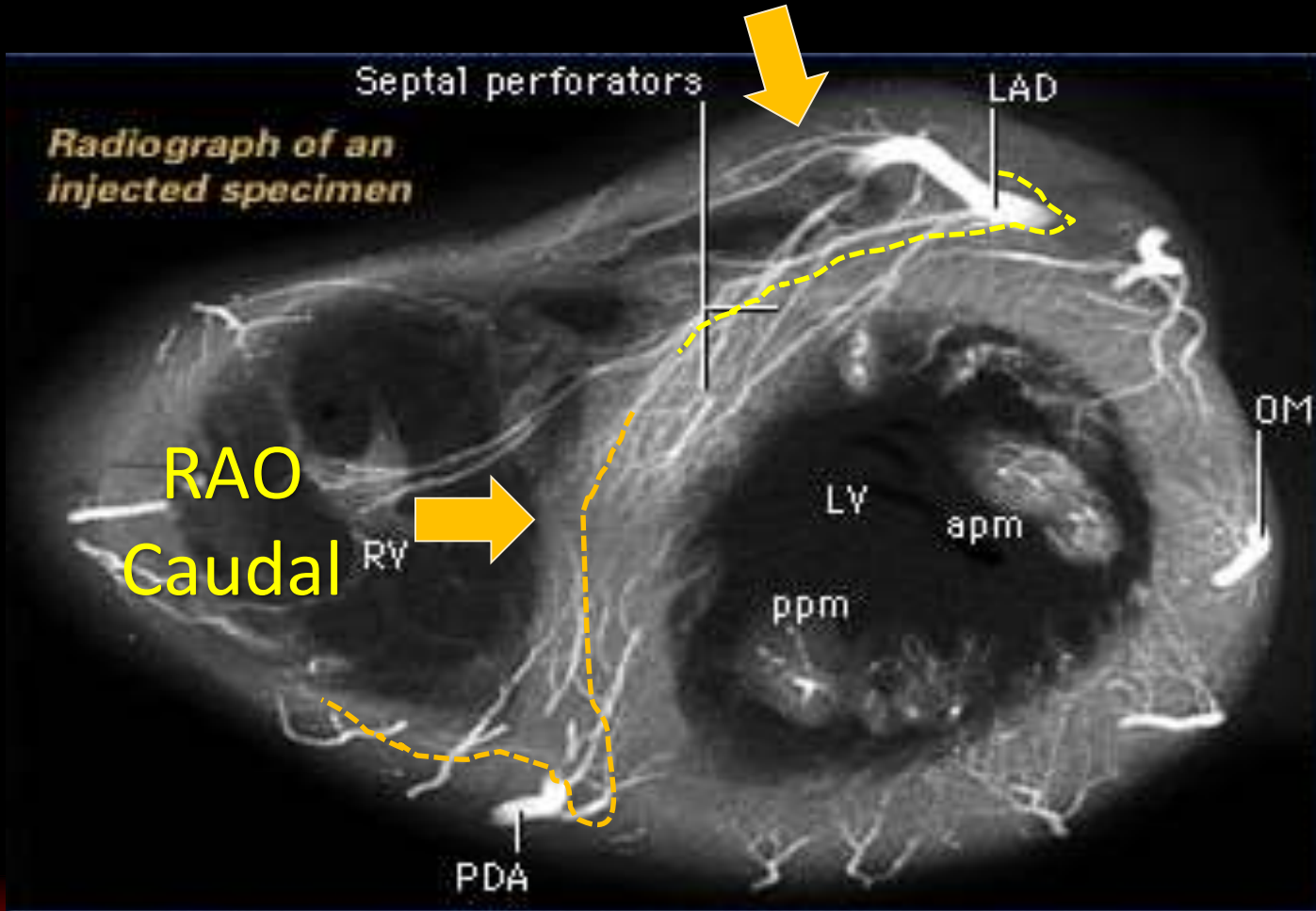
RAO Cranial





Anatomy of the Septal Channels

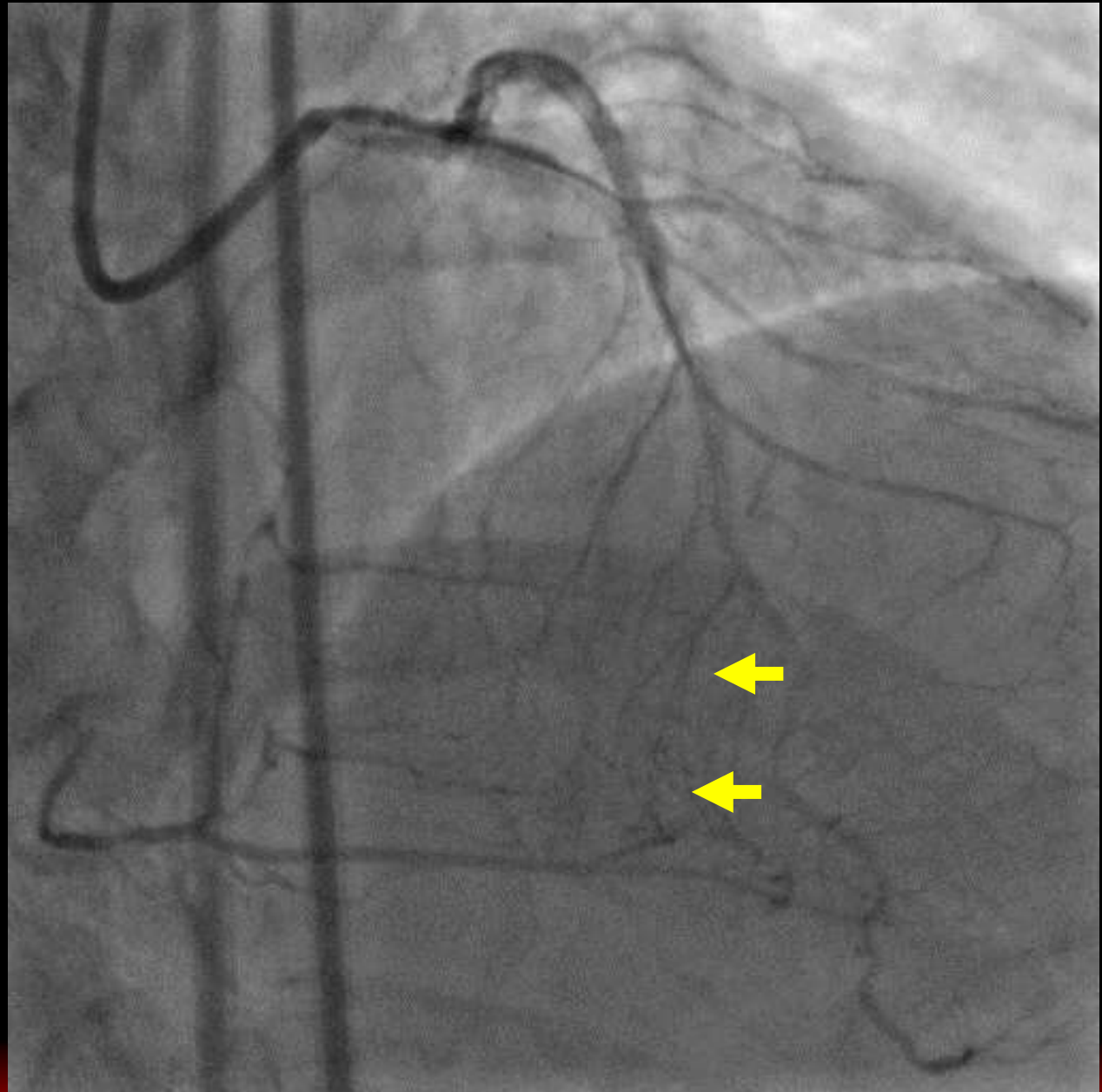
RAO Cranial





Septal

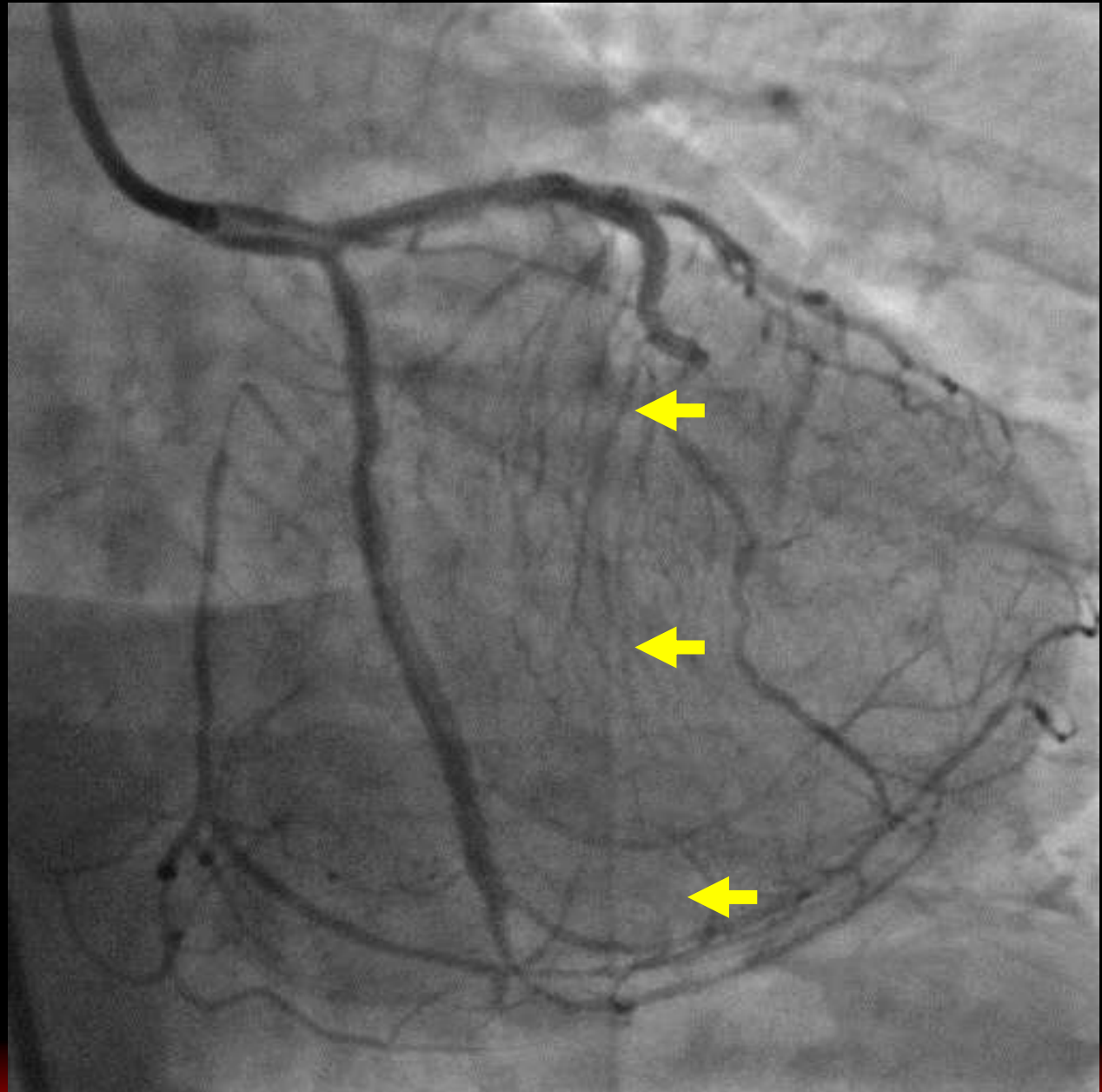
RAO Cranial





Septal

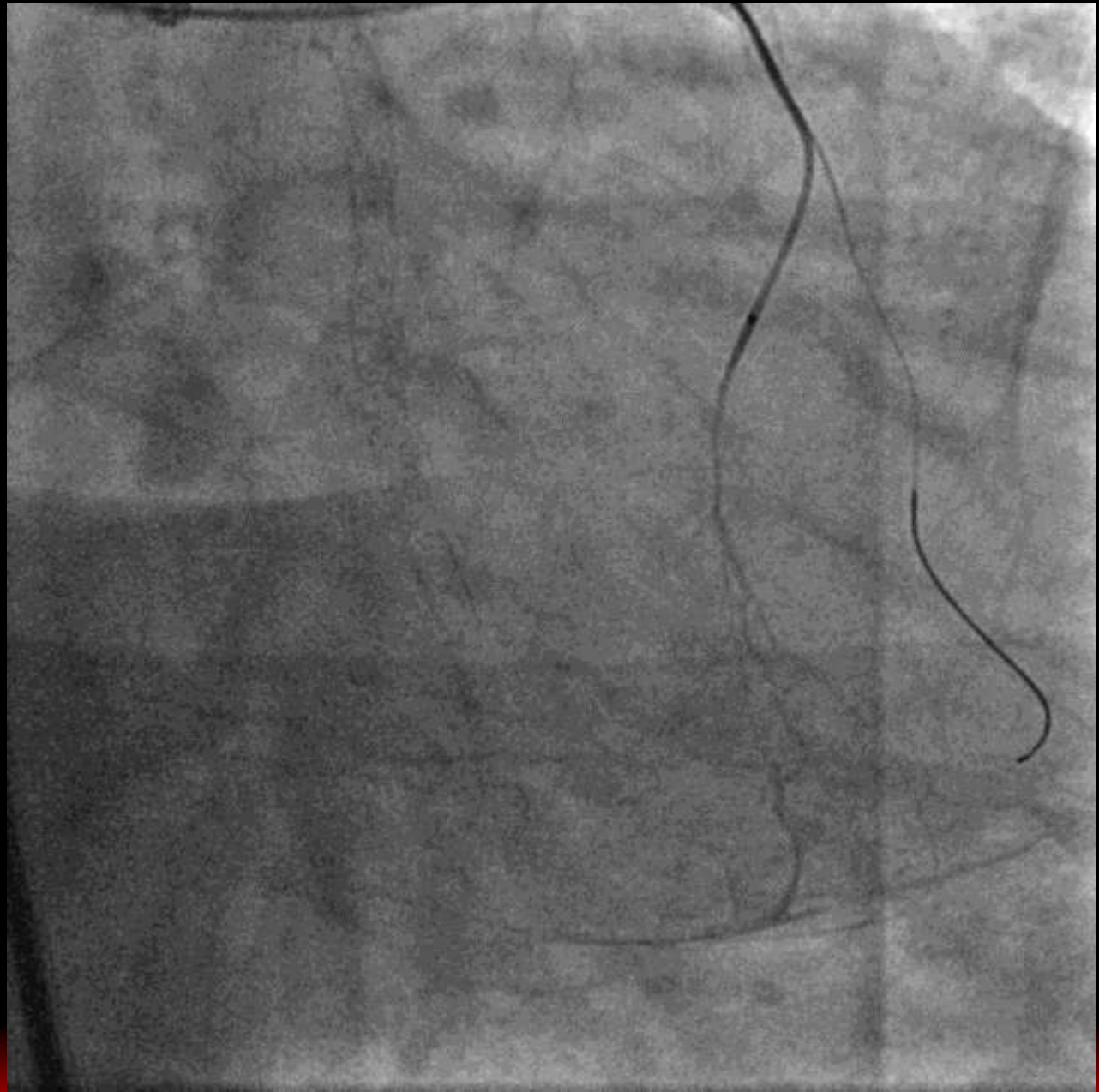
RAO Caudal





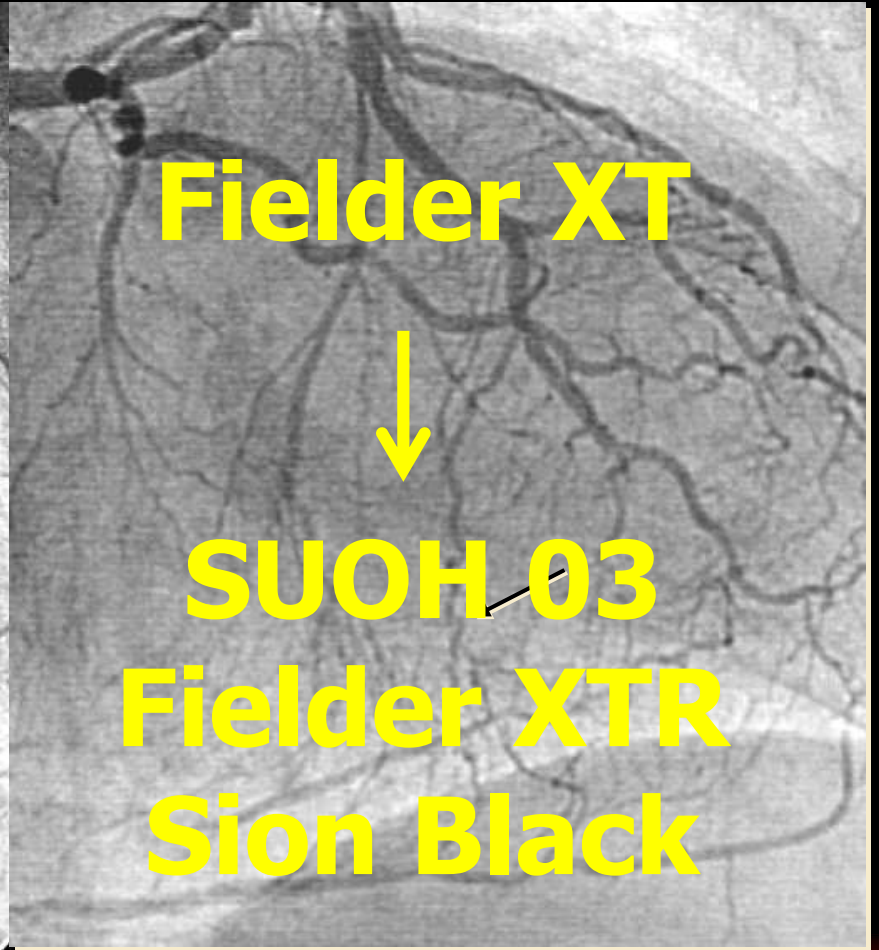
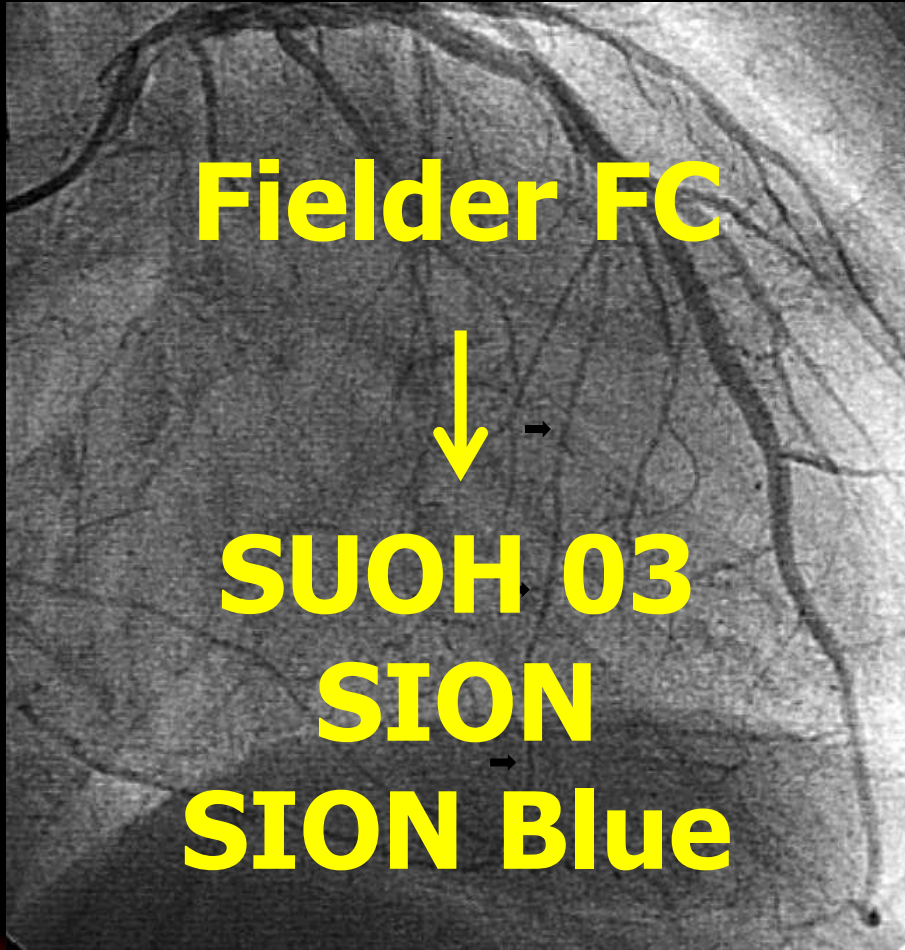
Septal

RAO Caudal



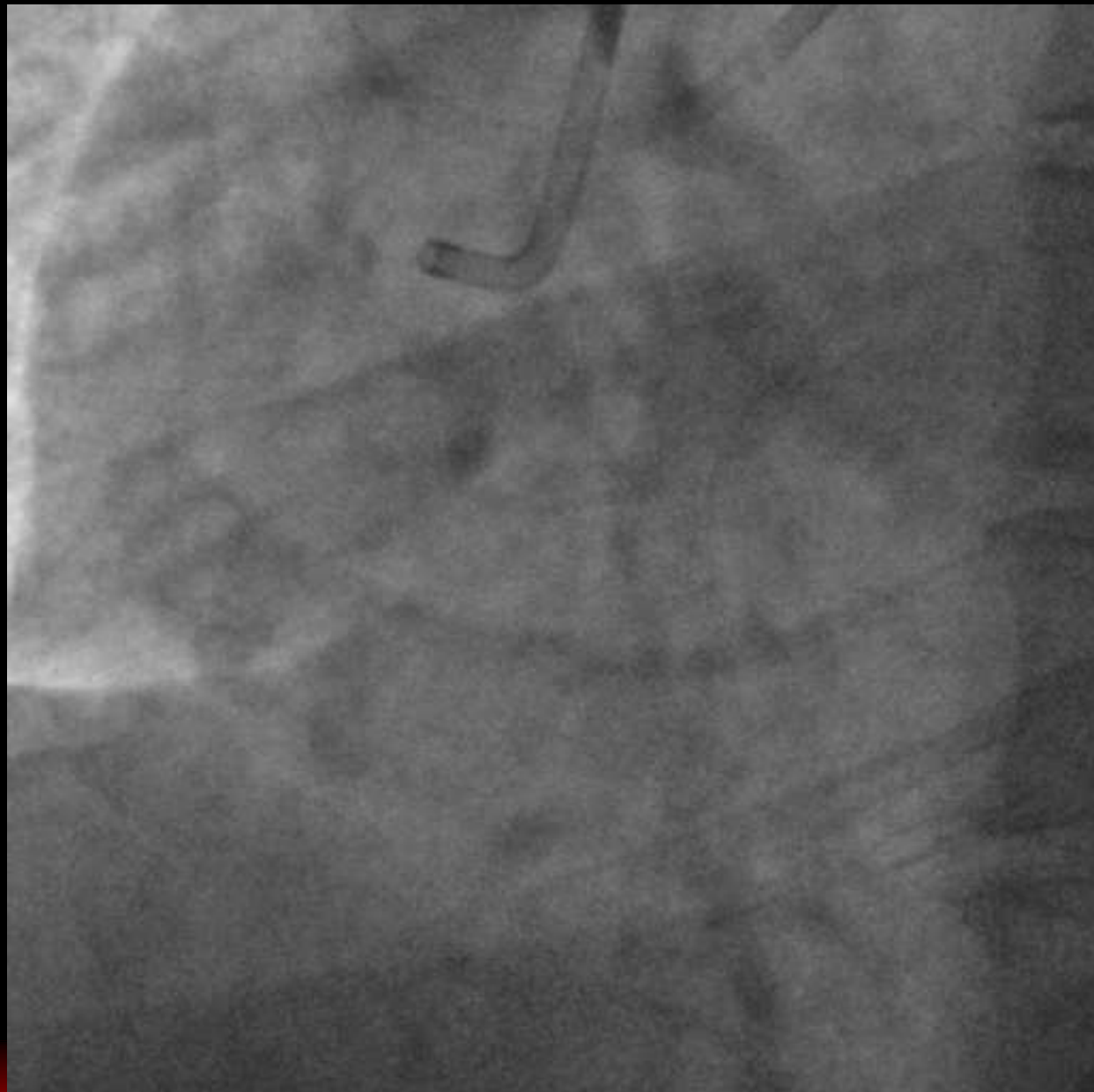


Septal Channel



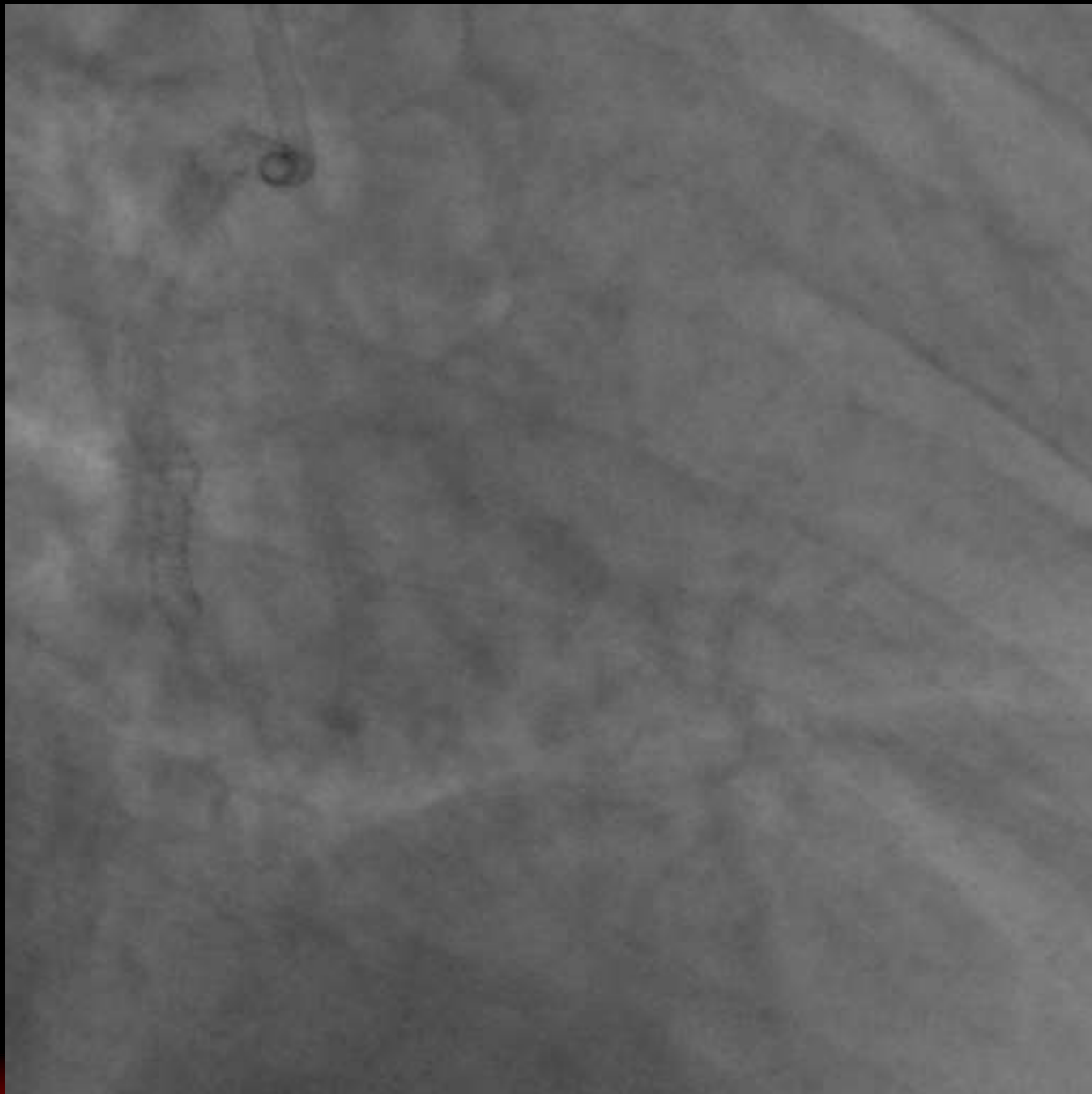


Case
Mid-RCA
CTO



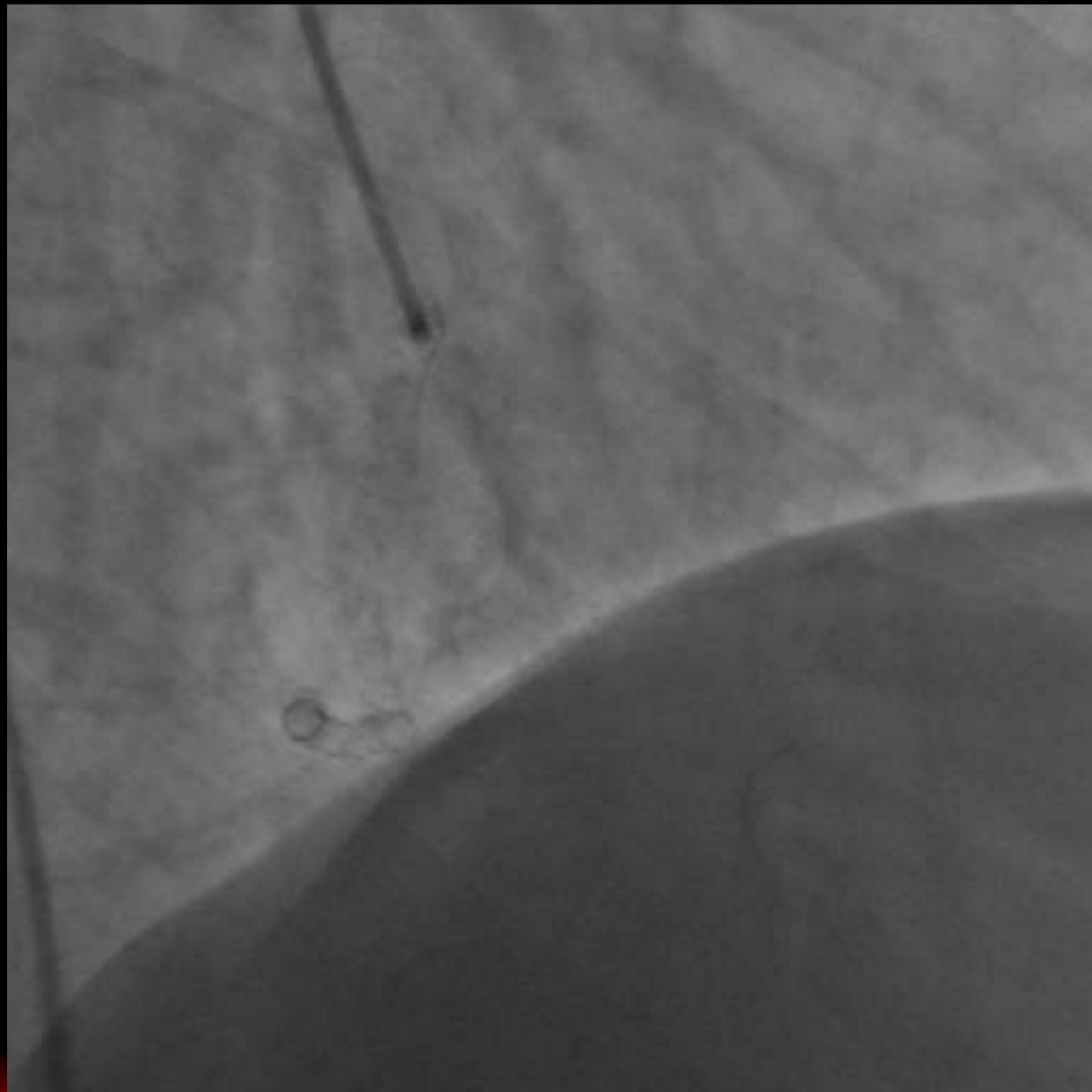


Final





3 Months Follow-up





6 Months Follow-up





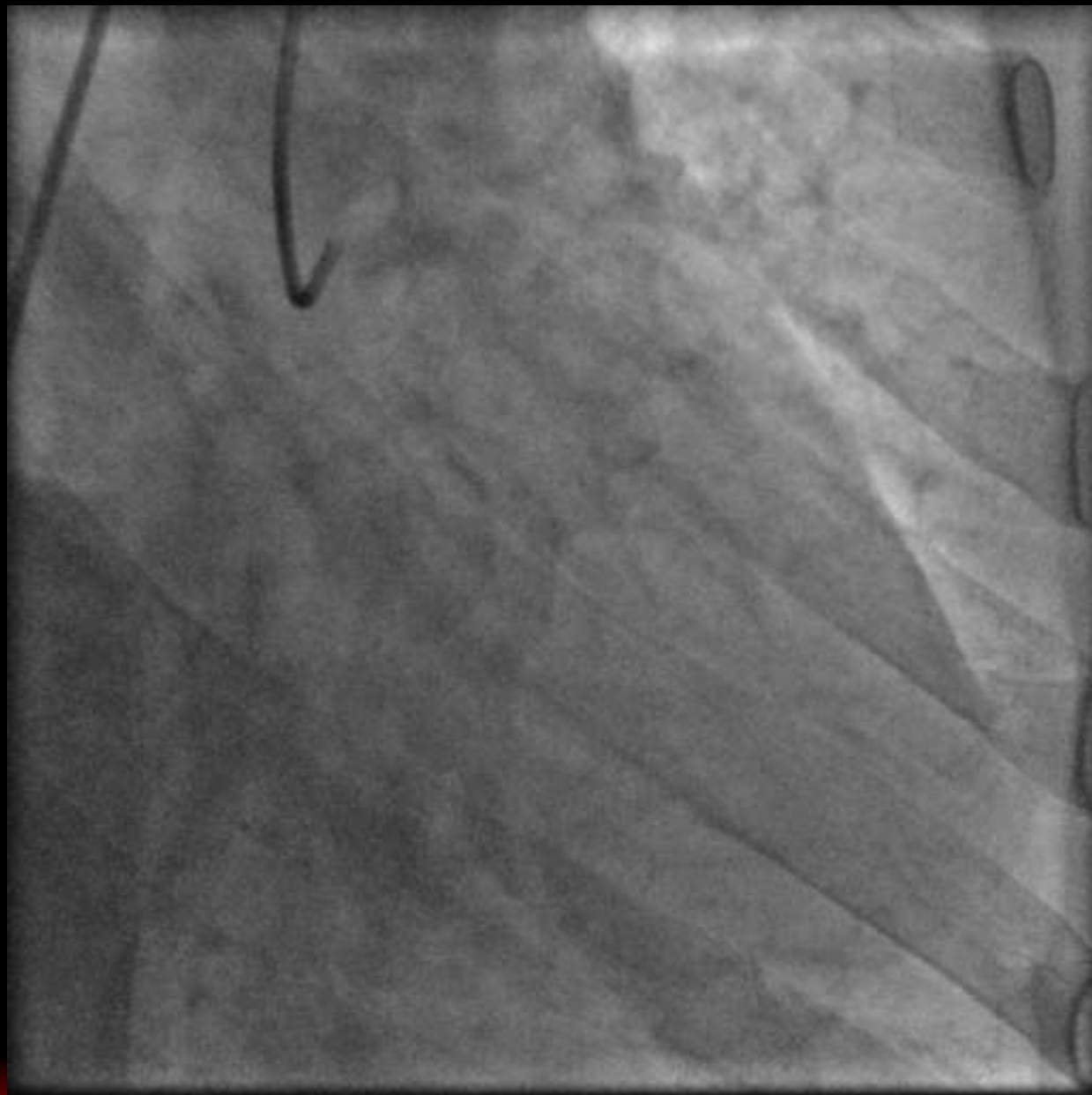
Case

LCA





LCA



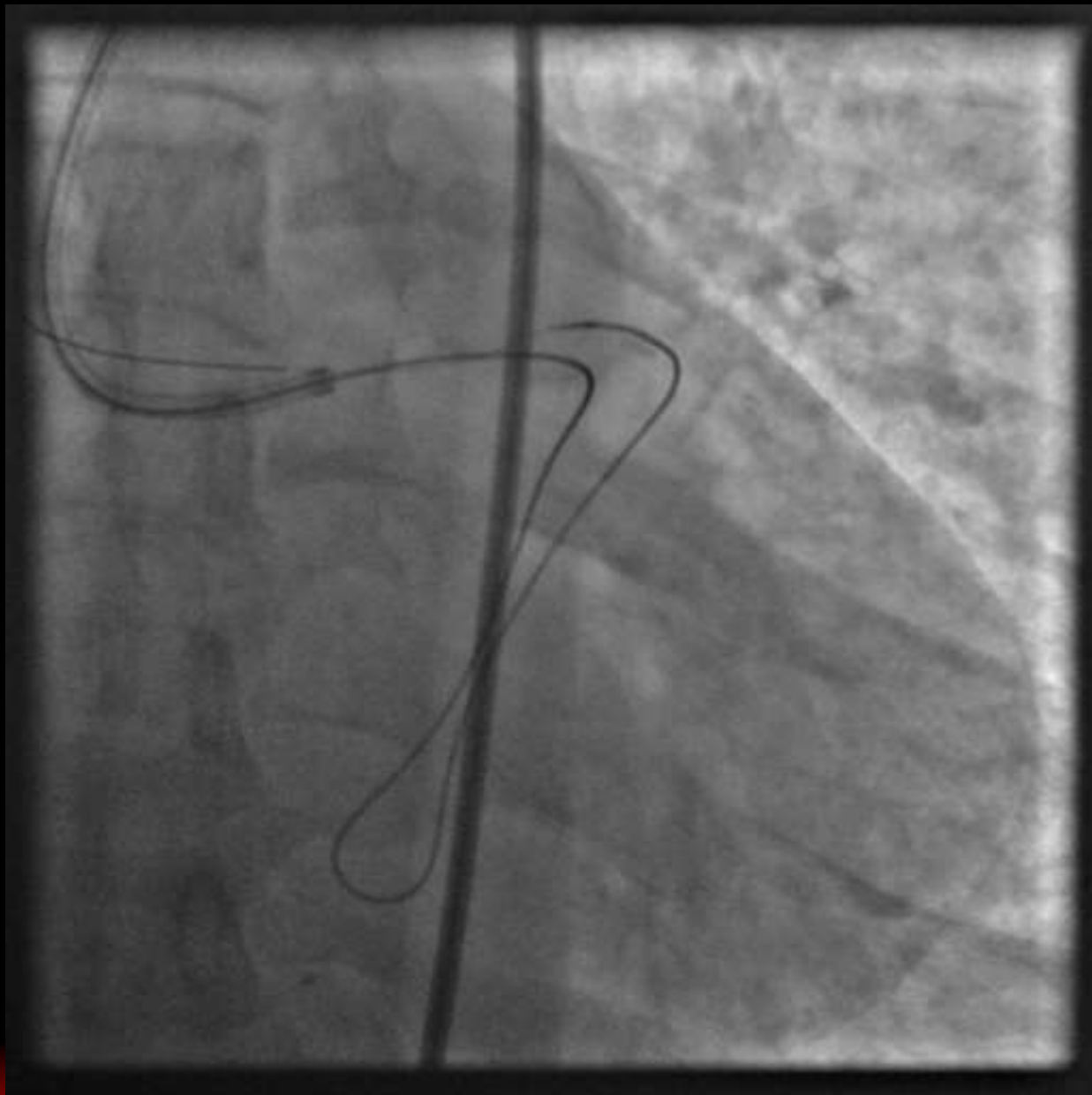


Retrograde Wiring with Corsair



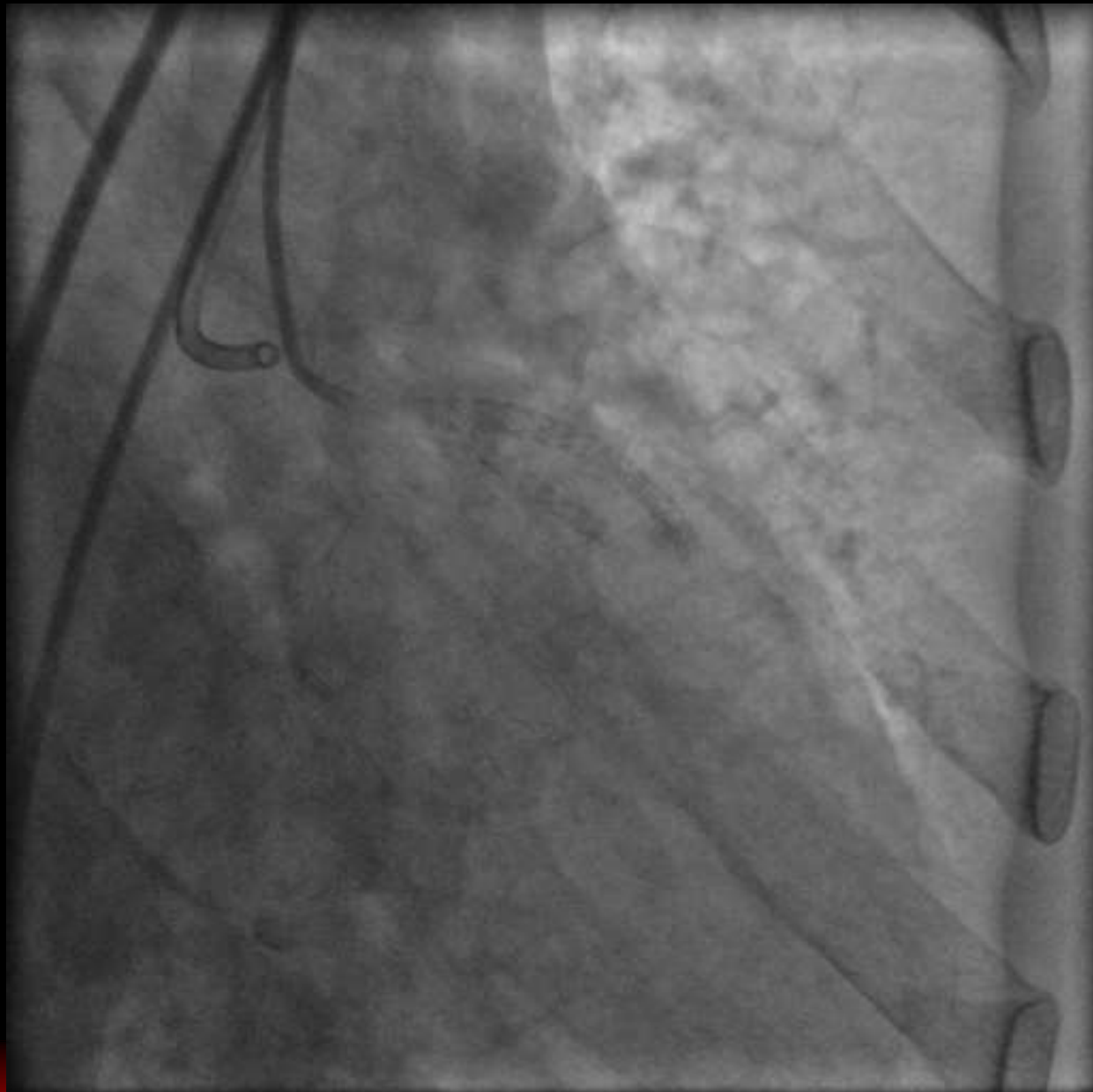


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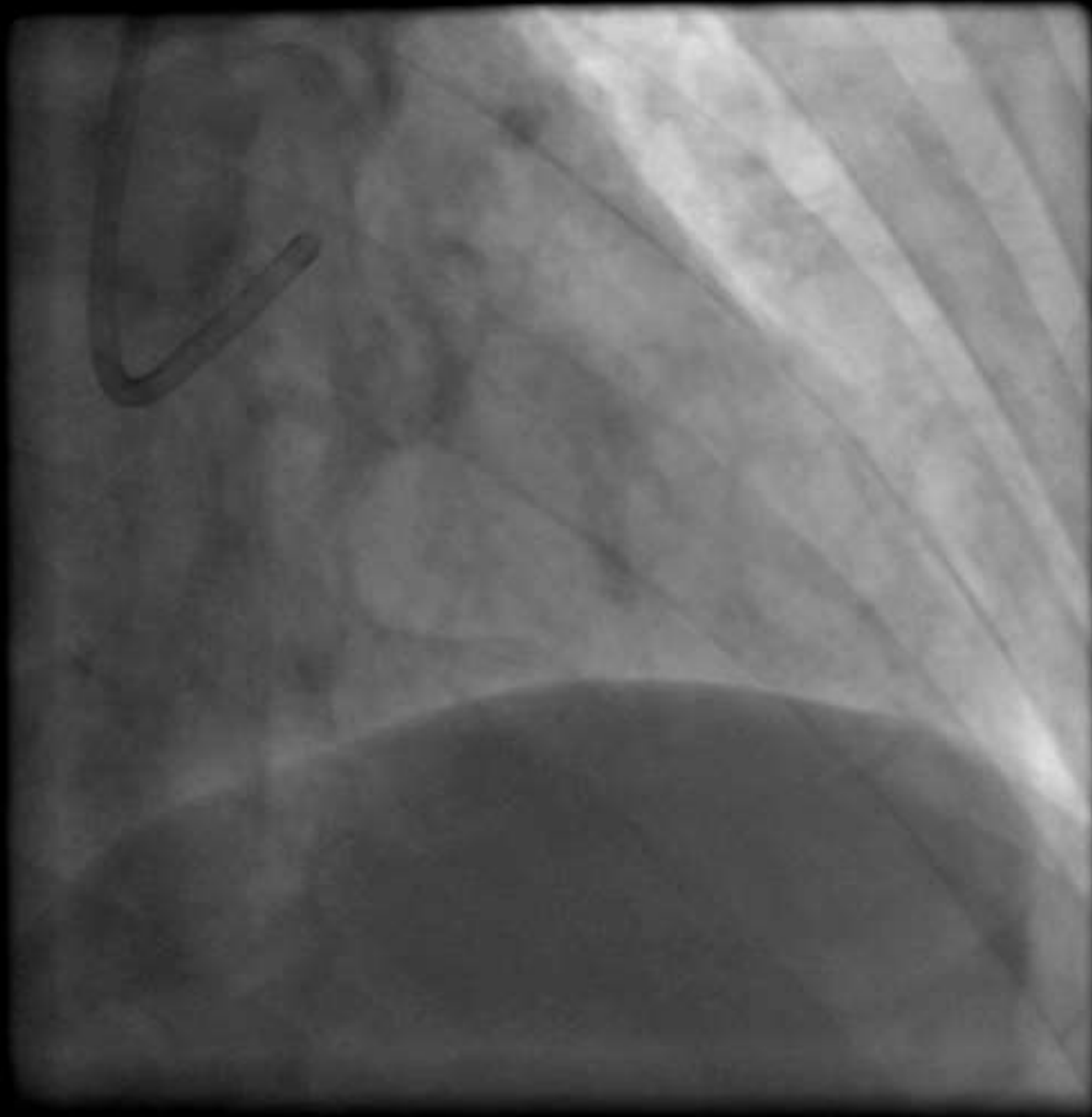


Final



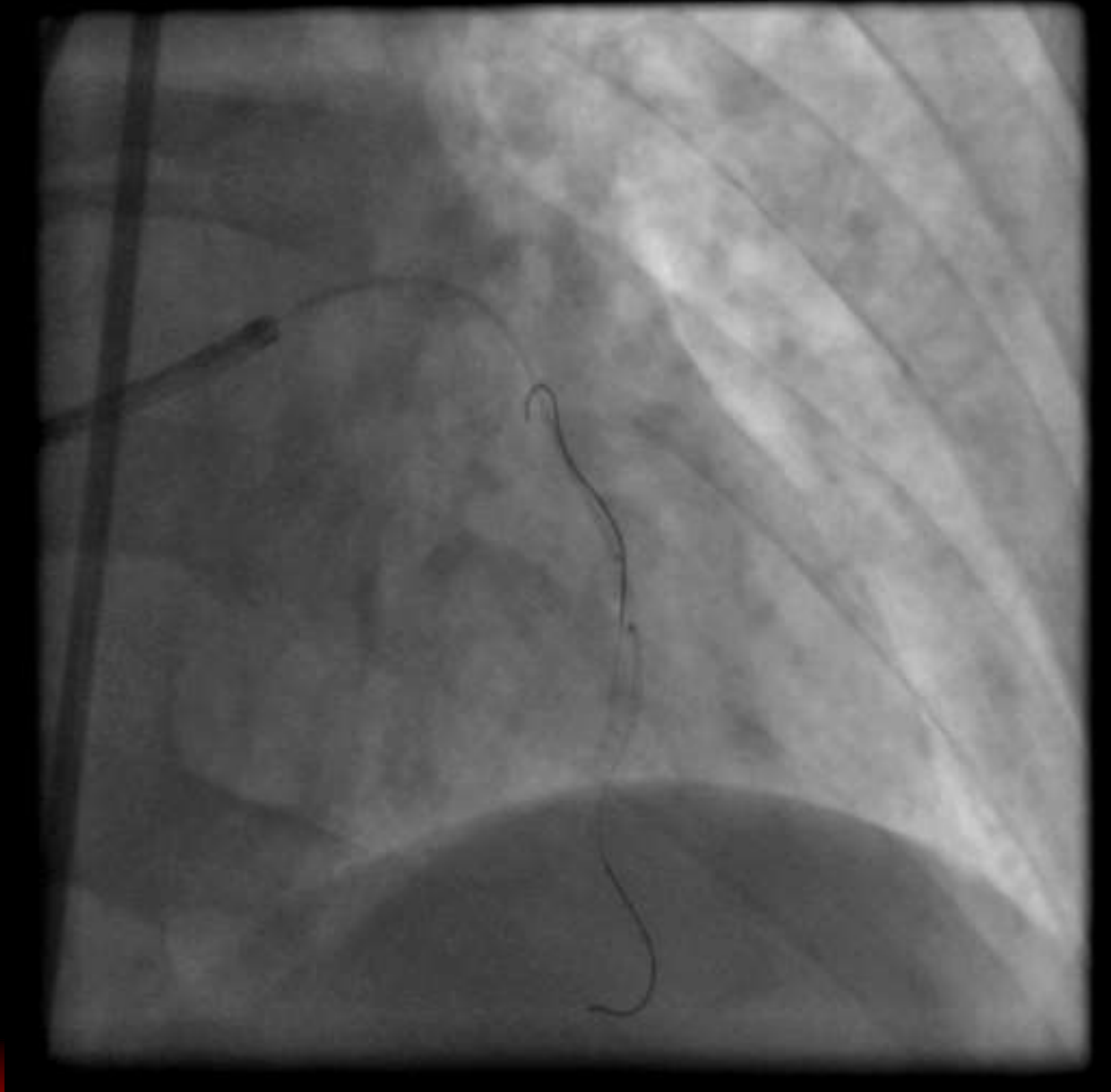


Case



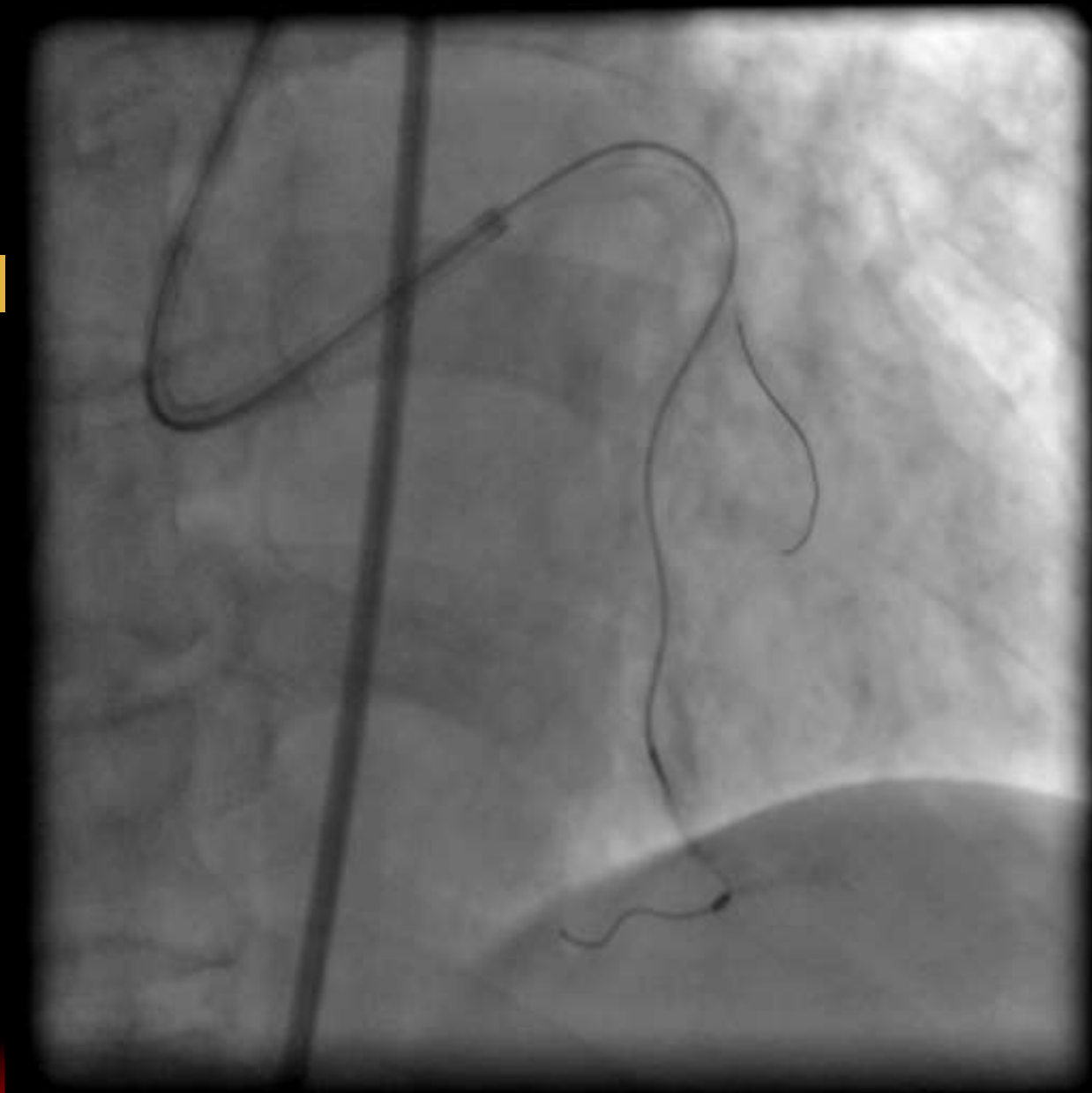


Reverse Wire Technique



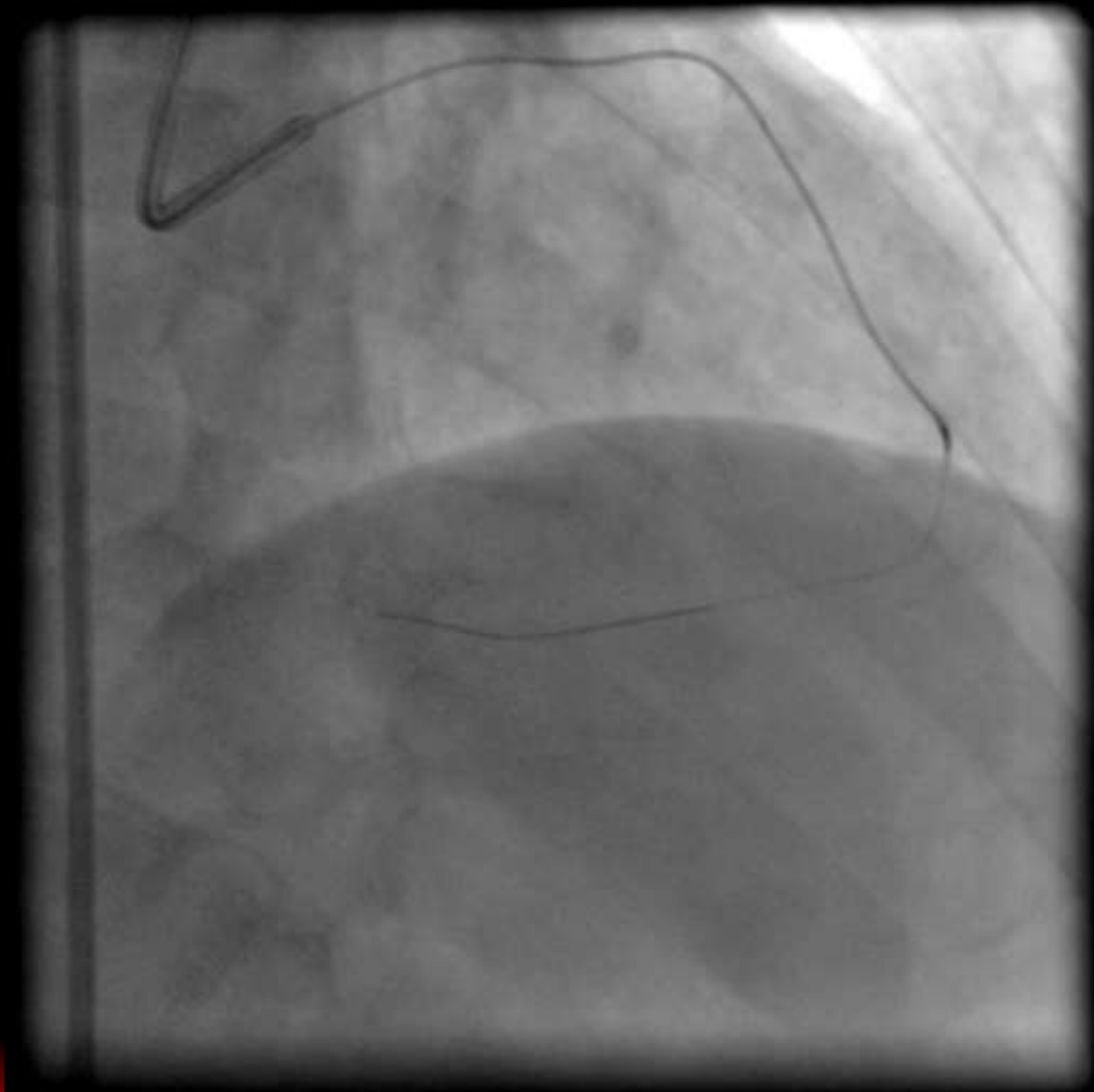


Unsuccessful Wiring



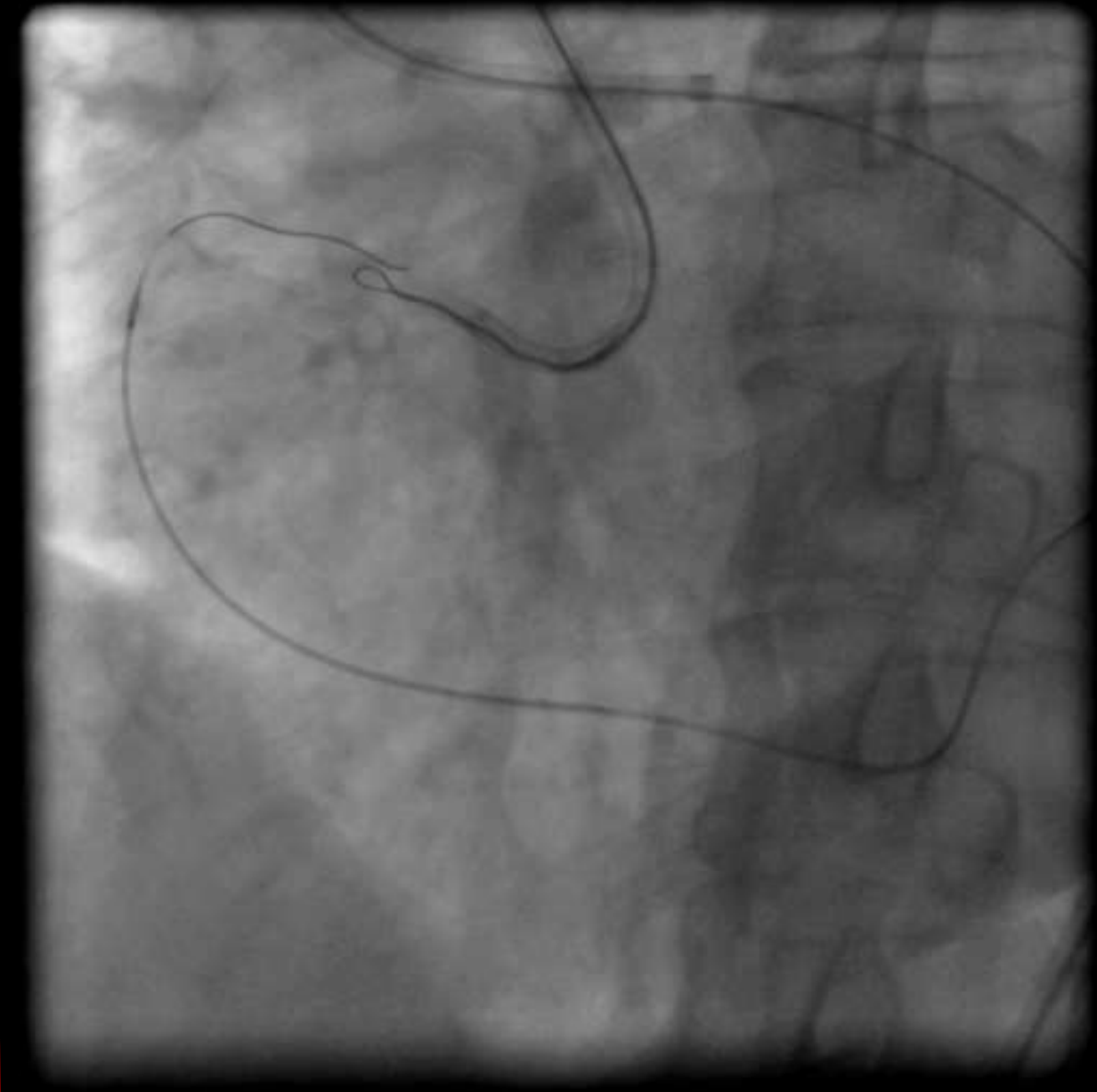


PL Channel



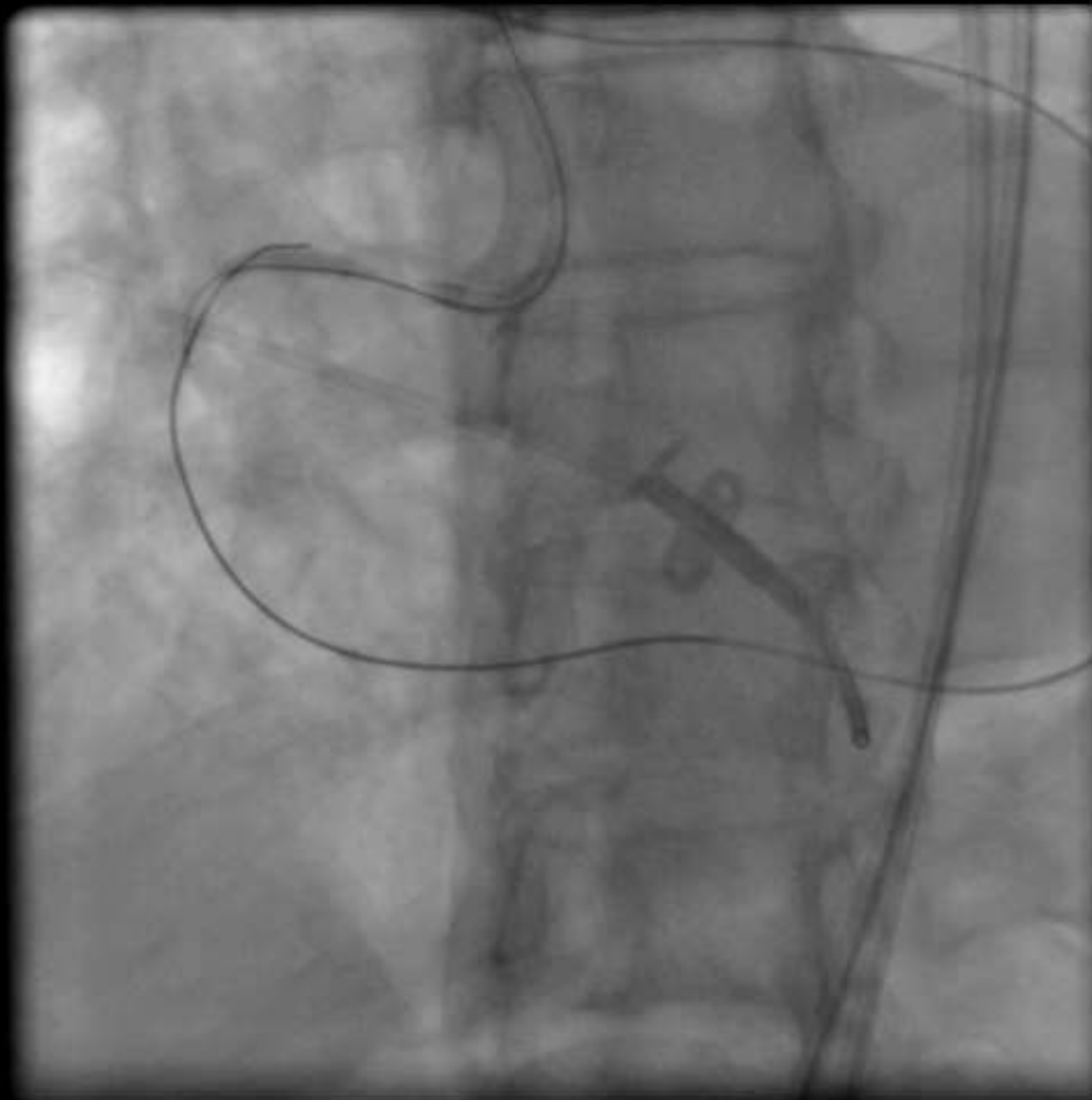


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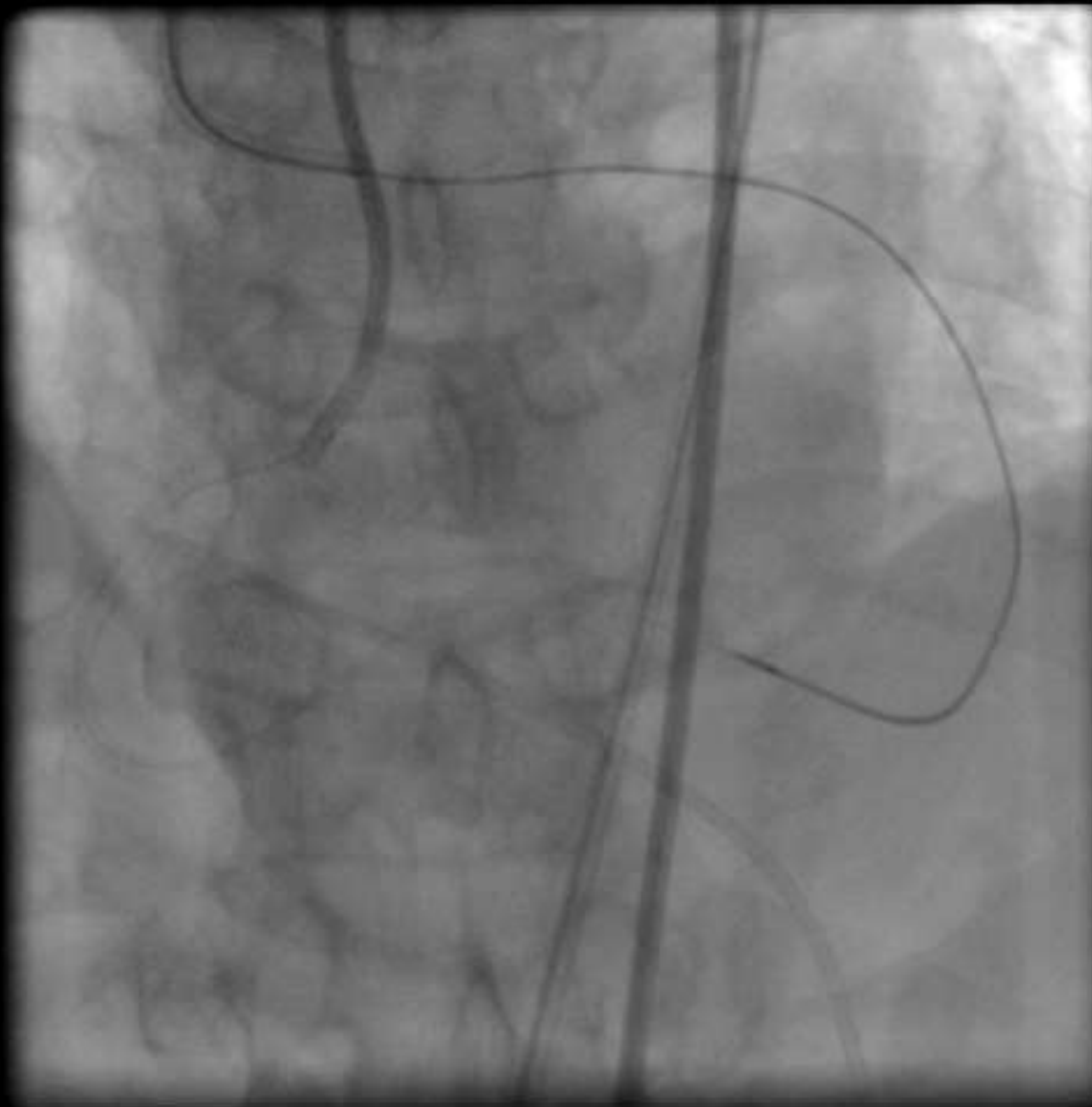


Tamponade





Final



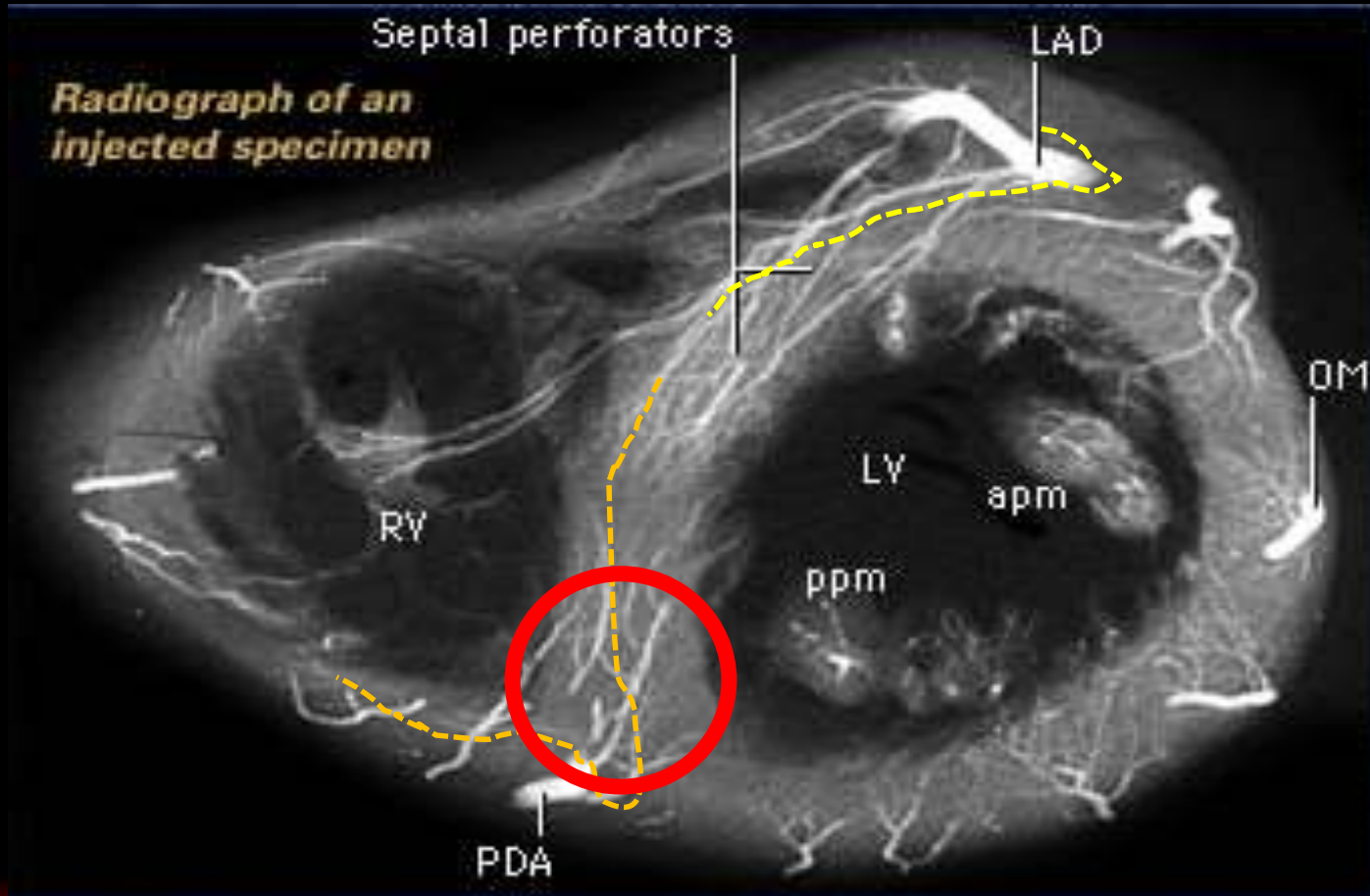


Channel Rupture



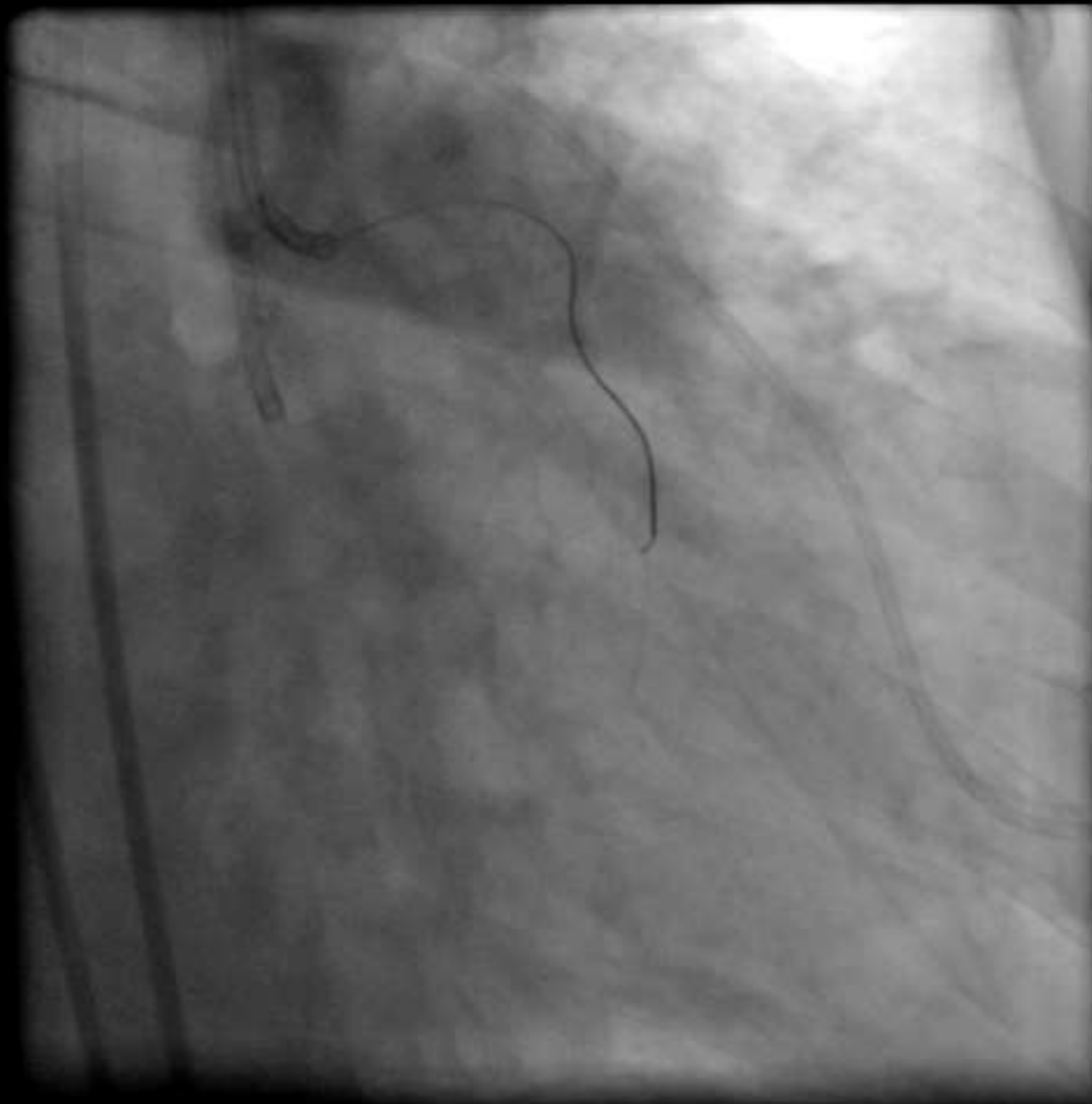


Septal Channels



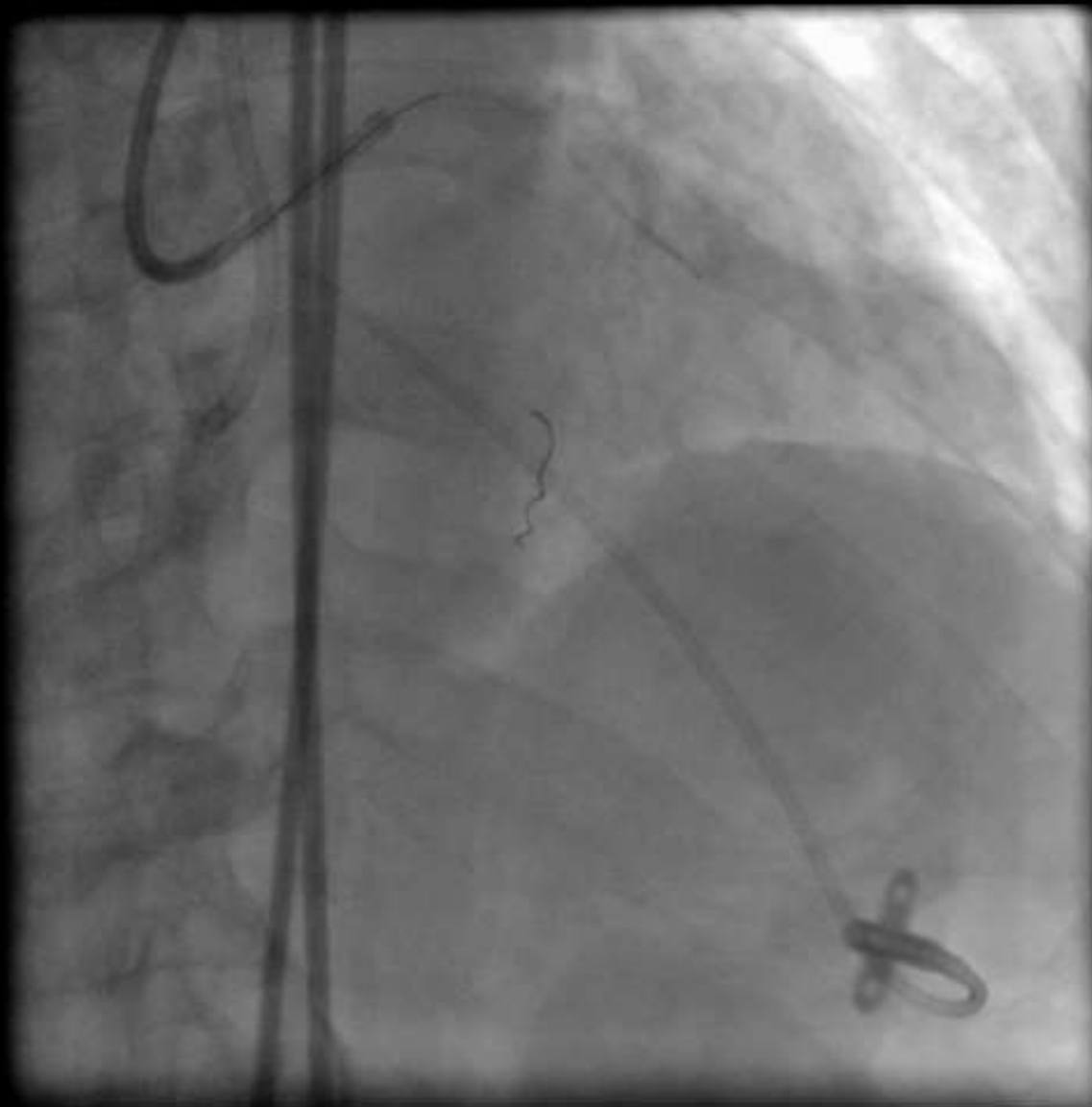


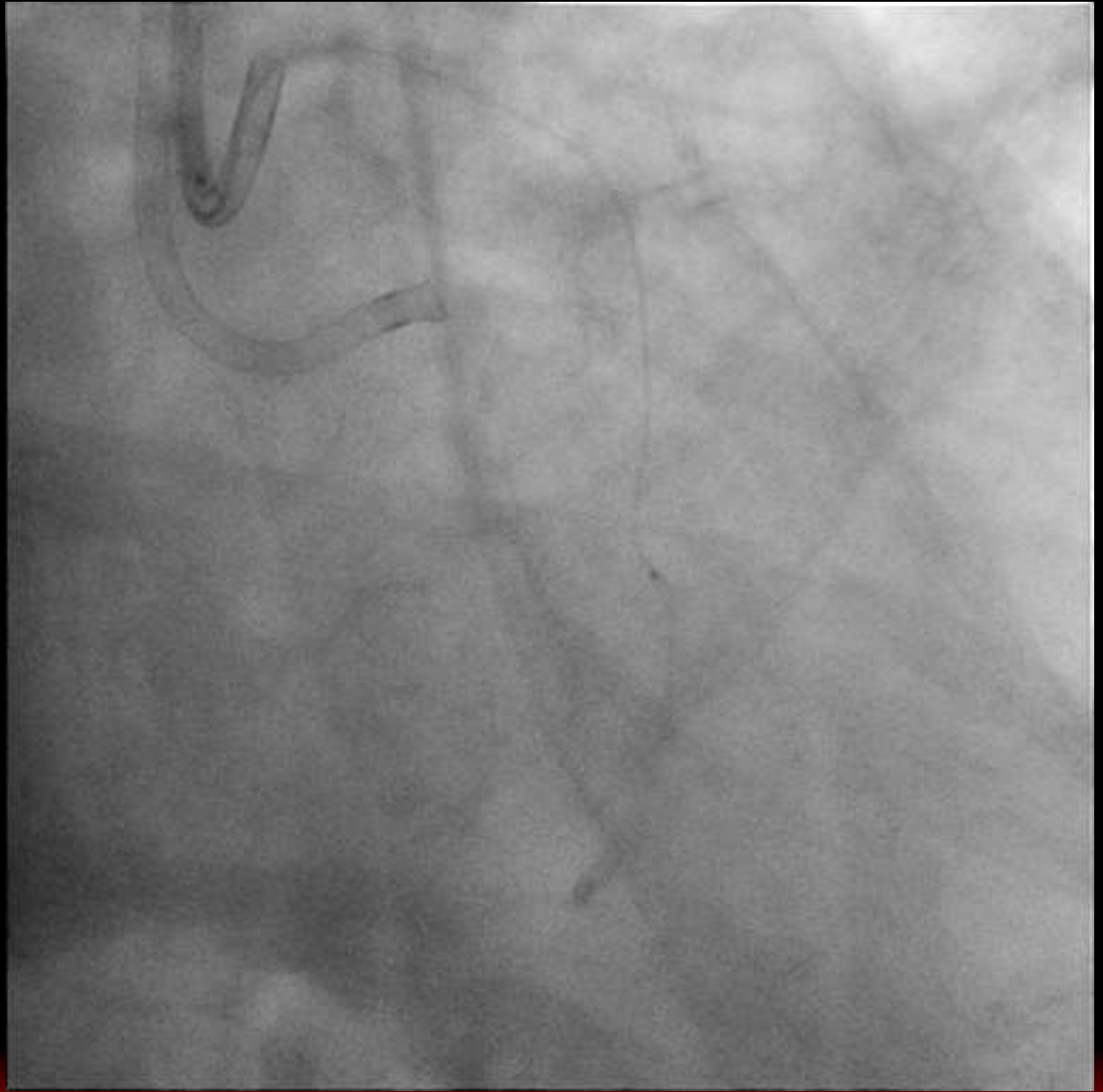
Coil Embolization





Final





Case
Hematoma
Without
Fistula



Enlargement of Hematoma





Summary

- 1. Septal channel is still basic in retrograde approach.**
- 2. SUOH-03 is feasible in my daily practice.**
- 3. Septal channel injury is not serious complication, but it is not always safe.**