

Epicardial channel perforation during coronary intervention by retrograde approach to chronic total occlusion

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Epicardial channel perforation during retrograde approach

50 y.o. male

Target lesion LCX (CTO)

Diagnosis OMI (P), EA

Coronary Risk Factors
HT, HL

Final CAG Findings 1/14/2011

RCA Seg2 100%

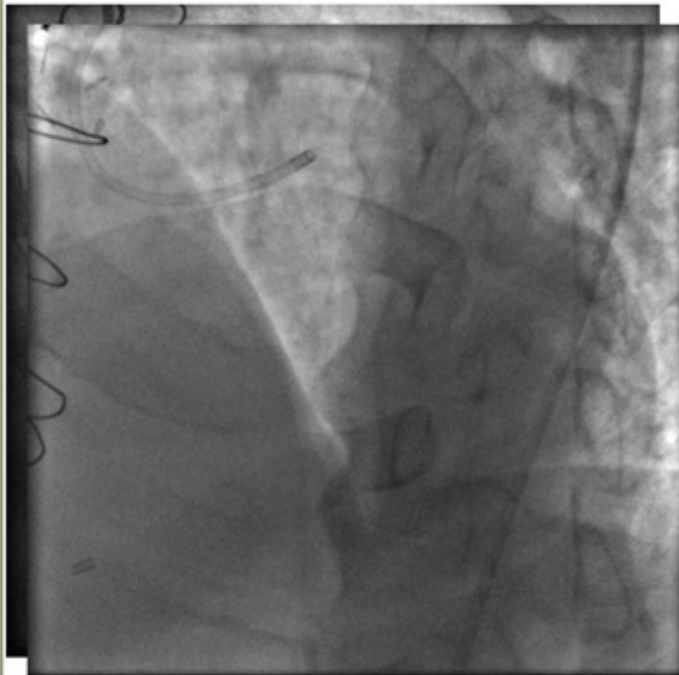
LAD Seg6 75%, Seg7 100%

LCX Seg11 100%

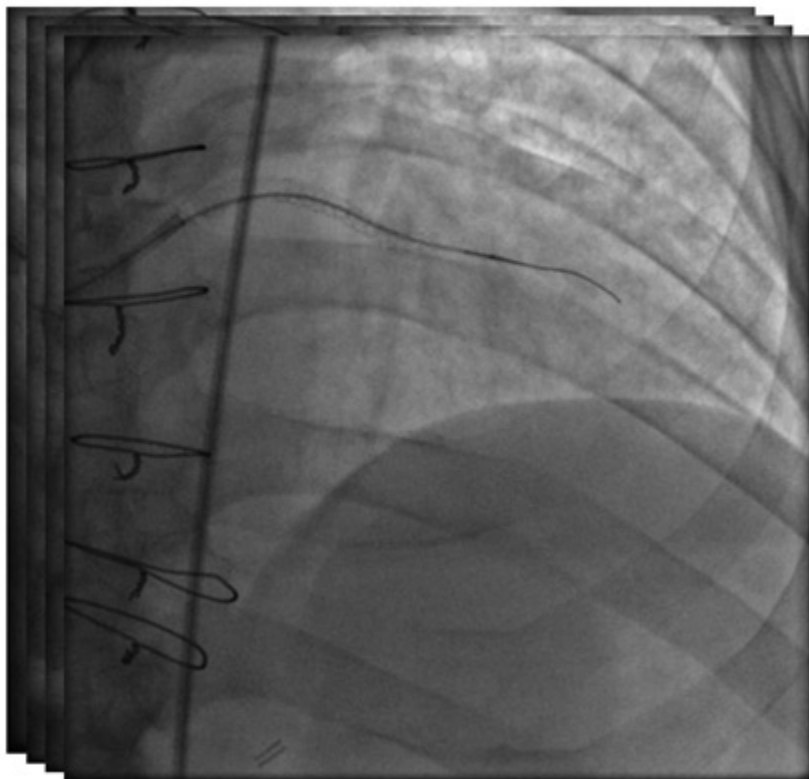
LITA to LAD patent

SVG to RCA patent

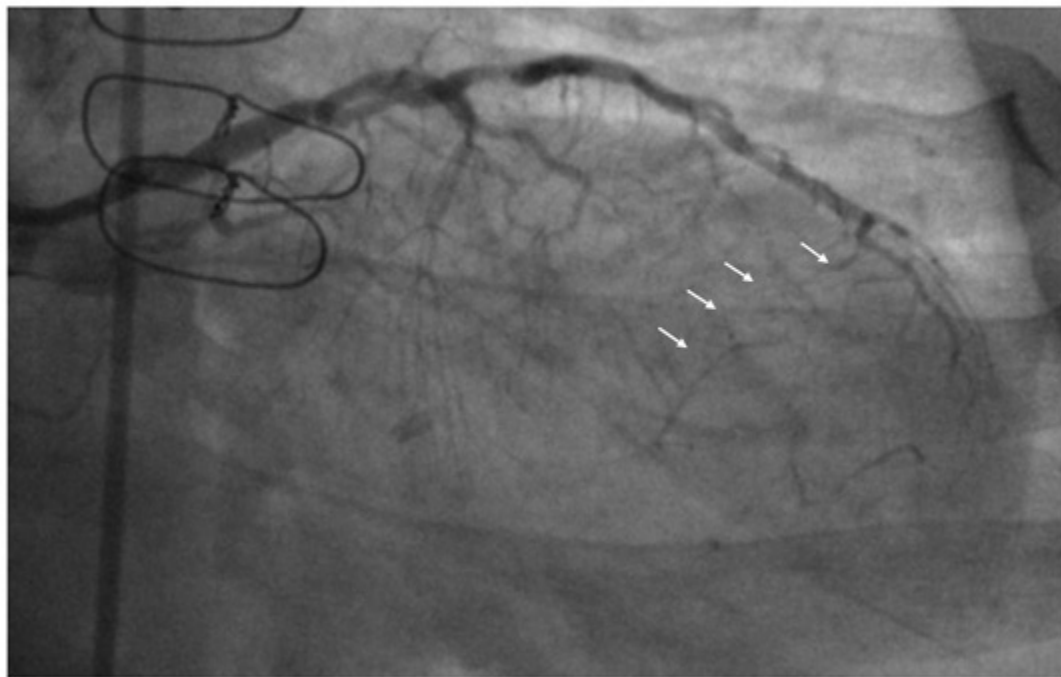
SVG to LCX 100%



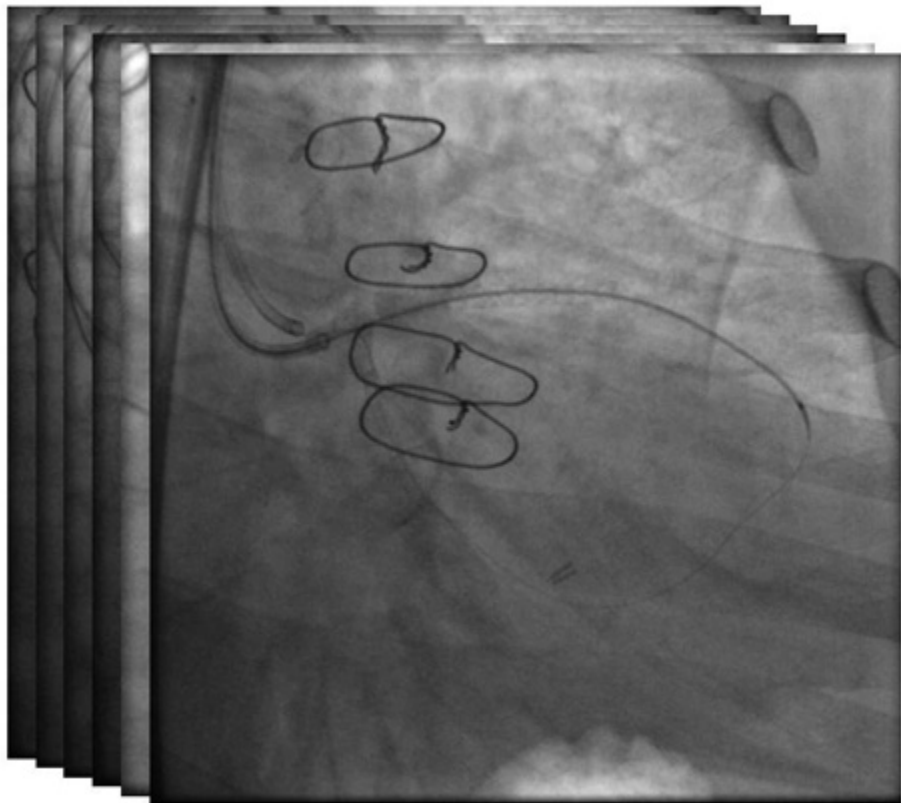
PCI to LCX with antegrade approach



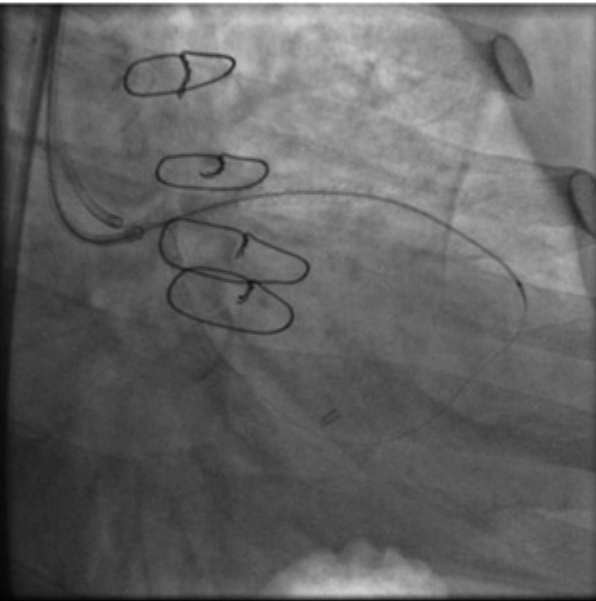
PL channel



PCI to LCX with retrograde approach



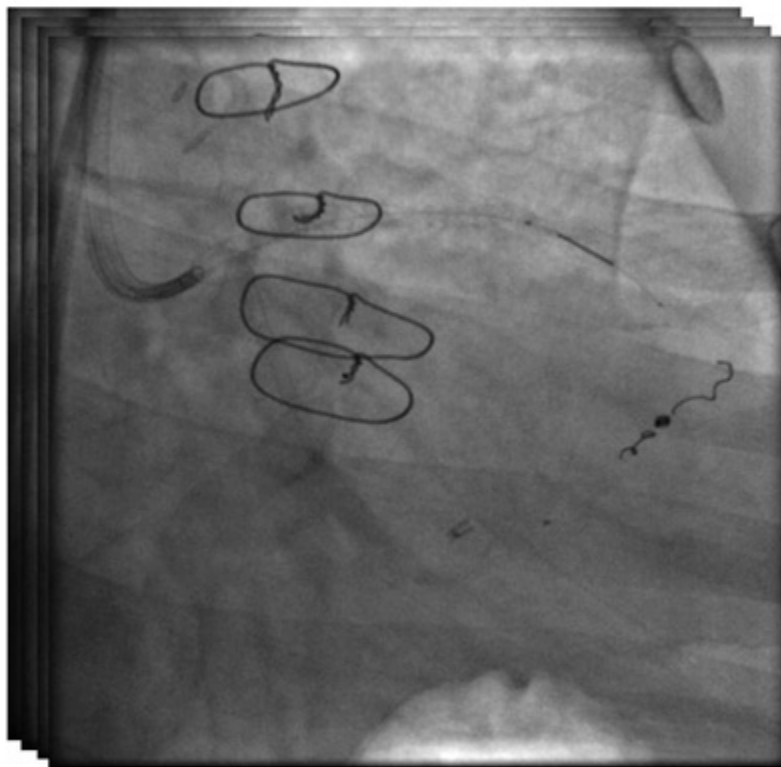
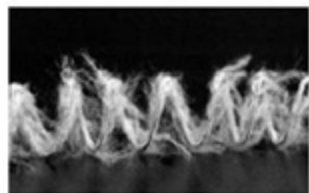
Epicardial channel perforation



Coil embolization

Cook Emboli/Micro Coil

HILAL Coil
Diameter: 2 mm
Length: 20mm
(if coiling 2mm)

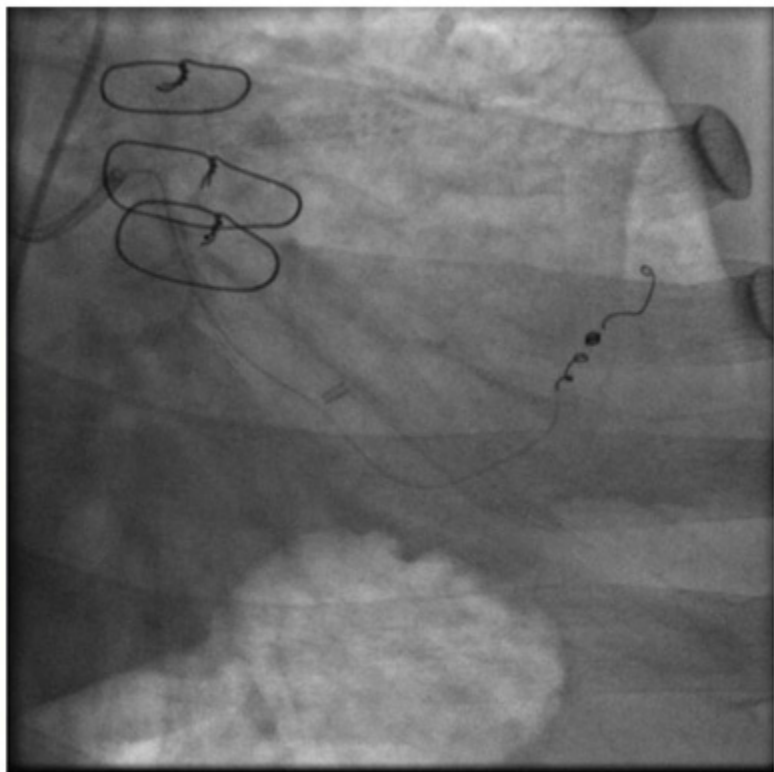
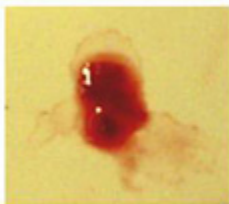


Prolonged balloon inflation on both sides under controlling ACT with the administration of protamine to induce thrombus formation



Injection of thrombus through the Finecross

**Thrombus
in an elaster**

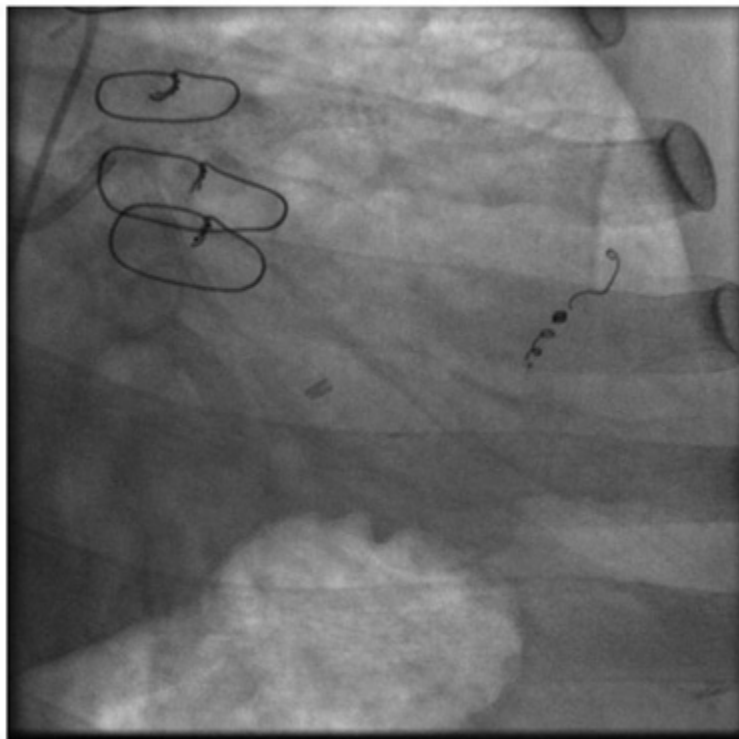


Injection of fibrin glue through the Finecross

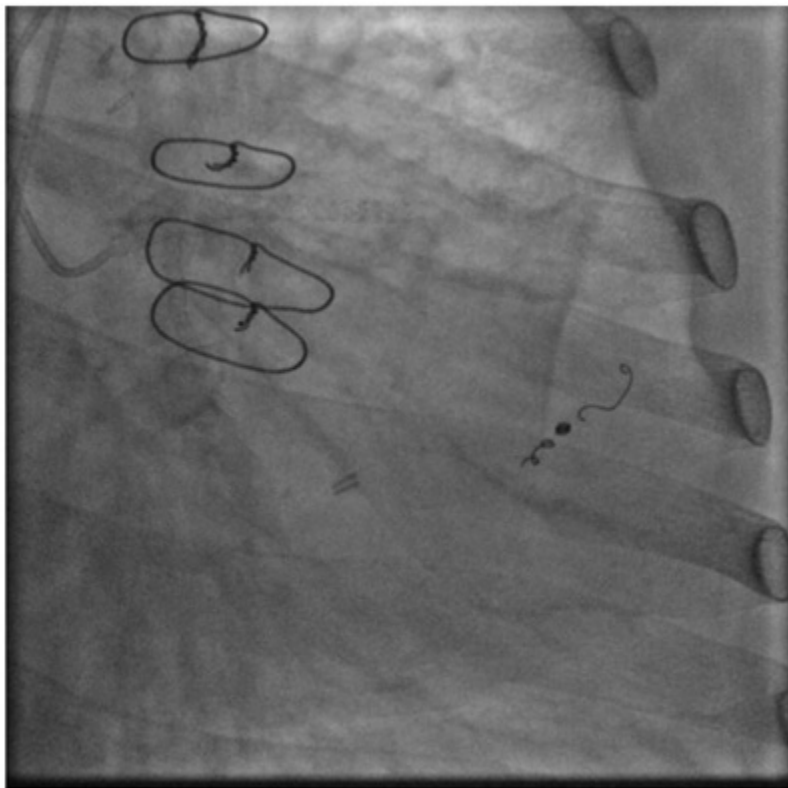
Fibrin Glue

(BeriprastR, CLS Behring)

Two component system



Final CAG



Summary

Epicardial channel perforation is sometimes difficult to seal even with embolization coils.

Coil embolization, if necessary with additional ballooning and the injection of autologous clots or fibrin glue, is effective for sealing the coronary collaterals perforation.