Retrograde approach for long RCA CTO lesion with severe contractile dysfunction

Hokusetsu General Hospital
Masahiro Yano
CASE 60 y.o. male

- CC: dyspnea at rest
- PH: anterior myocardial infarction 17 years ago (at that time PTCR was performed)
- Coronary risk factor: DM, HT, HL
- PI: The patient felt dyspnea on effort from the summer of 2010, the symptom worsened and he was admitted to our hospital on November 19, 2010.
CASE 60 y.o. male
CAG (12/10)
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Selection of therapy

(1) CABG
①: Off-pump CABG was considered impossible due to severe heart enlargement
②: On-pump CABG was very risky due to decompensated heart failure.

(2) PCI
①: LAD and LCX lesions were not difficult for PCI.
②: PCI for RCA CTO lesion was considered possible by CART technique due to rich collateral to RCA.

⇒ Therefore, we decided to undergo complete revascularization by PCI.
PCI (12/20)

Wizard1 with Corsair crossed LCX lesion
PCI (12/20)

SES  φ3.0 × 33mm
PCI (12/20)
PCI (12/20)

SES  φ3.5 × 33mm
PCI (12/20)
PCI (12/20)
Strategy for PCI

(1) IABP was inserted from left femoral artery.

(2) RCA

① 8F sheath was inserted from right femoral artery.
② GC: JR4.0SH

(3) LAD

① 7F sheath was inserted from right brachial artery.
② GC: EBU3.5SH
PCI (1/11)

Sion-blue with Corsair
PCI (1/11)

Sion-blue with Corsair
PCI (1/11)

Ultimate3 with Corsair
PCI (1/11)

Conquest pro with Corsair
PCI (1/11)

Conquest pro with Corsair
PCI (1/11)

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PCI (1/11)

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PCI (1/11)

Conquest pro with Corsair
PCI (1/11)

Conquest pro with Corsair
PCI (1/11)
PCI (1/11)

Miracle12 with Corsair
PCI (1/11)

Miracle12 with Corsair
PCI (1/11)

Φ2.5mm balloon
PCI (1/11)

IVUS
PCI (1/11)

Φ2.5mm balloon
Even plastic wire could not cross!!
PCI (1/11)

GC:8F SAL1.0SH
PCI (1/11)

Rinato crossed from antegrade!!
PCI (1/11)
5 EESs were deployed
5 EESs were deployed
Final
Conclusion

- We experienced the PCI case of long RCA CTO lesion with severe contractile dysfunction.
- Retrograde approach was very useful for long CTO case.
- Switching the guiding catheter was the effective option for the case.