Case #2 AMC
RCA CTO

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Conflict of interest

- I, Gerald S. Werner, MD, have no conflict of interest to declare with regard to the following presentation

Case #2

Brief Case Summary

A 58 year-old male was admitted for effort chest pain lasting a few months. Following coronary angiogram showed total occlusion at proximal RCA. Staged PCI was planned for the RCA.

Past Medical History

- Previous MI: N
- Previous CABG : N
- Previous PCI: N

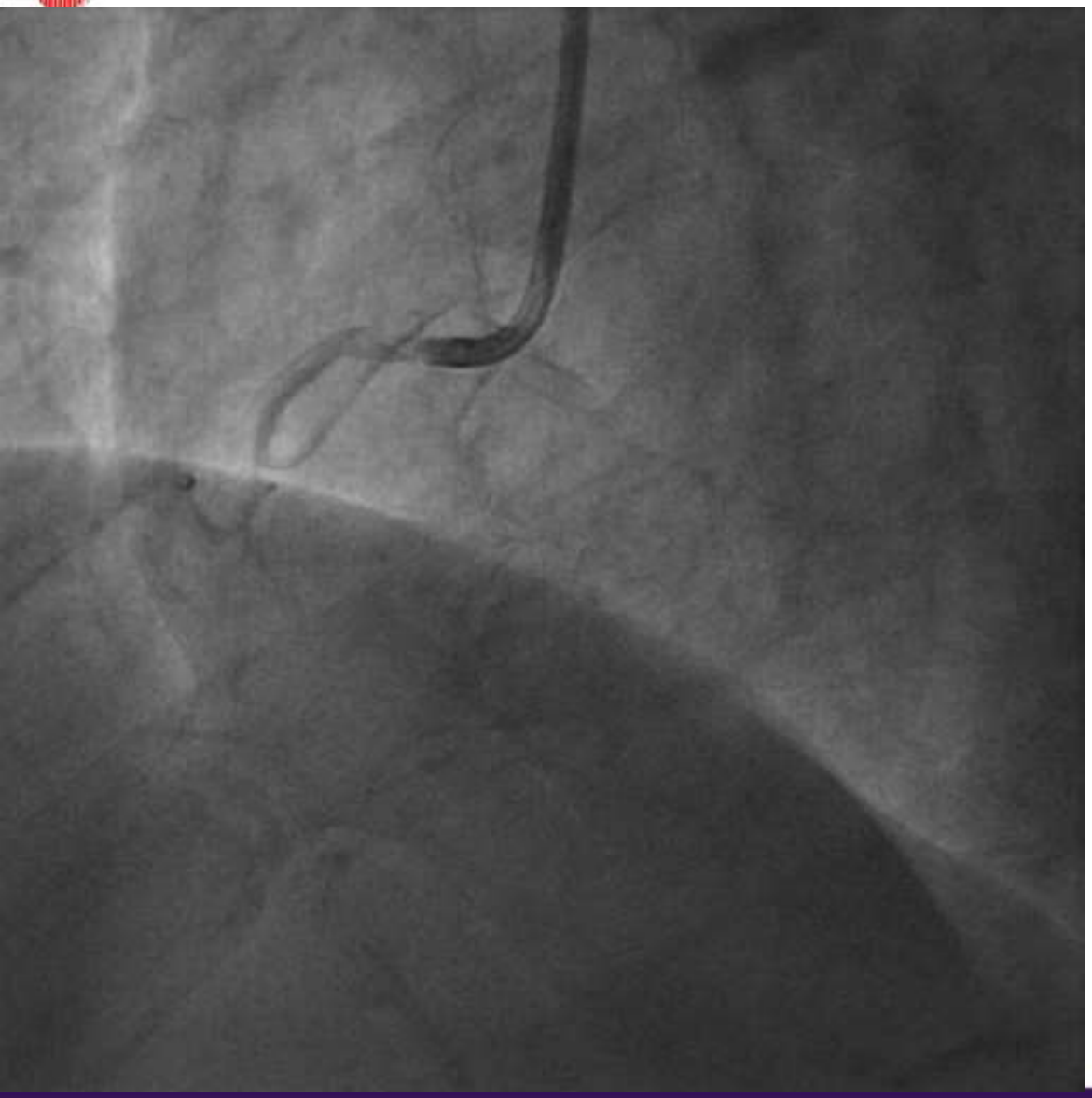
Demographic Characteristics

- Diabetes: Y
- Hypertension: N
- Hyperlipidemia: N
- Smoking: Y
- Family History: N
- Age: 58
- Sex: Male

Clinical Presentation

Stable angina

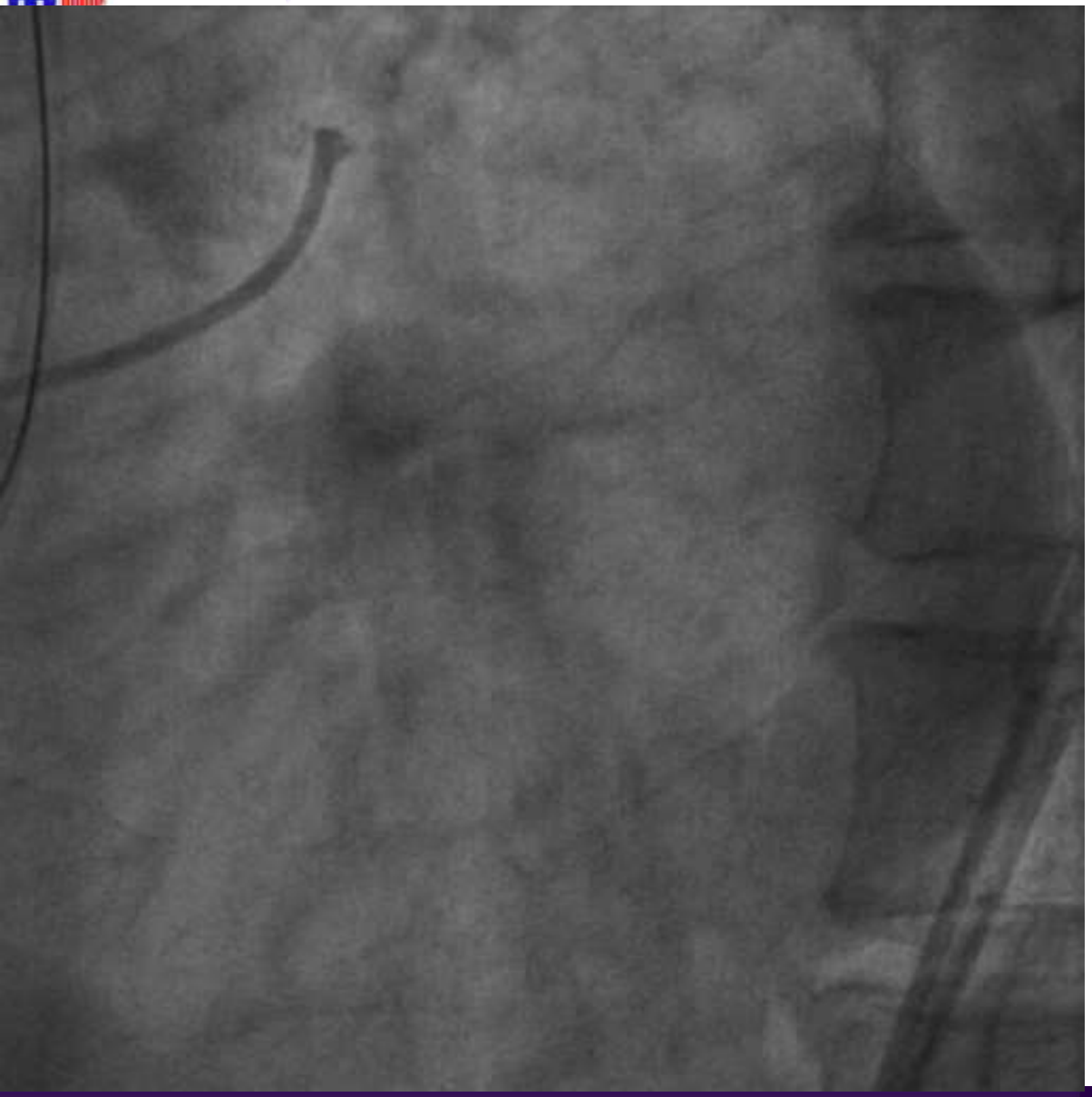
The lesion



Ambiguous cap without stump at the take-off of a large side-branch

No visible calcium

How long ?



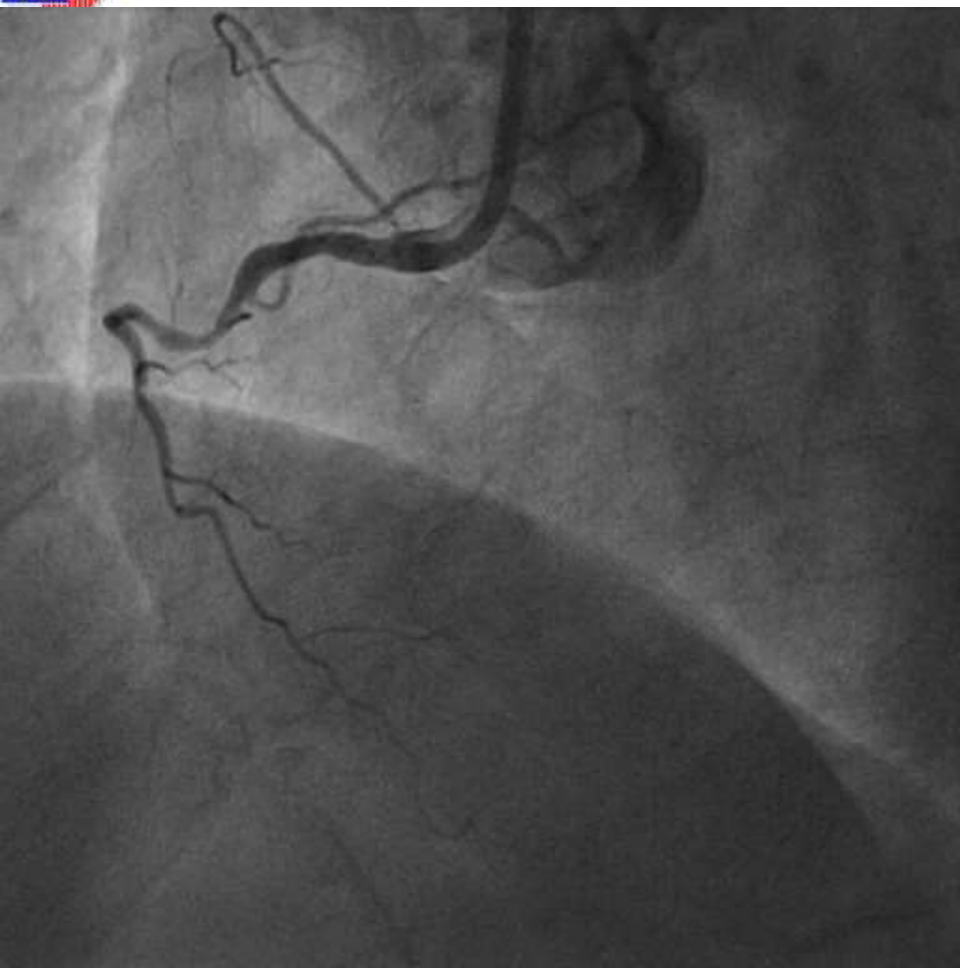
Ambiguous cap without stump at the take-off of a large side-branch

No visible calcium

At least 30 mm

No expected bend within the lesion

How difficult ?



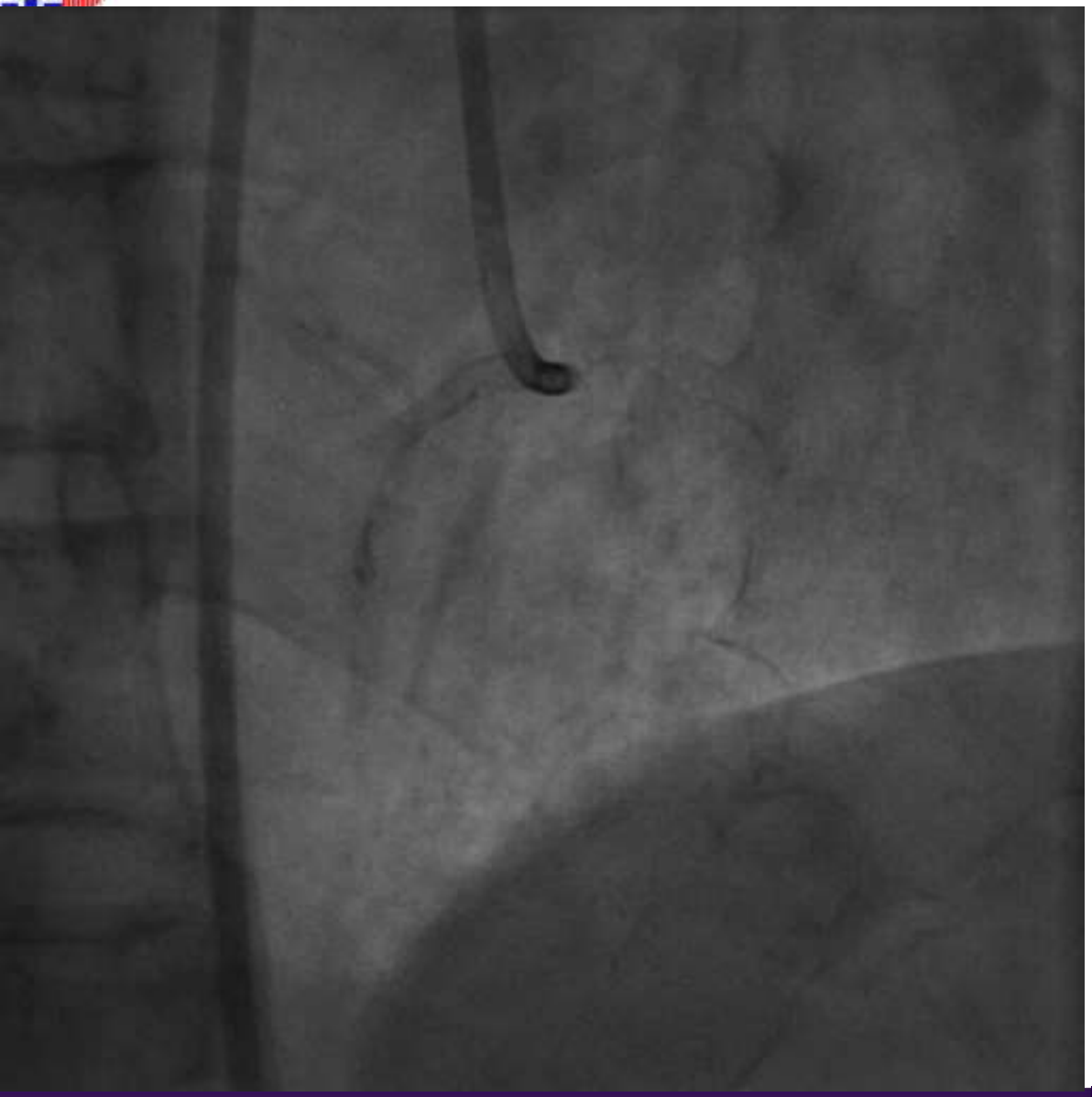
J-CTO Score:	
Stump	1
Calcium	0
Bend	0
Length	1
Retry	1

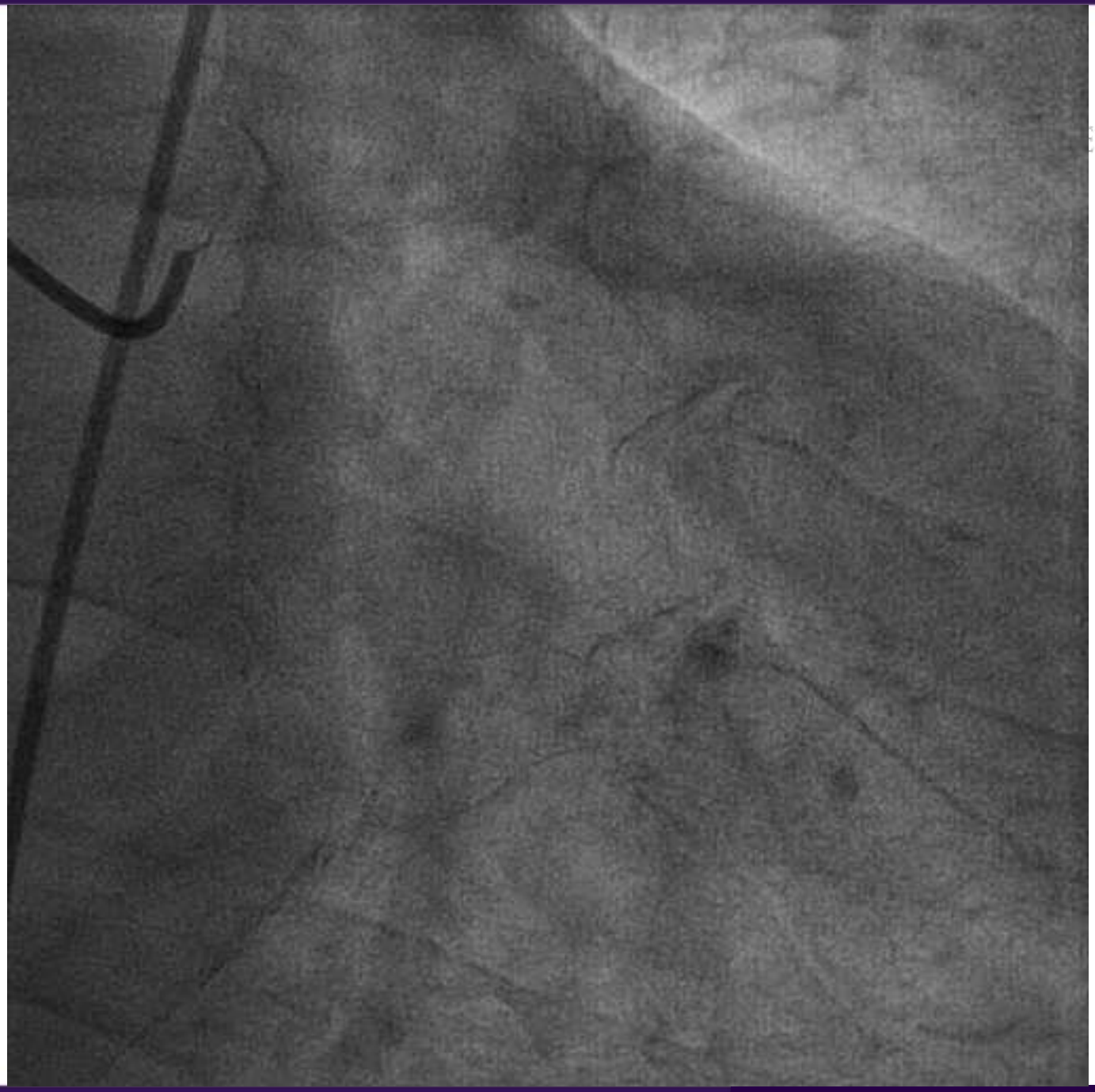
3

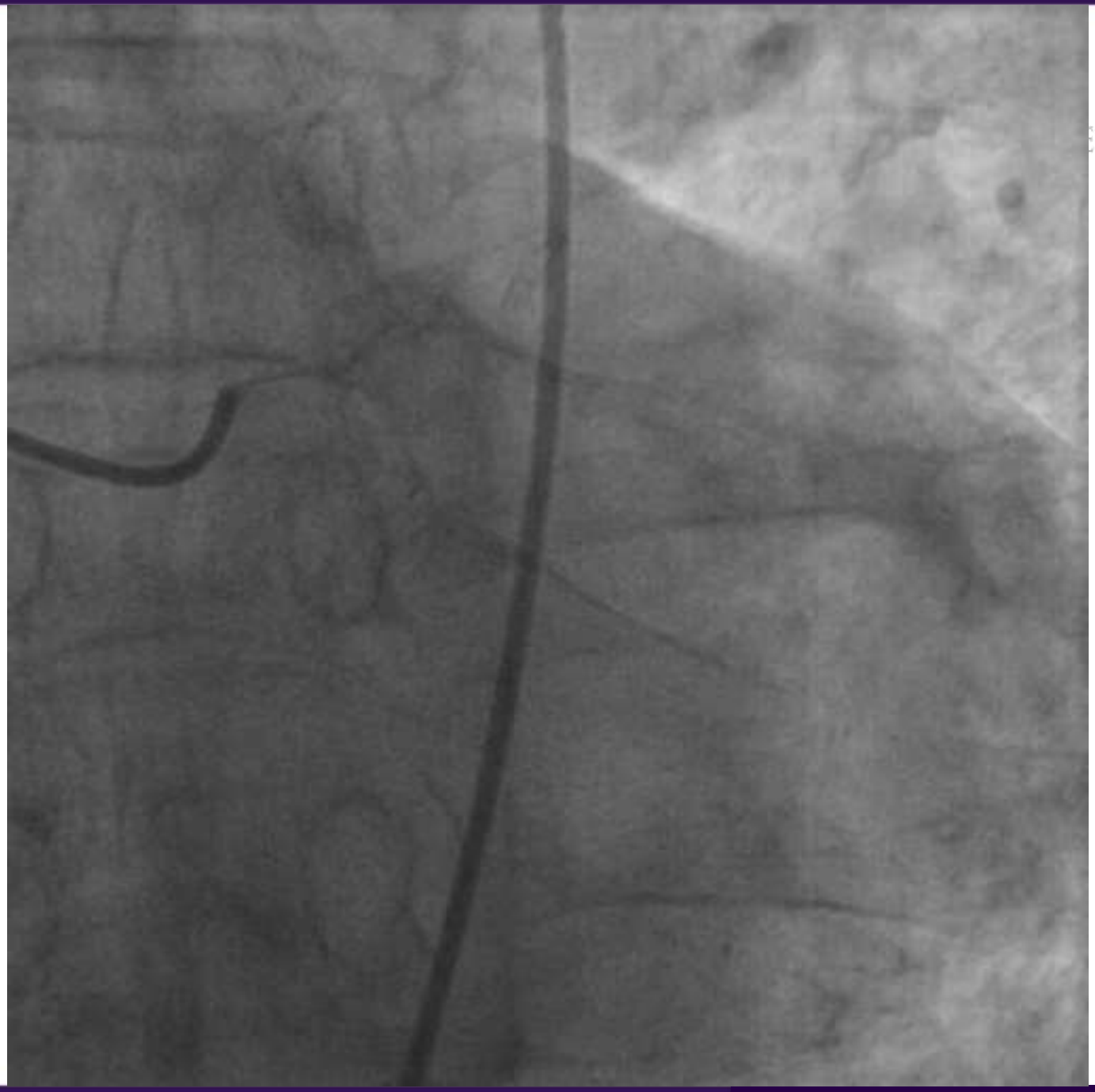
CASTLE Score:	
CABG	0
Age 75	0
Stump	1
Tortuosity	0
Length	1
Extent CA	0

2

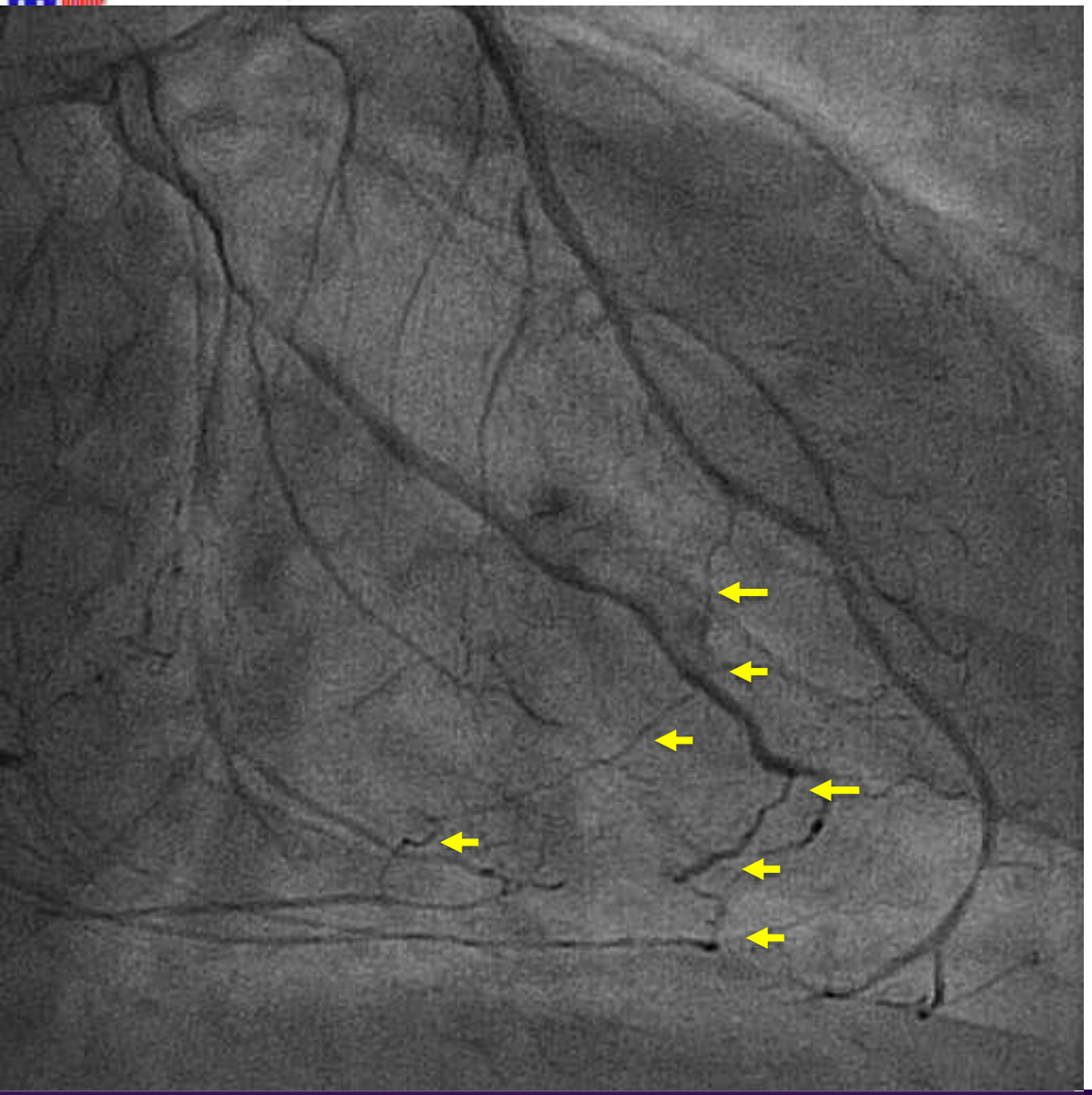
RAO: maybe a little calcium ?



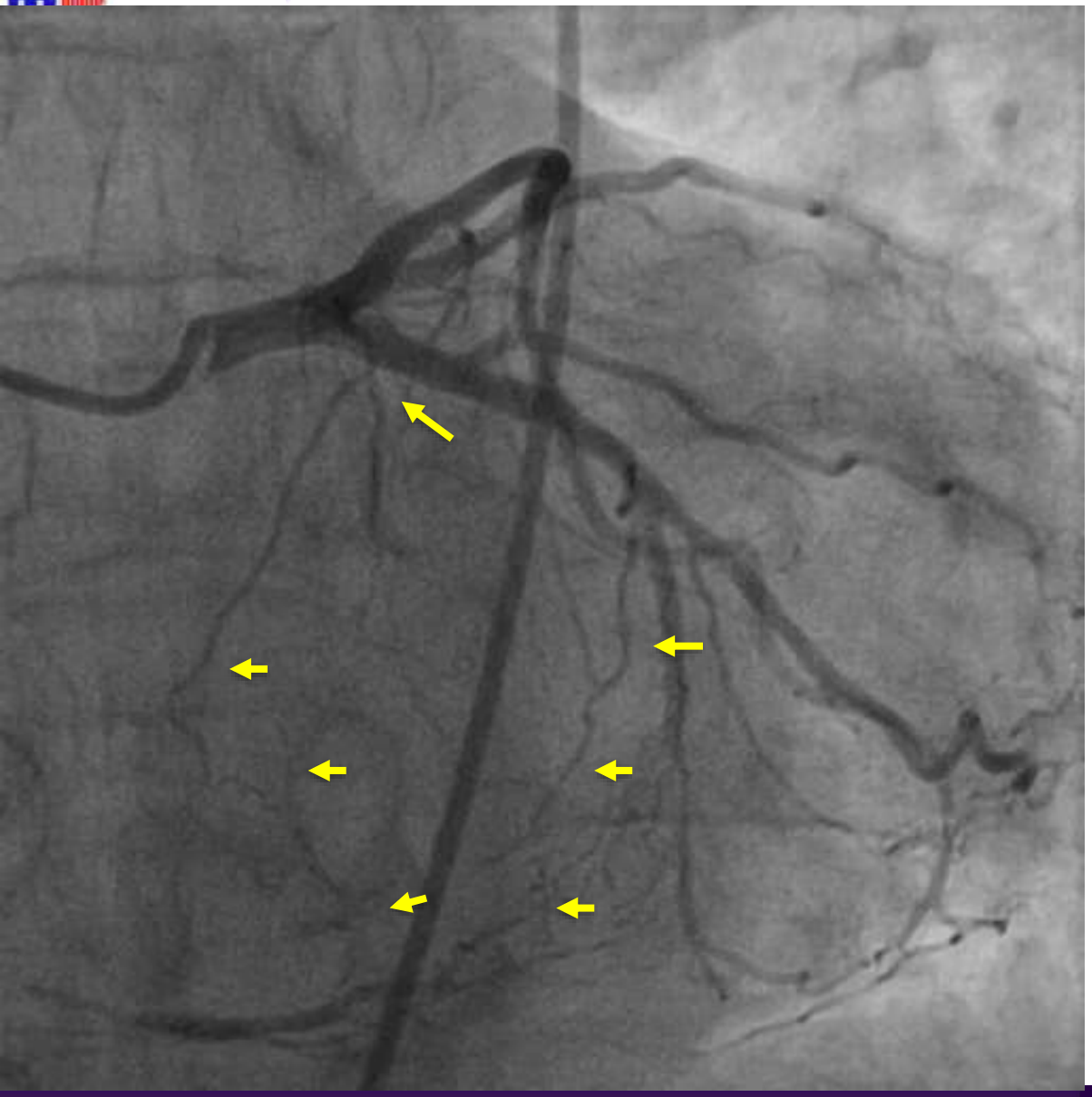




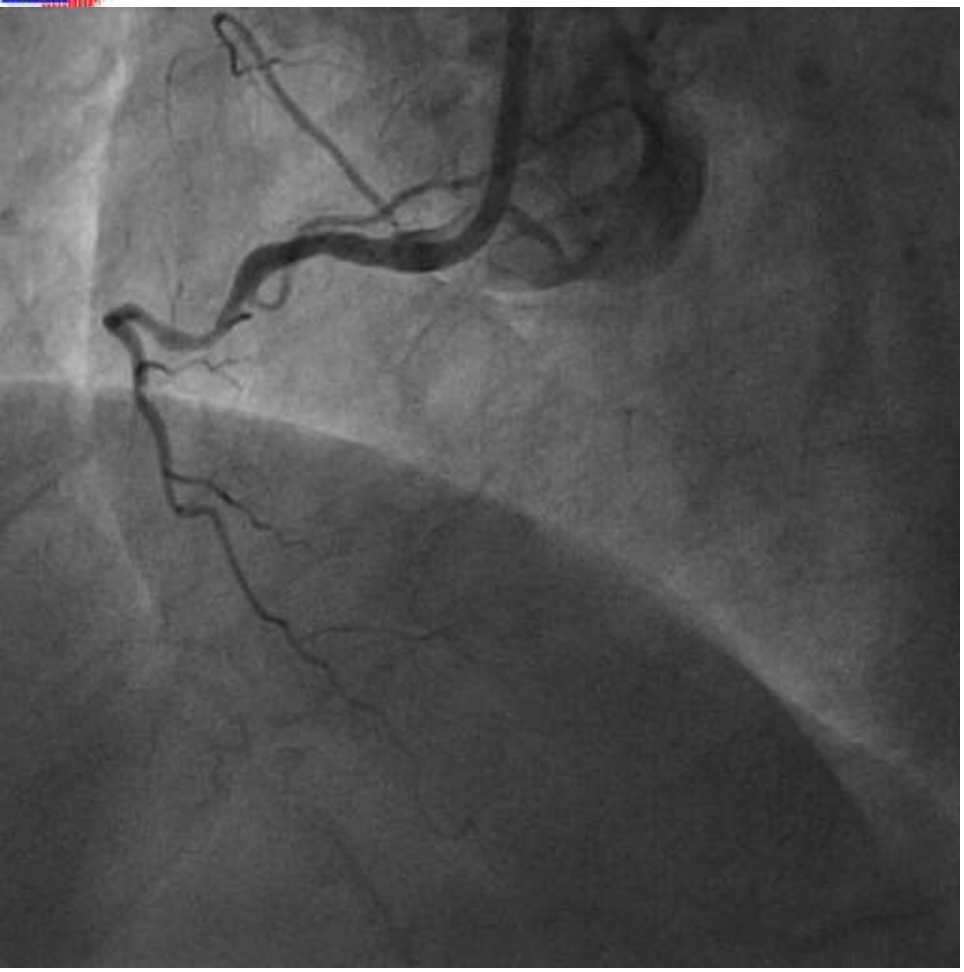
Collateral options ?



Collateral options ?



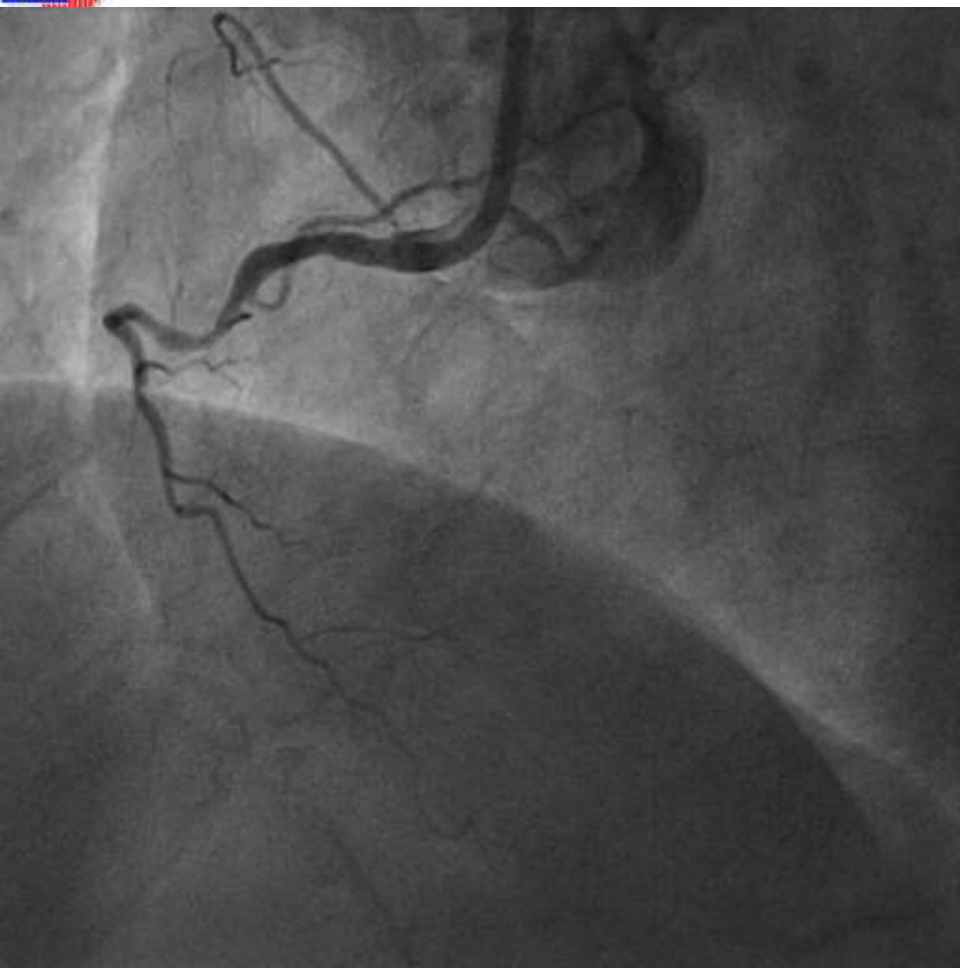
My thoughts



For a pure antegrade approach the distal target is very small, but still I want to enter the vessel luminally at the proximal cap

There is no optimal retrograde channel in order to start retrograde first and mark the proximal cap by a retrograde wire

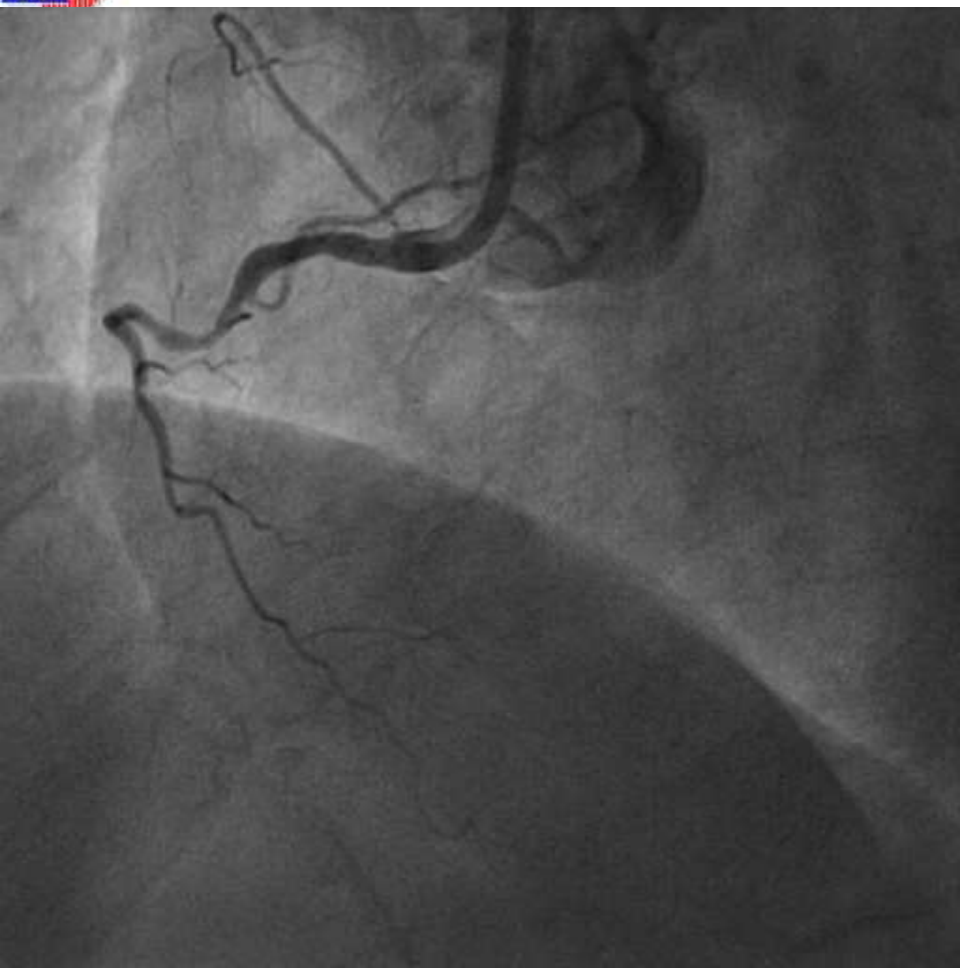
My strategy



AL 1 SH for the RCA transfemoral
EBU 3.75 SH for the LCA preferably transradial

1. IVUS examination of the proimal cap
2. IVUS guided proximal cap penetration (Gaia 2)
3. Step-down andvancement of wire under contralateral vision
4. Retrograde channel tracking, probably PL of LCX or distal septal

My bail-out strategy



1. If antegrade wire gets to the target close but subintimal
Parallel wire with CP12

2. If I do not get retrograde access, then StingRay reentry