# A case of mid-LAD CTO at bending portion required both retrograde and antegrade approach

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**onary risk factors** :

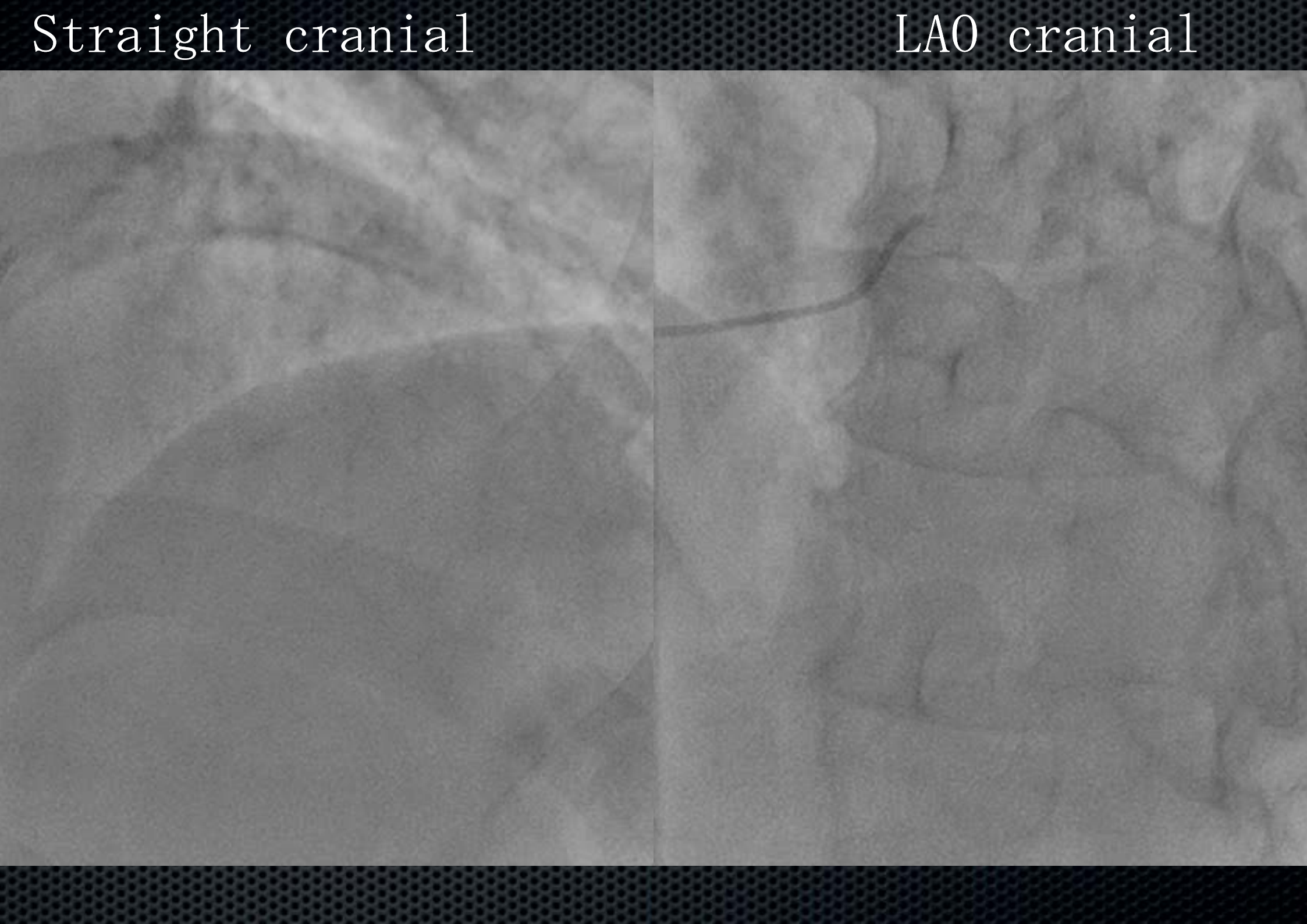
rtension, diabetes melitus, dyslipidemia, ex-smoker

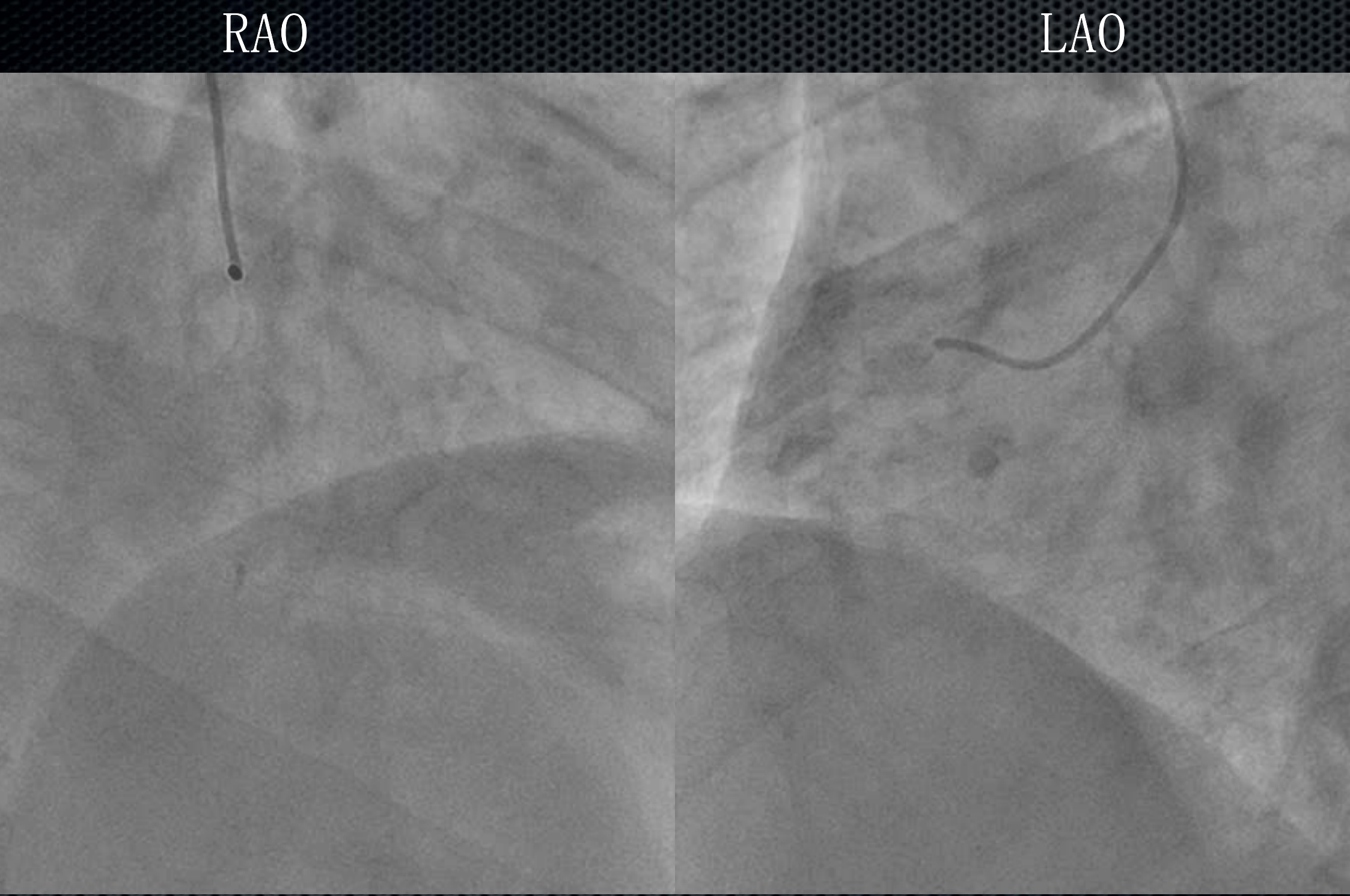
**history** :

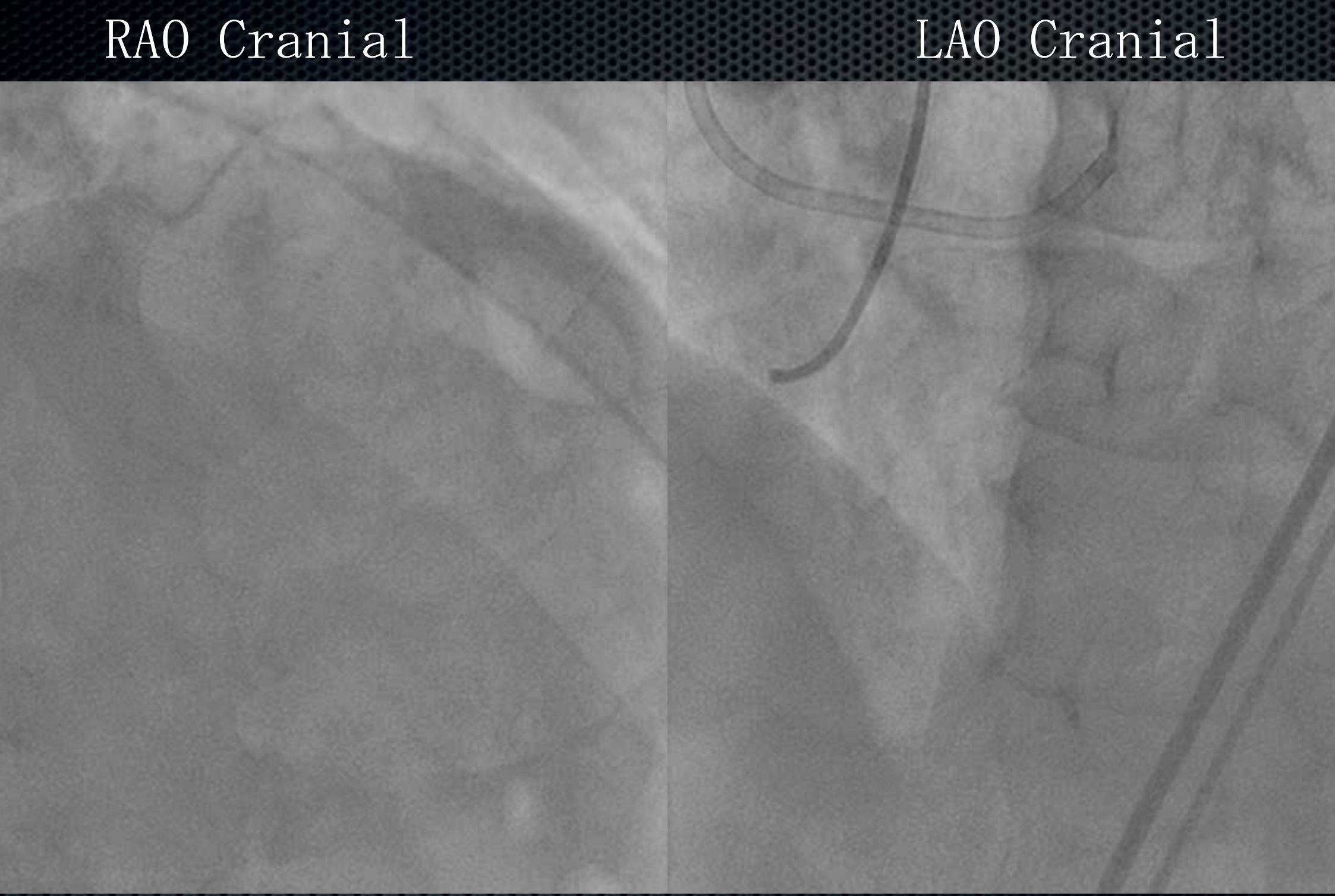
ad no evidence of prior MI, prior PCI or prior CABG.

**ent illness :**

vas referred to the hospital for further examination because of
rmal electrocardiogram. Excise Tc scintigraphy revealed reversibl
mia and viability of the antero-septal wall. Coronary angiogram
ved mid-LAD CTO at bending portion. Left ventriculography show
hypokinesis of anterior wall and ejection fraction was 69%. We
ned PCI for the LAD CTO.


Straight cranial
LAO cranial

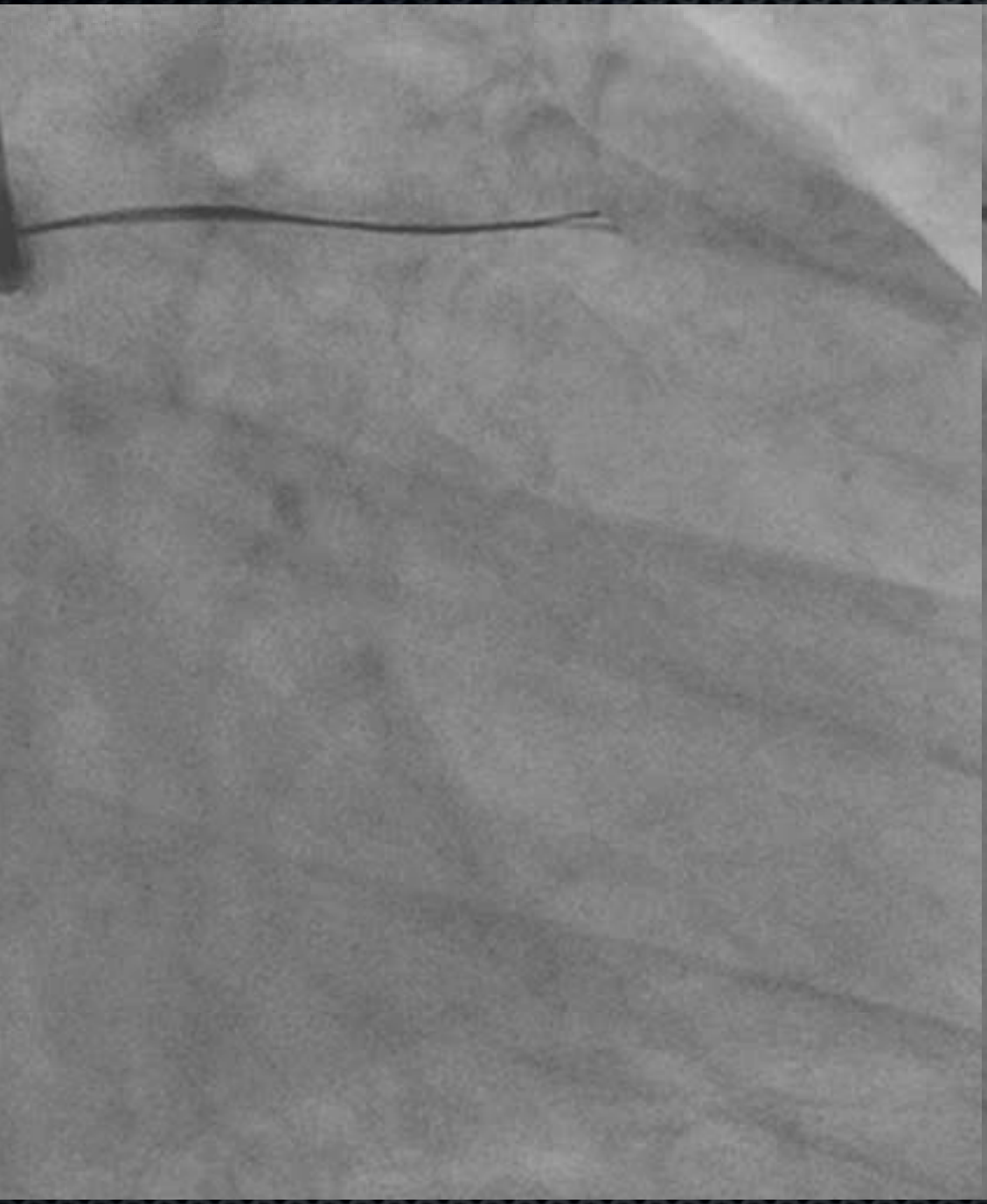

RAO
LAO

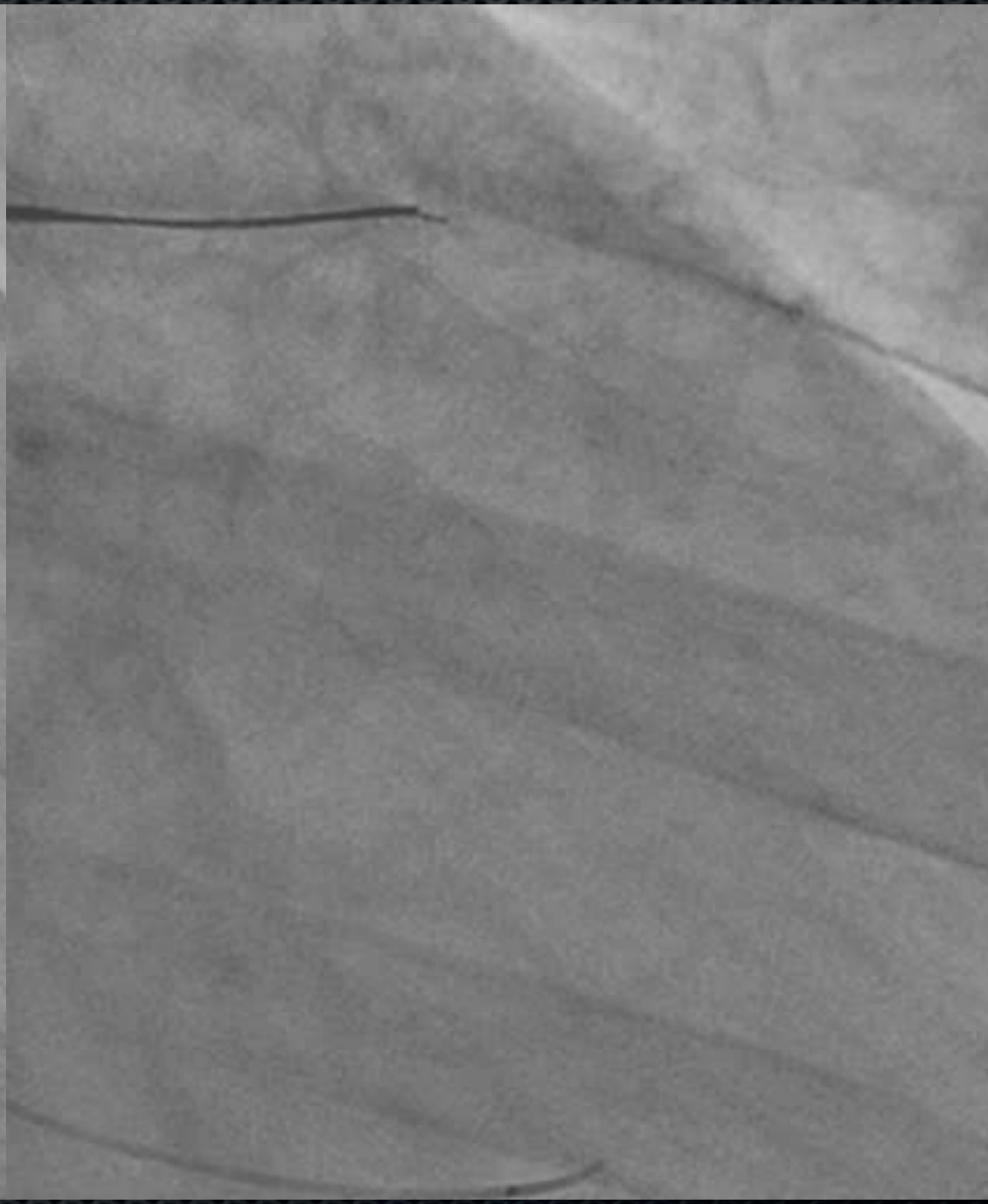

RAO Cranial
LAO Cranial

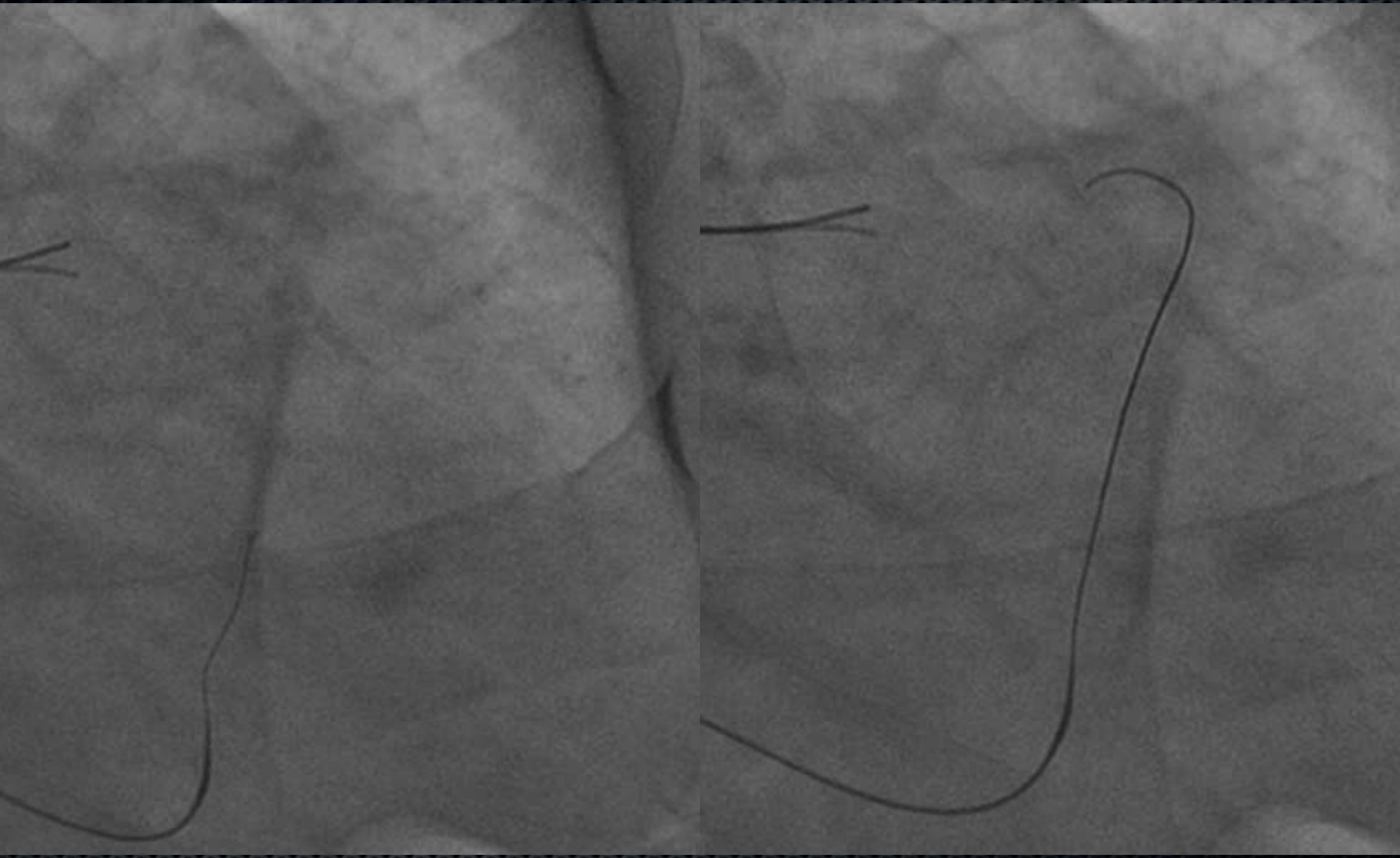
r + Fielder XTR → XT → Abyss Intermediate

RAO Caudal

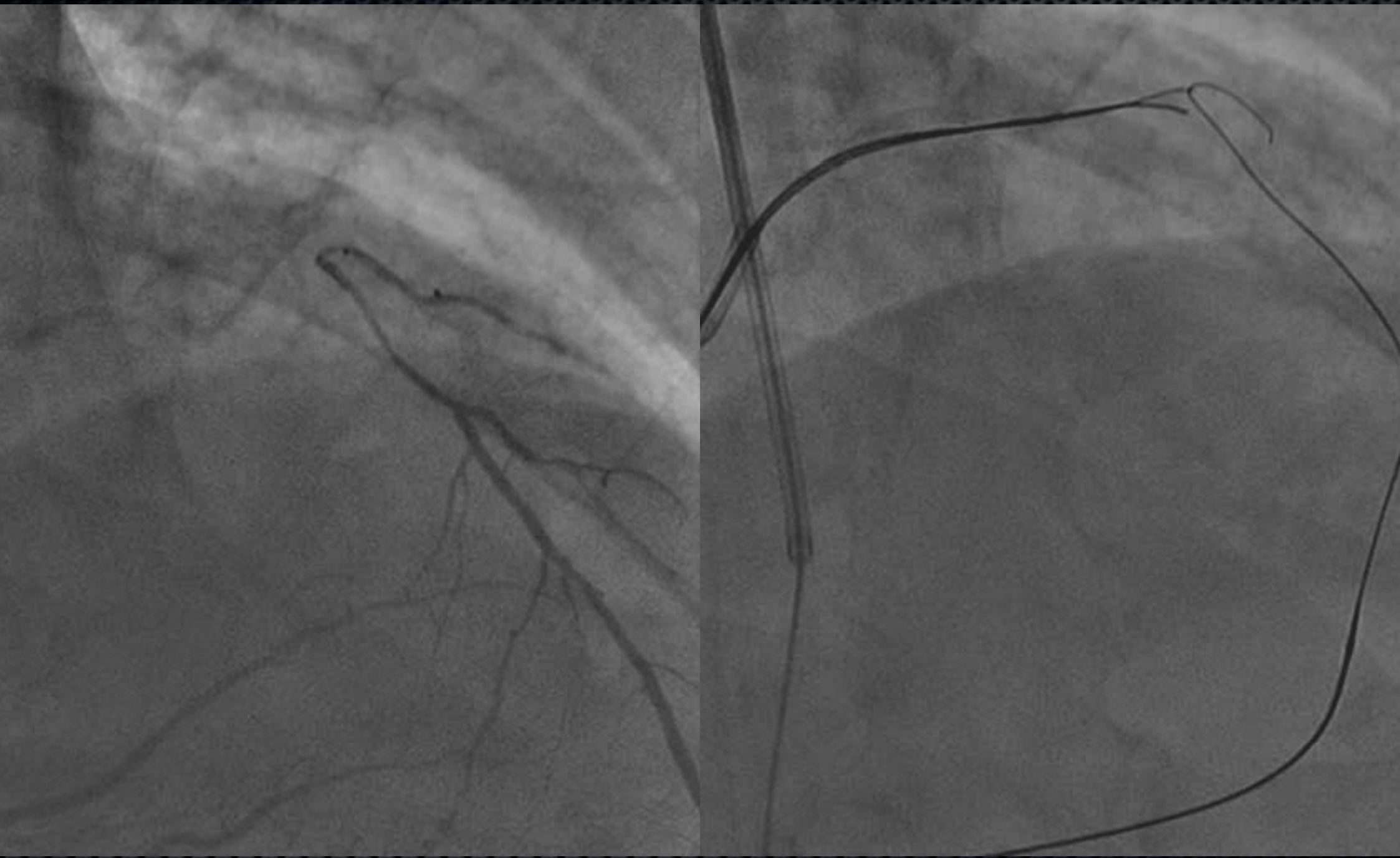
Tip injection with Cor



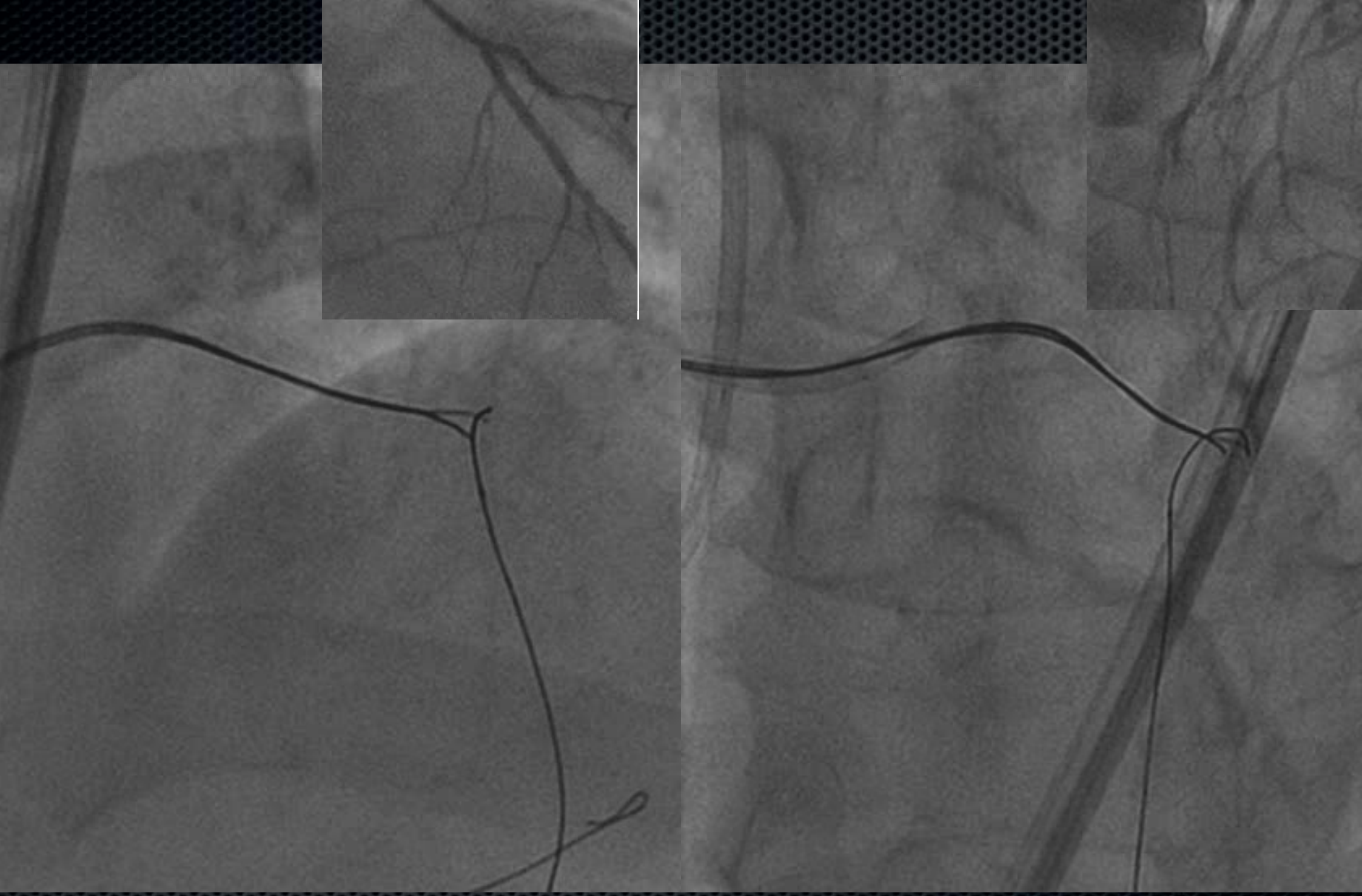




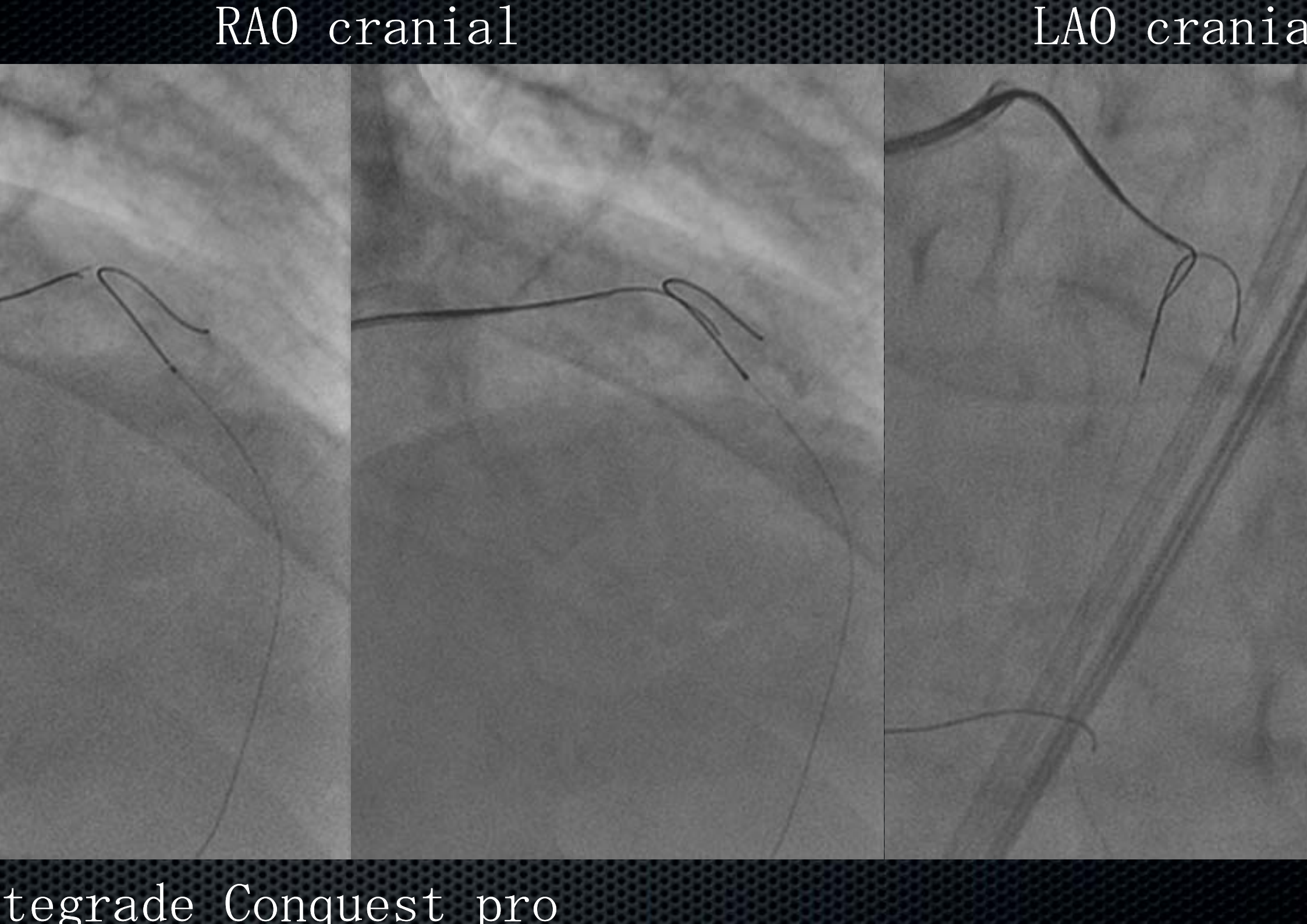
RAO cranial control

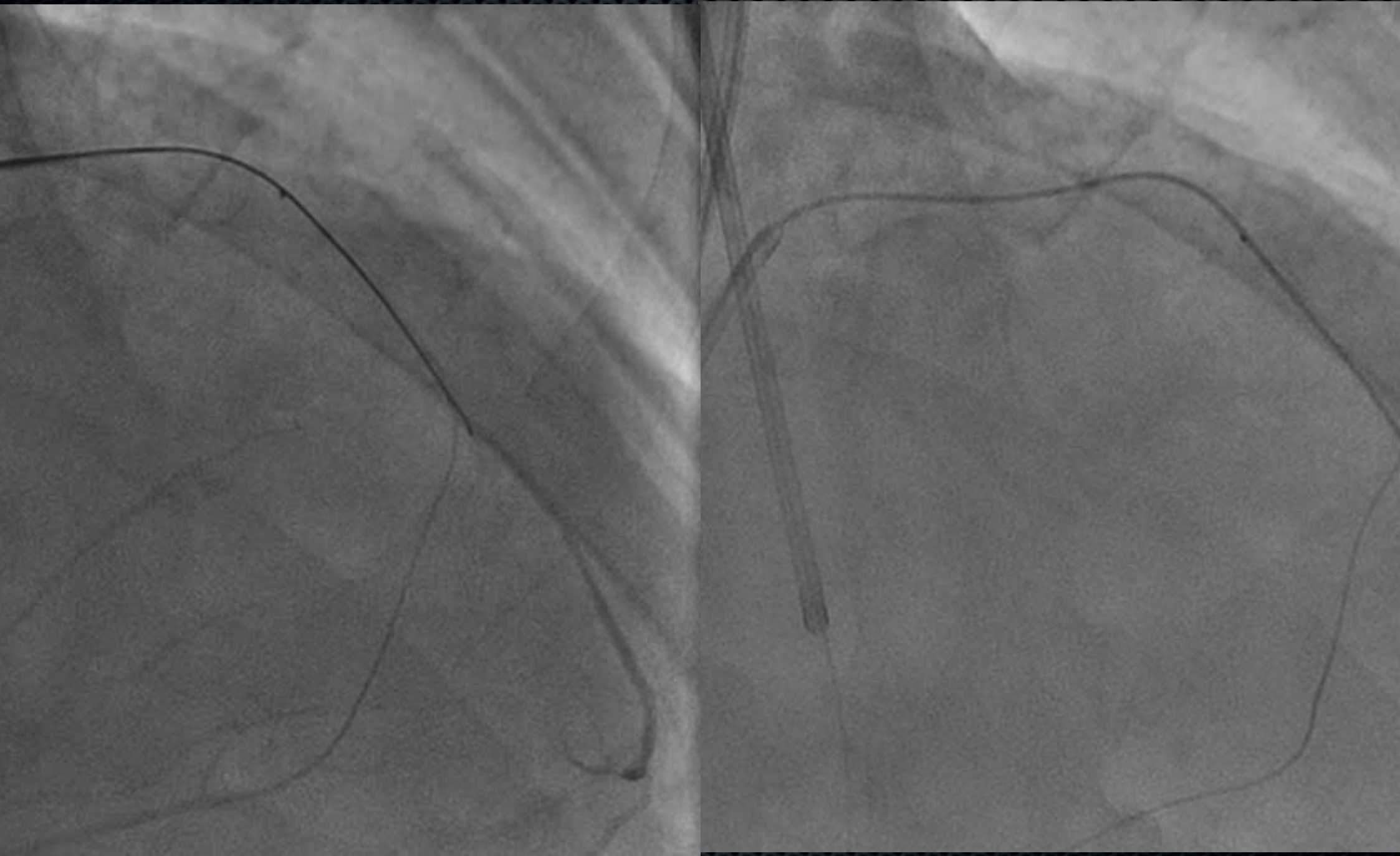


Corsair could not pass collateral channel

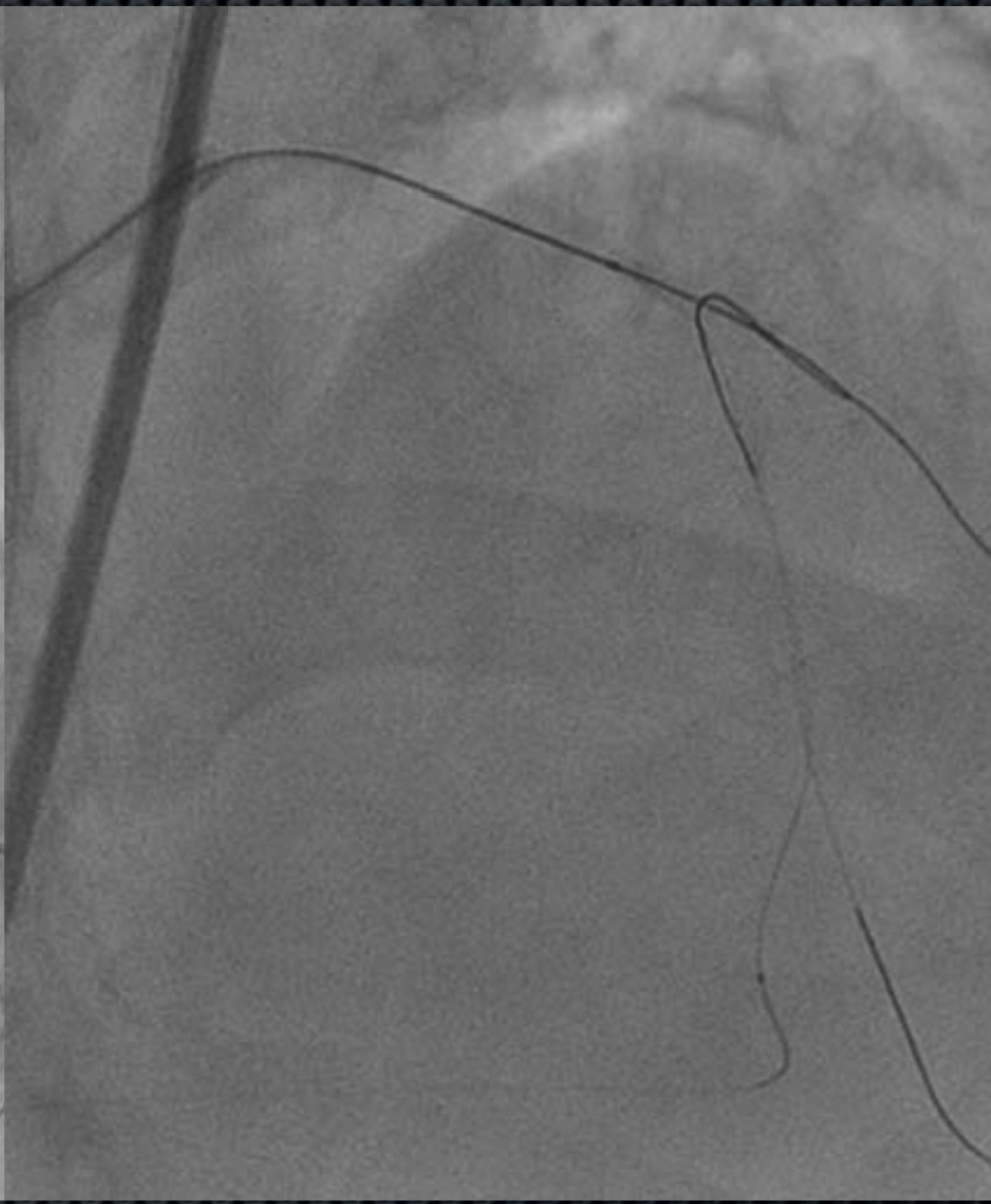


trograde wire could not advance into the CTO and easi

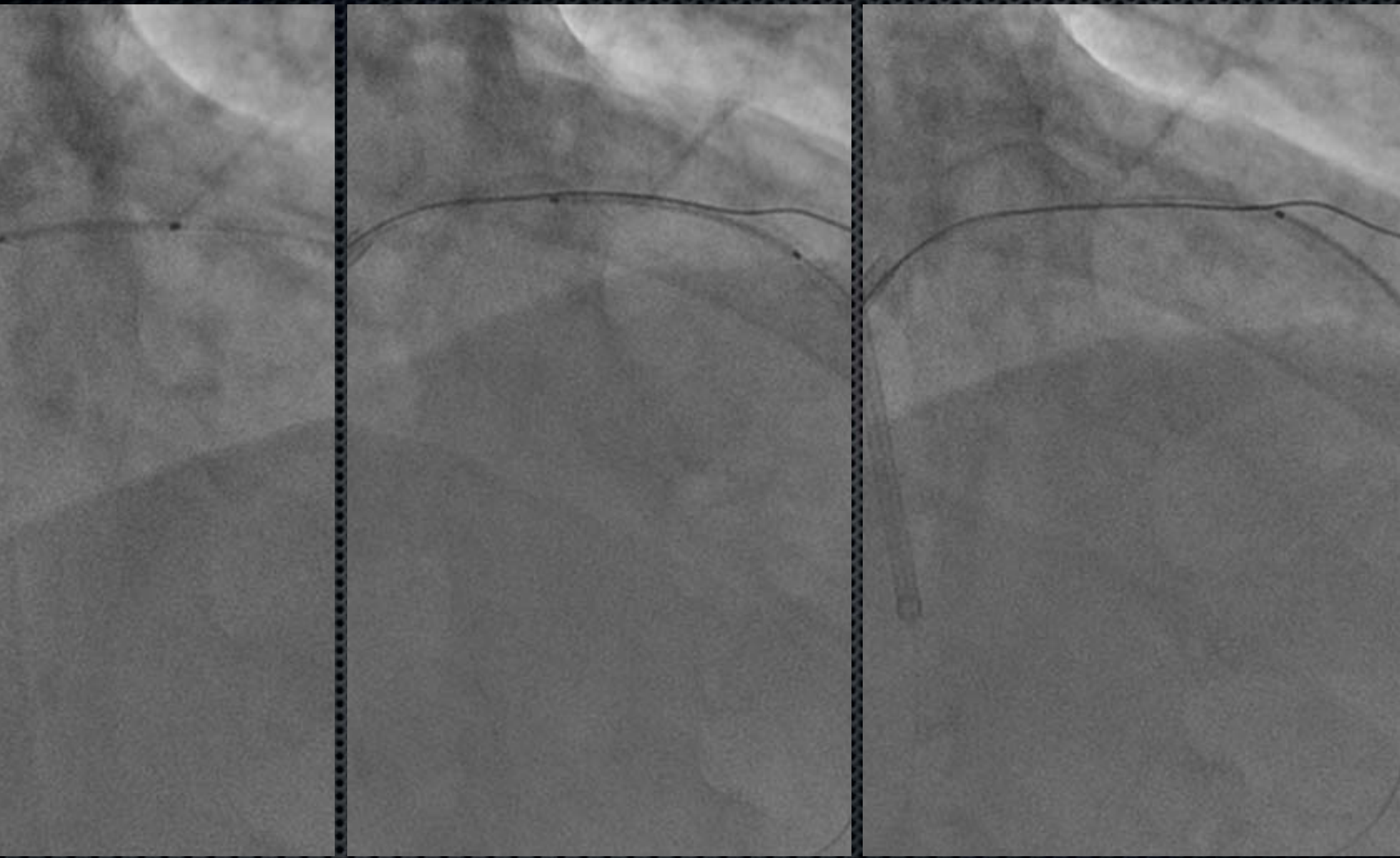

RAO cranial
LAO crania
tegrade Conquest pro



LAD POBA 2.0



Dx POBA 2.0


ES 3.5x18
EES 3.0x28
EES 2.5x28

# Final CAG

# Conclusions

We performed PCI for mid-LAD CTO by bi-directional approach.

The CTO lesion was located at bending portion.

Because of acute bend of the lesion, both antegrade and retrograde wire manipulation were difficult.

Using the retrograde wire as a marker, we could recognize the distal true lumen continuously with multi-angle projection, the antegrade wire could cross the CTO lesion successfully.