Cardiac CT Knows Where Chronic Total Occlusion Entry Is.

CCTI Conference

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Working group

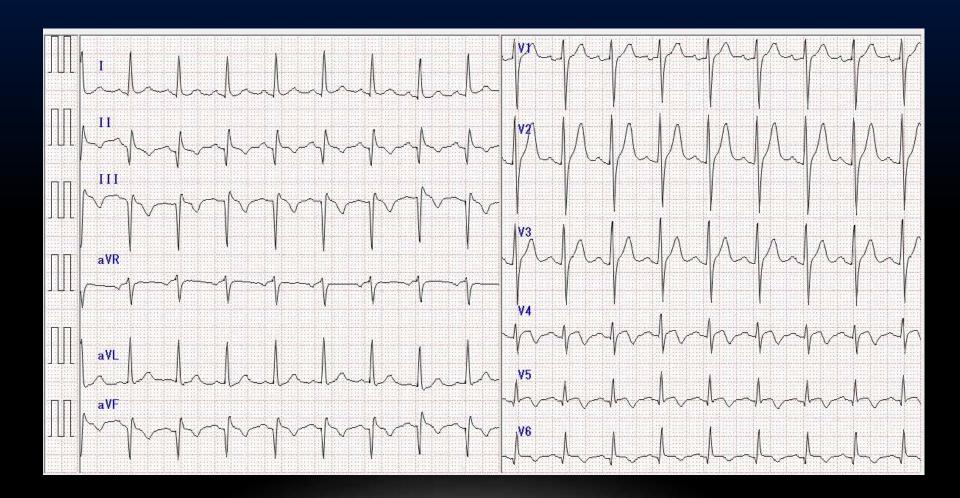
Case

√ 72 y.o. male

This patient had silent myocardial infarction. He had cholecystolithiasis and cholecystitis, and was planed to be performed cholecystectomy by surgon. QS pattern and negative T wave in 11,111,aVF in ECG and decreased LV wall motion and wall thinning of inferior in preoperative examination.

Coronary risk factor: past smoking

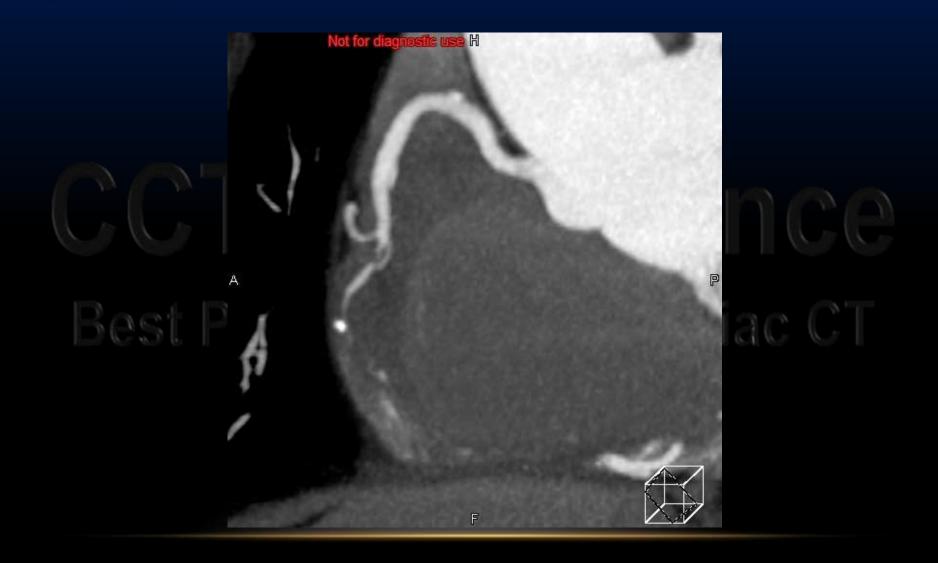
ECG



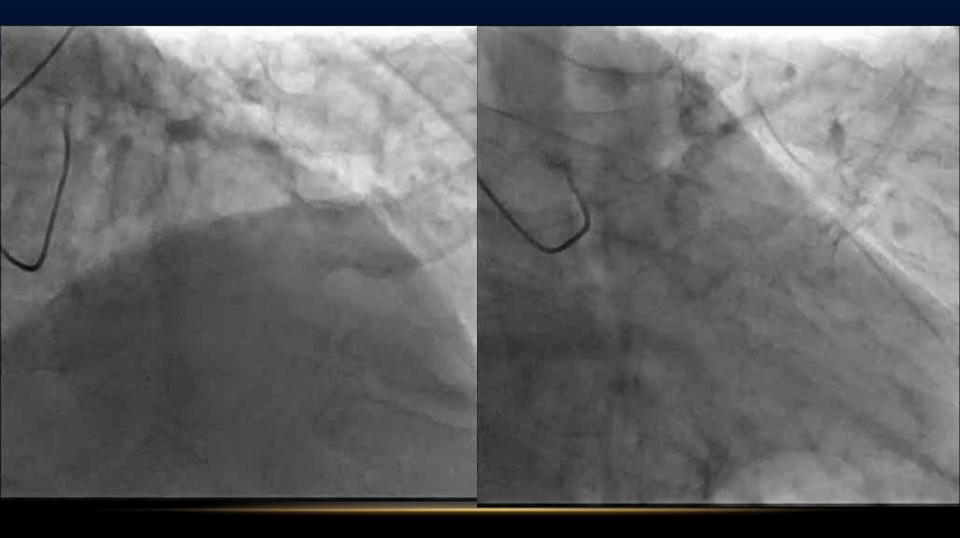
UCG



Cardiac CT



CAG LCA

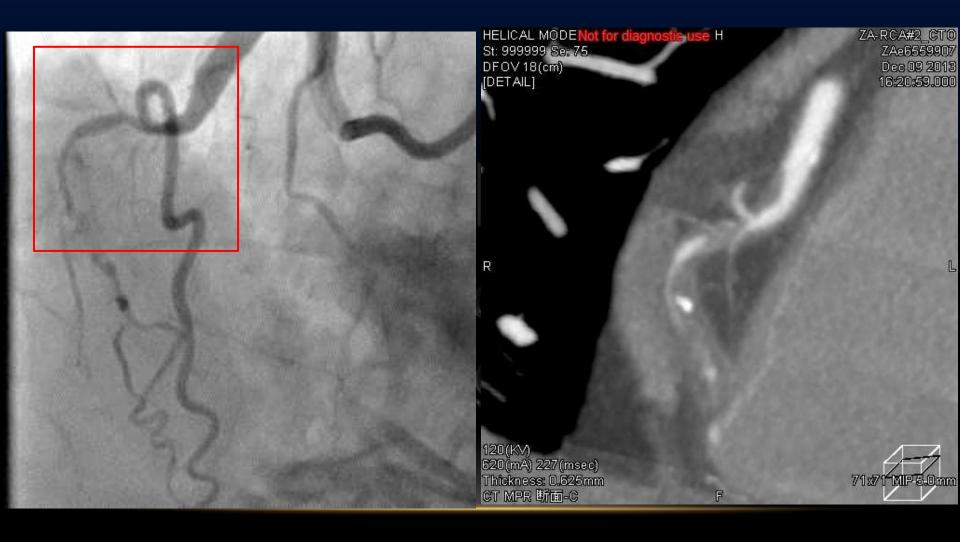


Control CAG



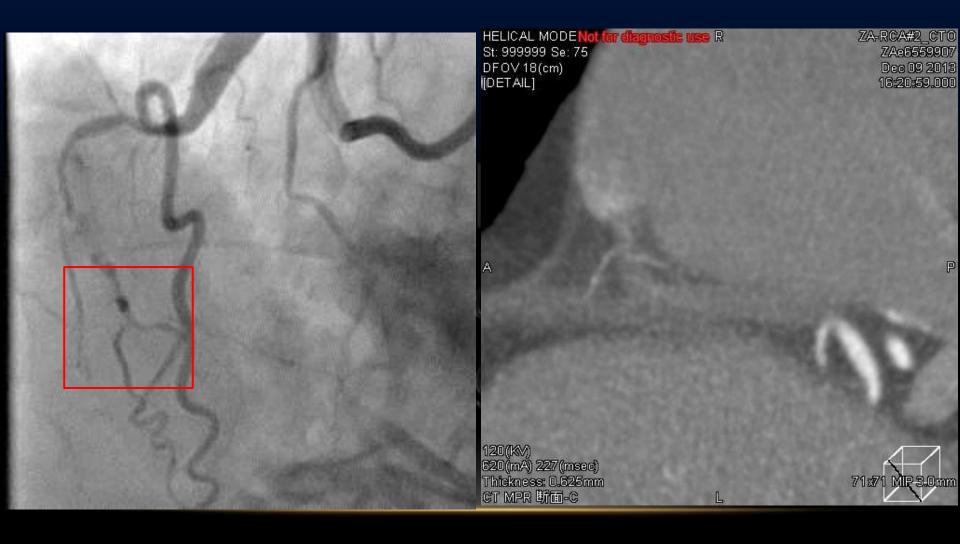
Control CAG



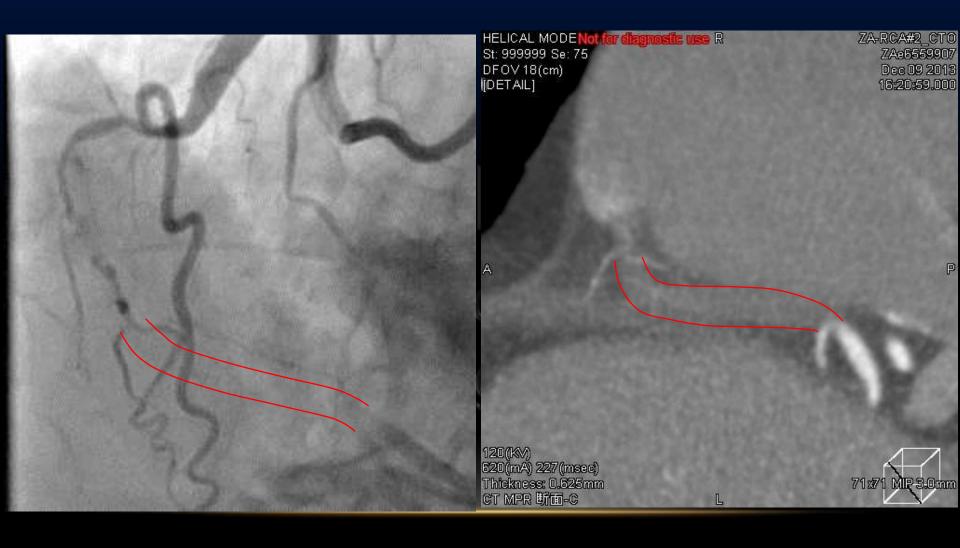








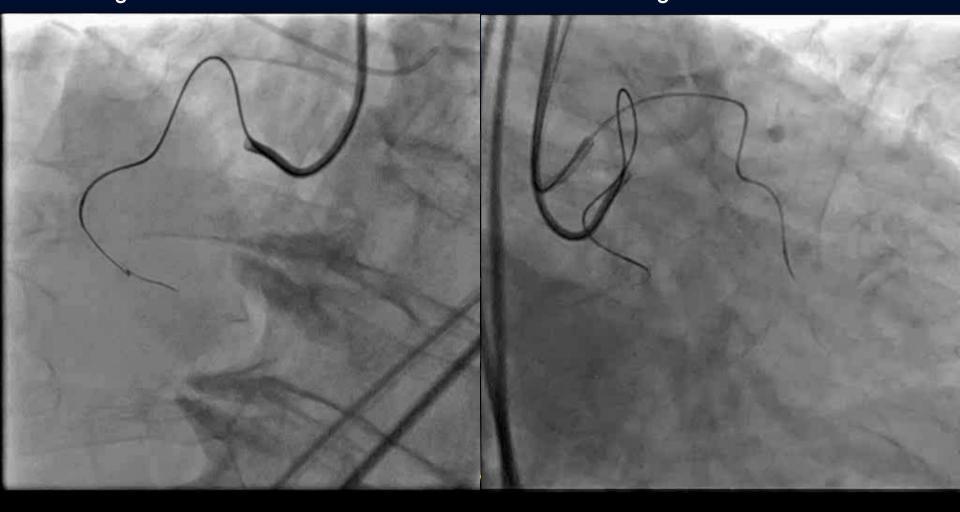




Antegrade and Retrograde approach

Antegrade: XT-R with 7Fr. AL1

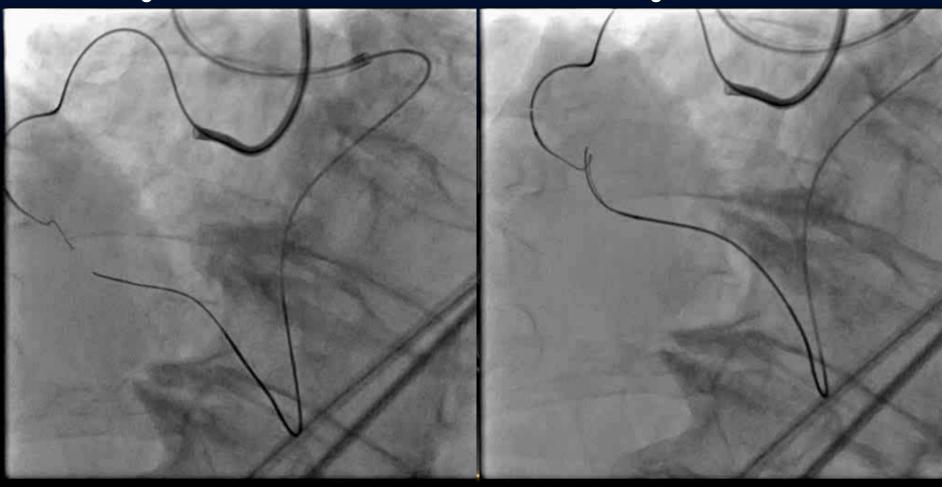
Retrograde: 7Fr. QL4



Retrograde approach

Retrograde: Ultimate Bros 3

Retrograde: FielderFC



Reverse CART and Externalization

Reverse CART with 3.0mm balloon

Pre dilatation with 3.0mm balloon



Stenting

Promus Element 3.5*38mm

Promus Element 3.5*38mm



Stenting and KBT

Promus Element 3.5*20mm

KBT 2.0/3.0mm balloon



Final CAG



Summary

- CTO entry point was not identified by CAG and antegrade wiring seemed to be difficult.
- Cardiac CT visualized CTO entry point clearly. CTO entry had no stump and it was realized early on that antegrade wire could not enter into CTO segment and retrograde approach was need.
- PCI became successful by retrograde approach and reverse CART.

Conclusion

- CT information is very helpful to make PCI strategy of complex CTO.
- Deep CT evaluation will make result of CTO PCI better.

Best Performance of Cardiac CT Working group