

My Best Case in 2014

IVUS Guided wire Reentry in CTO

– A case of RCA CTO

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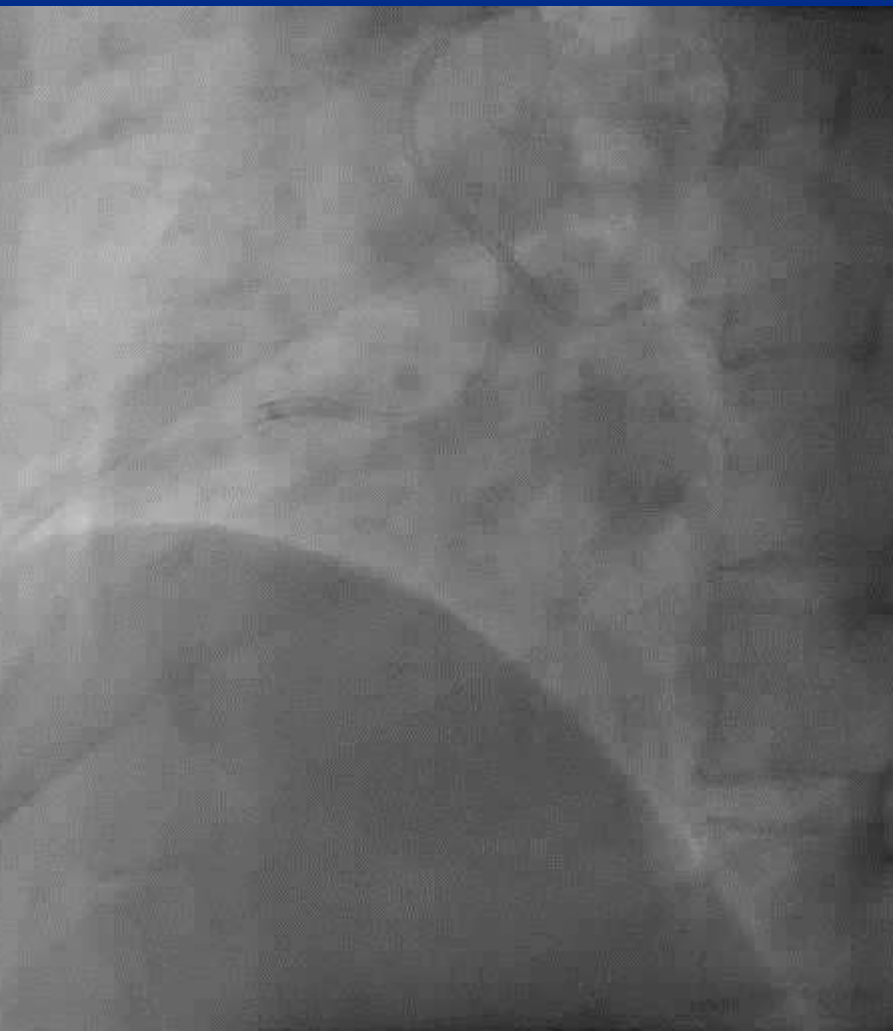
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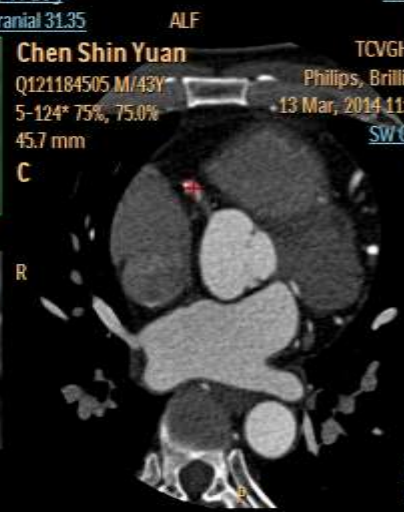
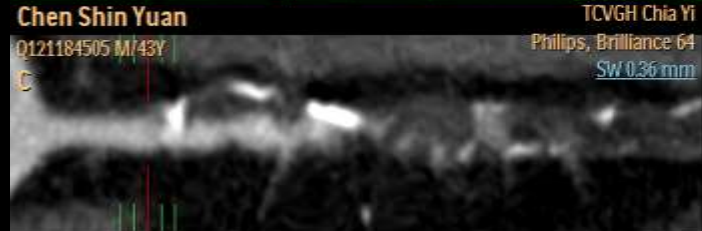
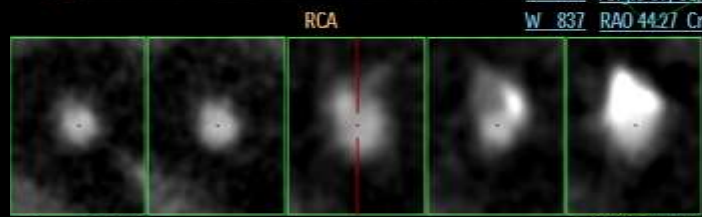
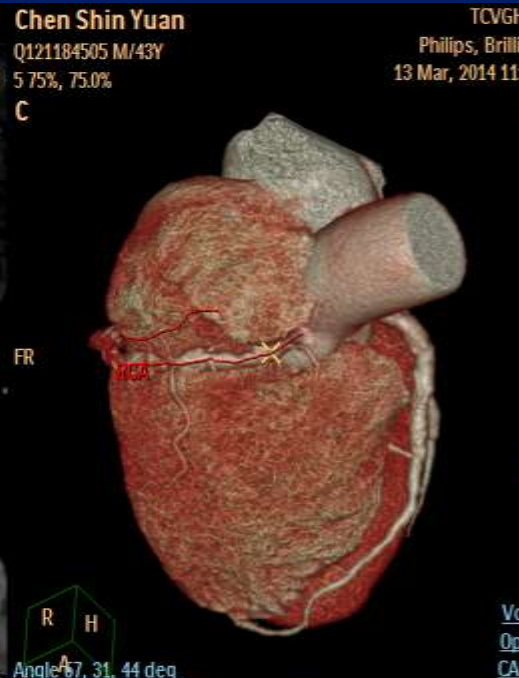
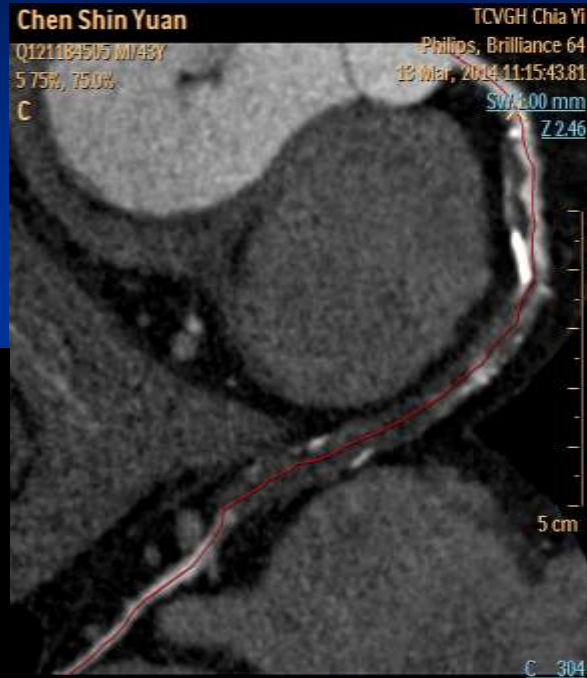


- 45 Y/O M, H/T, family Hx
- ACS S/P PCI over LAD-D1
- RCA long CTO – PCI failed



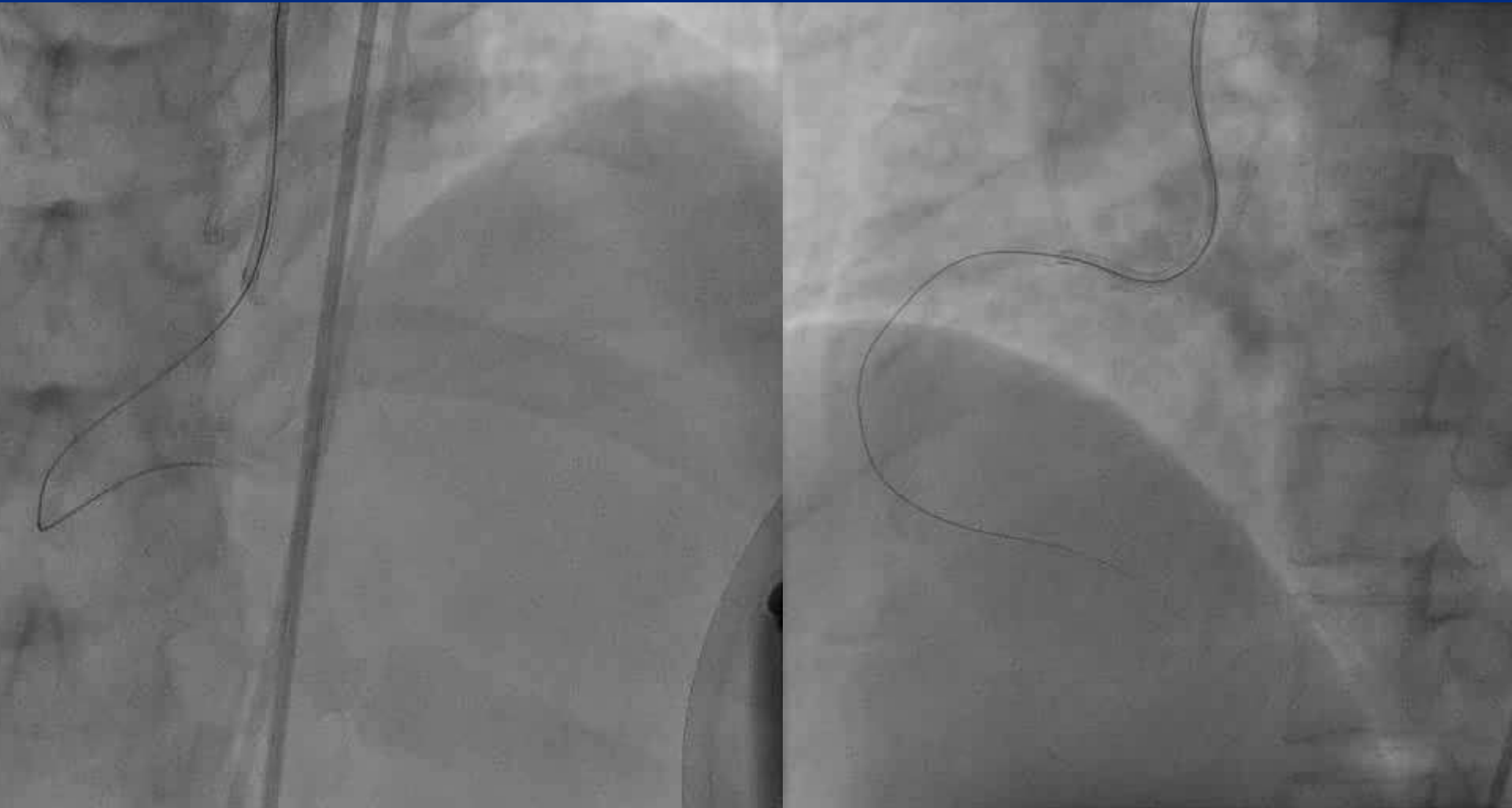
• MDCT

- large RCA with long CTO lesion (> 5 cm) and some calcification



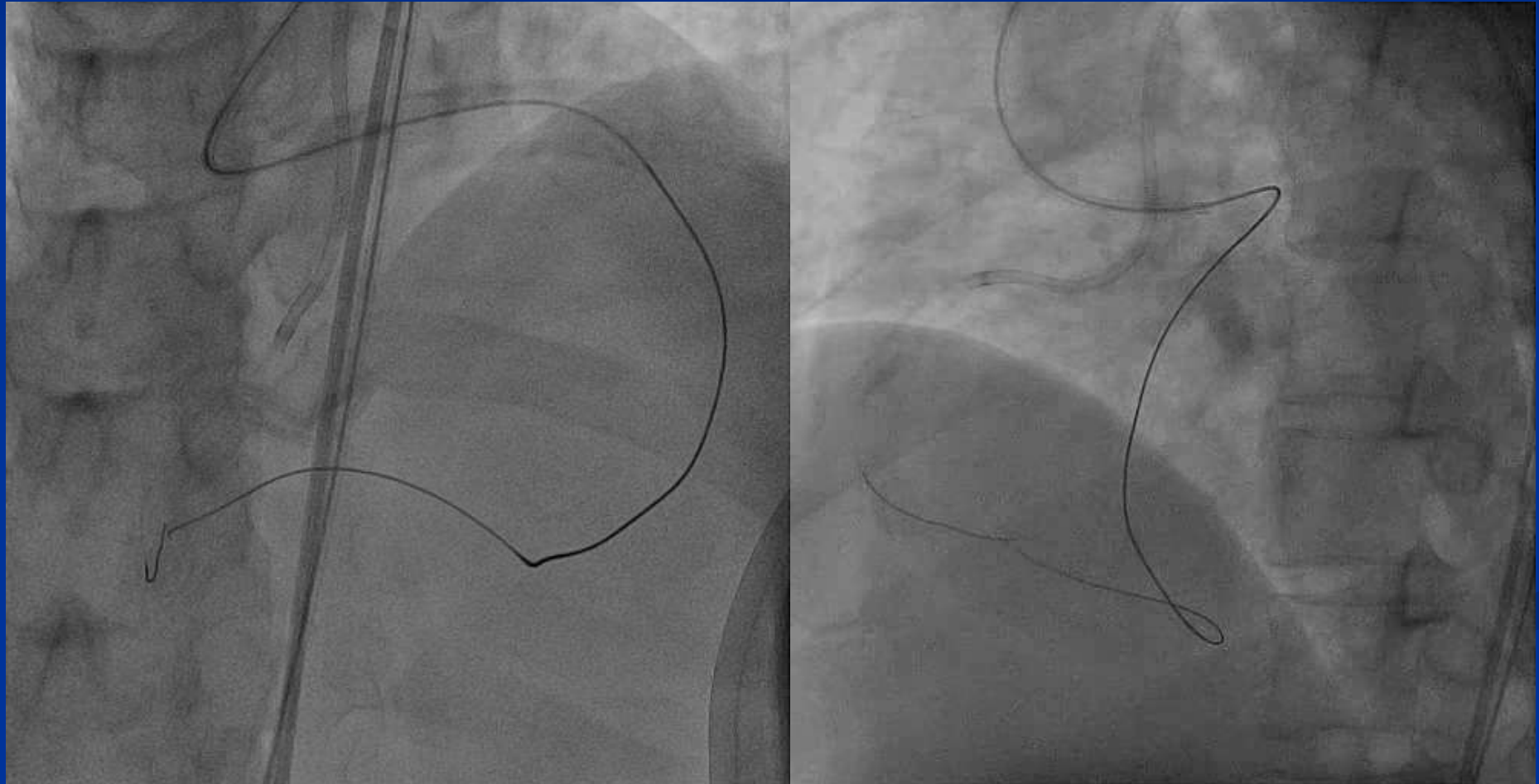
Antegrade approach

Filder FC >> Provia 12 GW..... false lumen likely



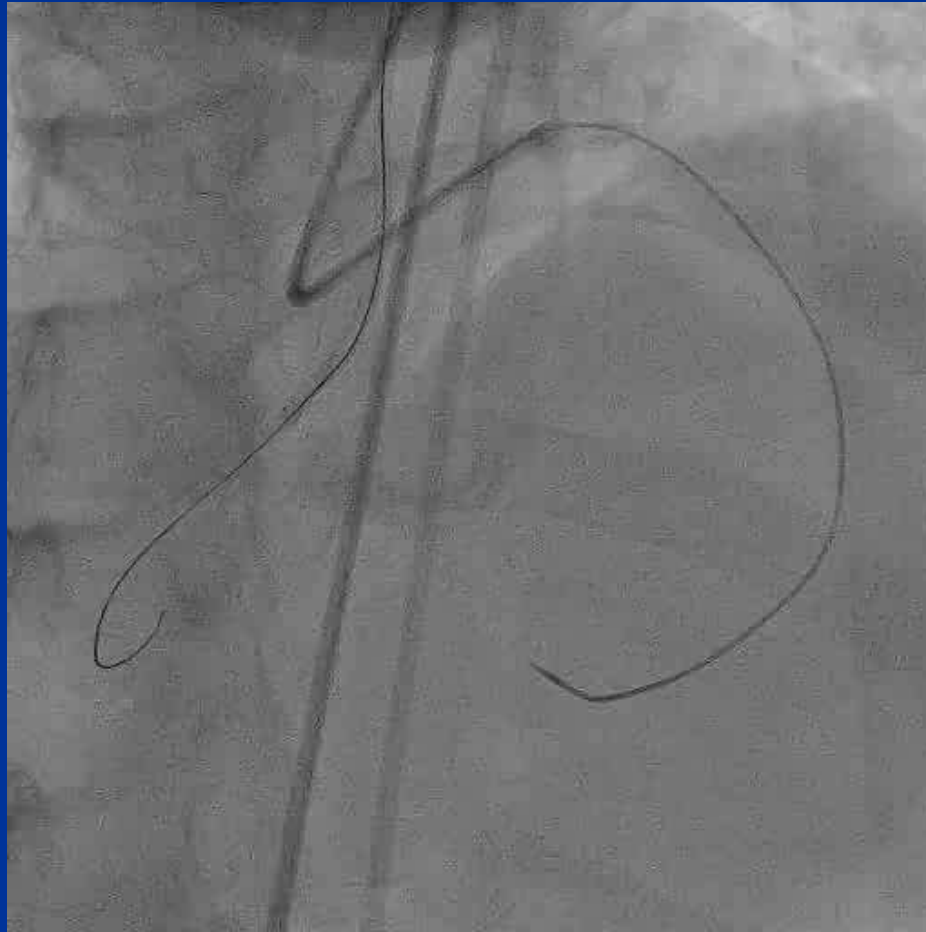
Retrograde approach

>> try kissing wire tech but both GW cannot advanced (ante provia 12, retro U3)



Retrograde approach

- >> try Conquest GW
- causing dissection of PDA br !!!
- try another collateral, but all failed



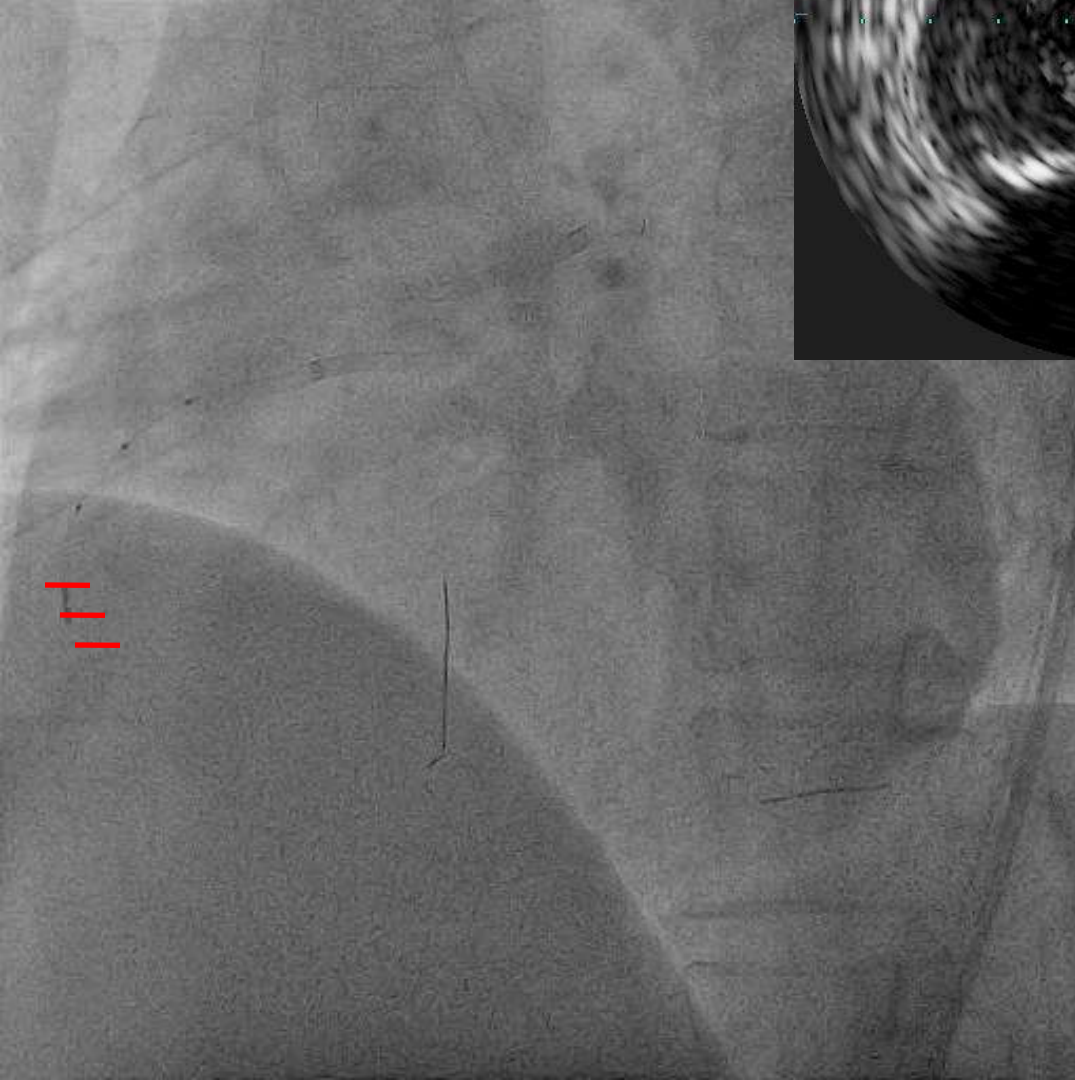
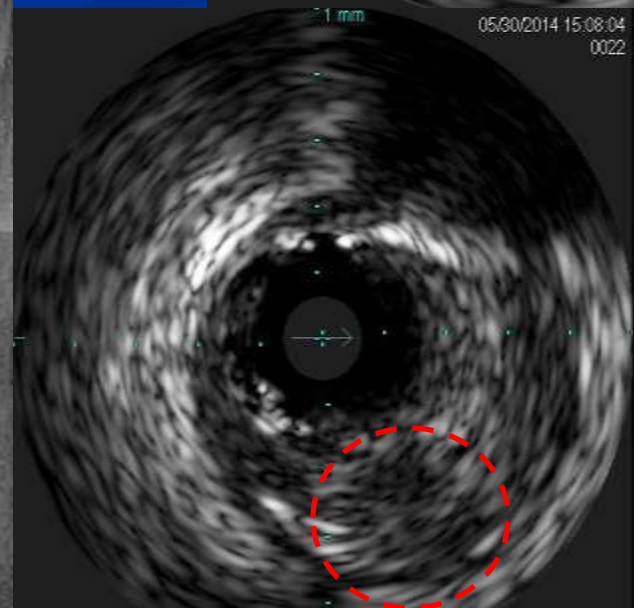
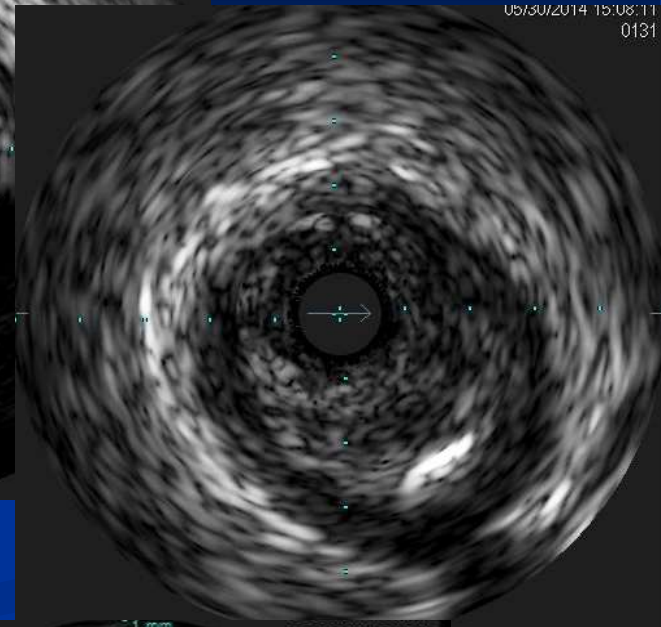
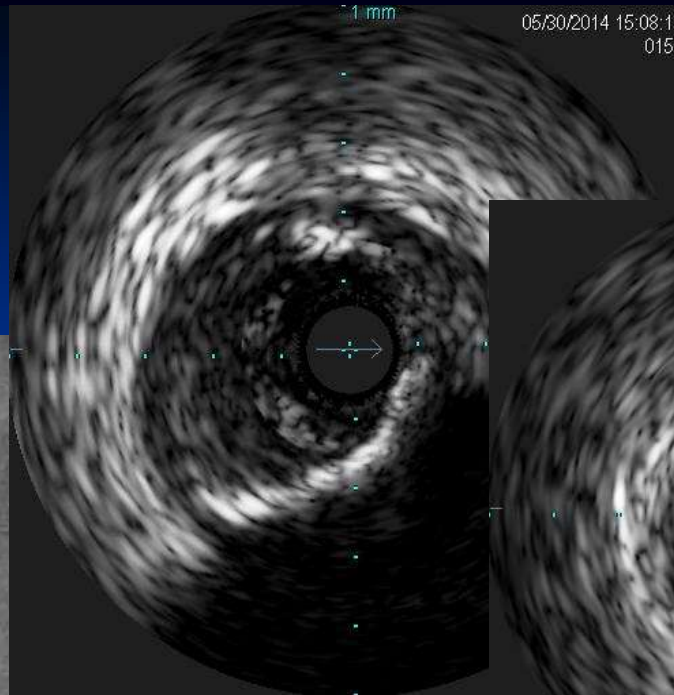
Antegrade approach again

>> try Conquest GW / Provia 12 GW

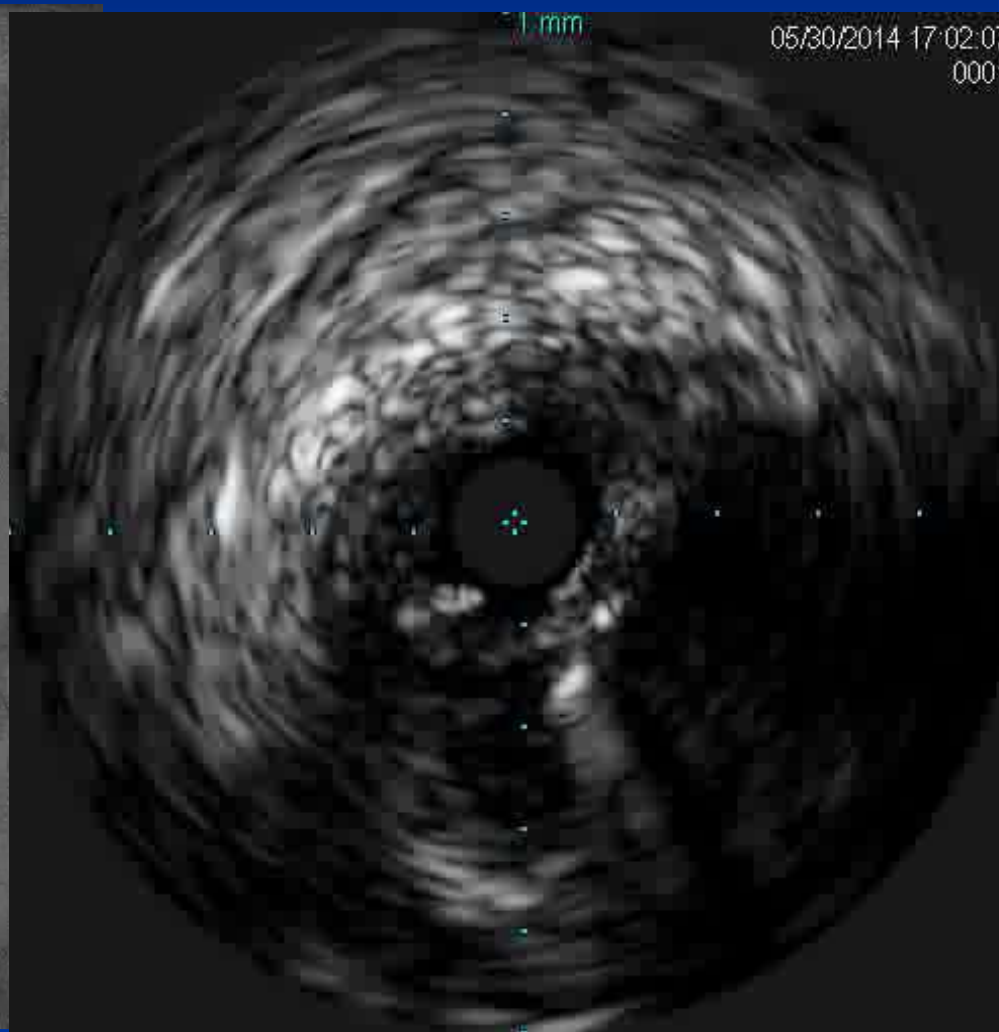
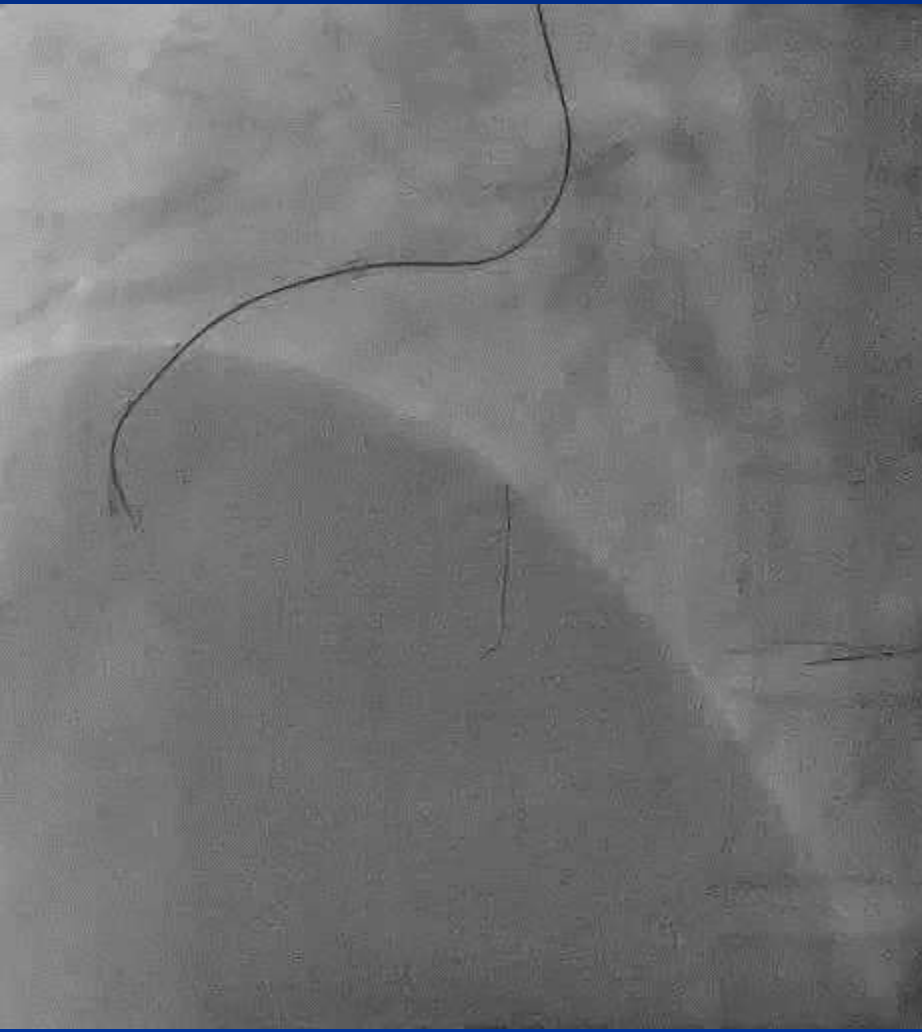
>> probably true-false-true!!!

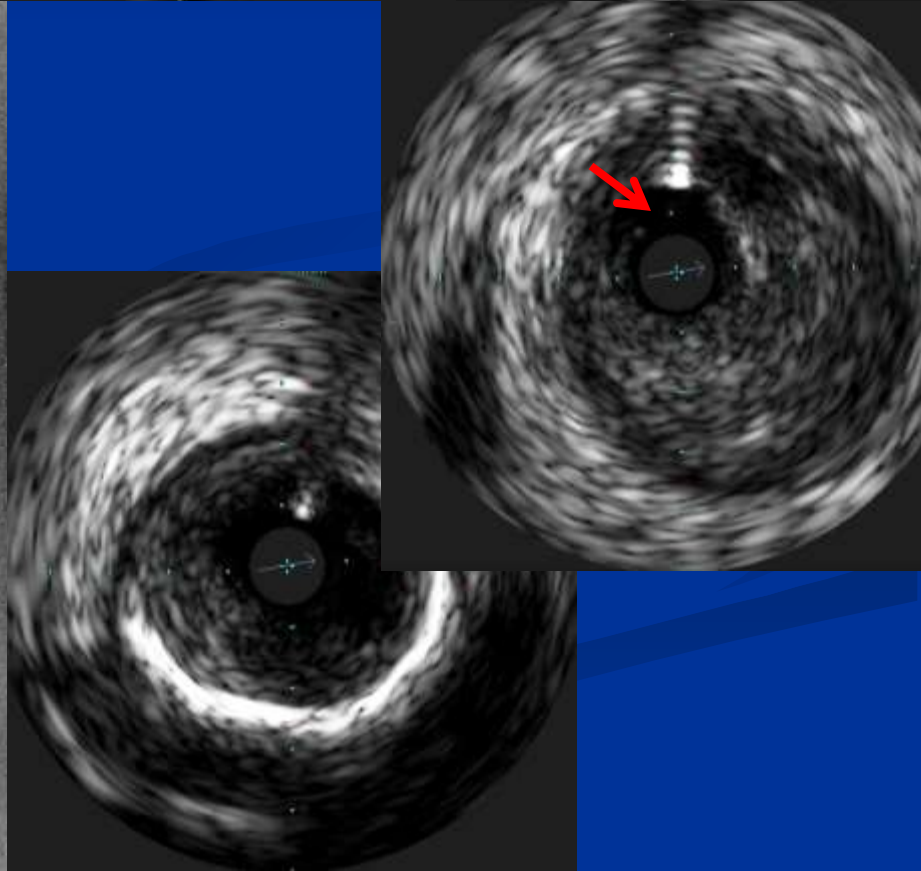
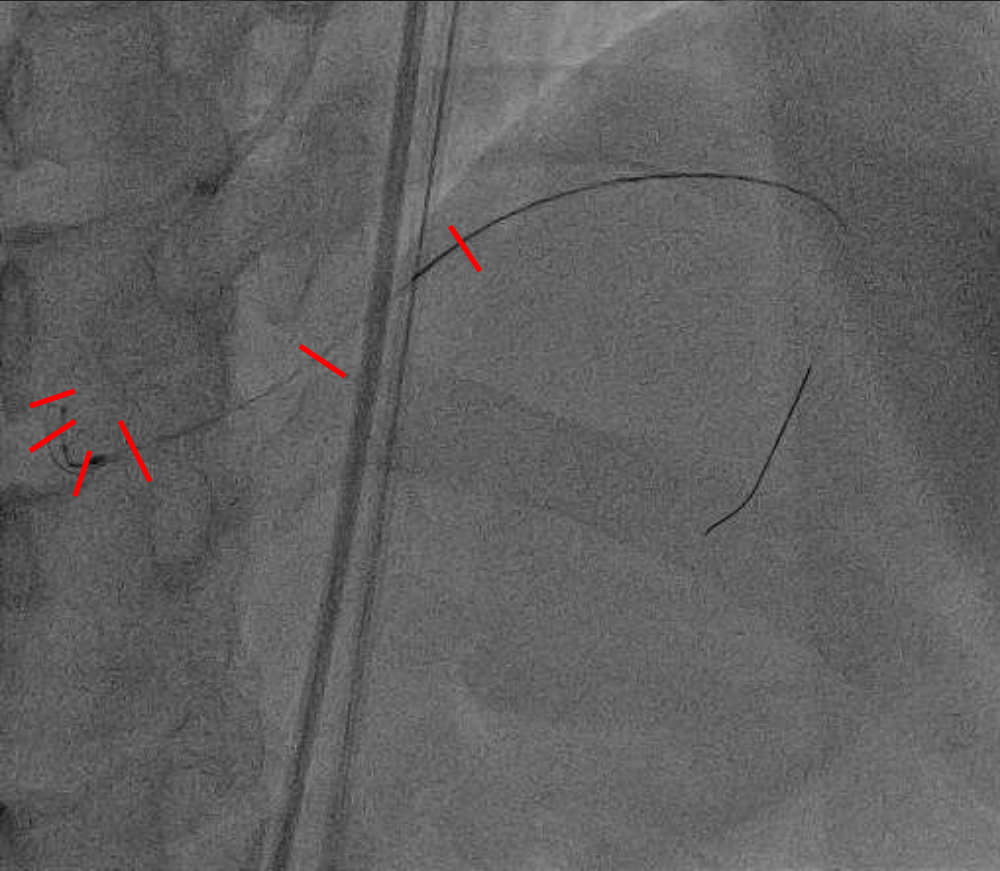
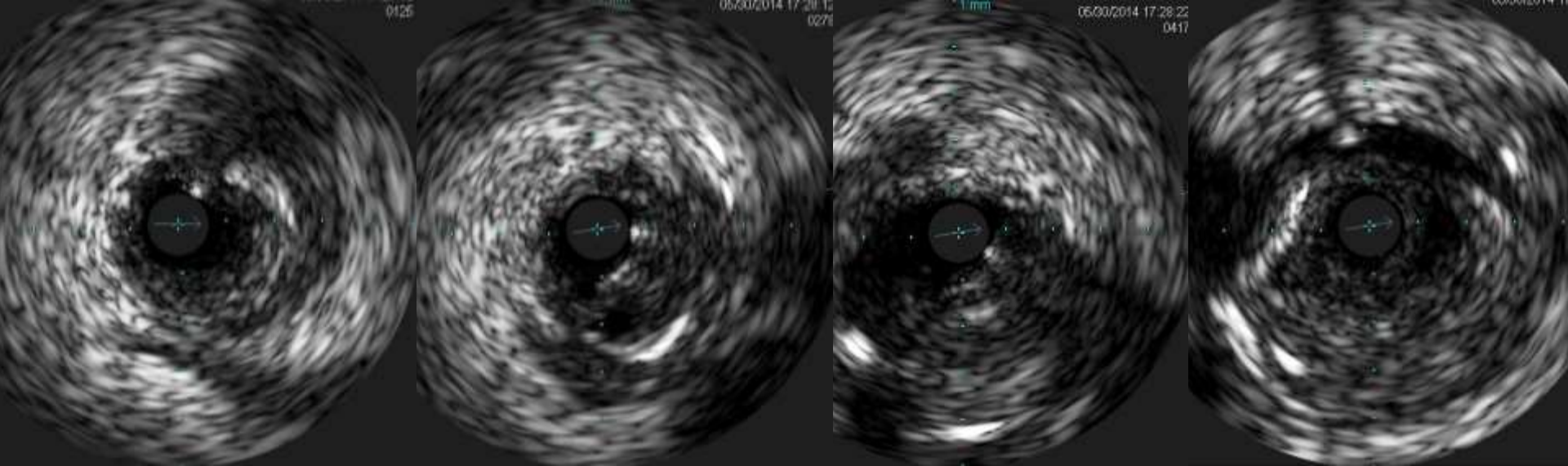


Identify the entry-point by IVUS

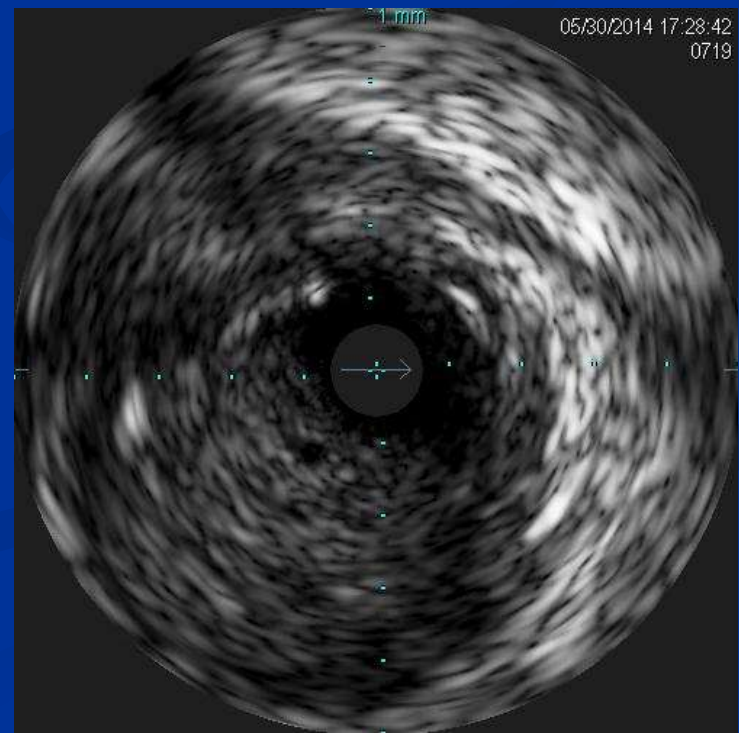
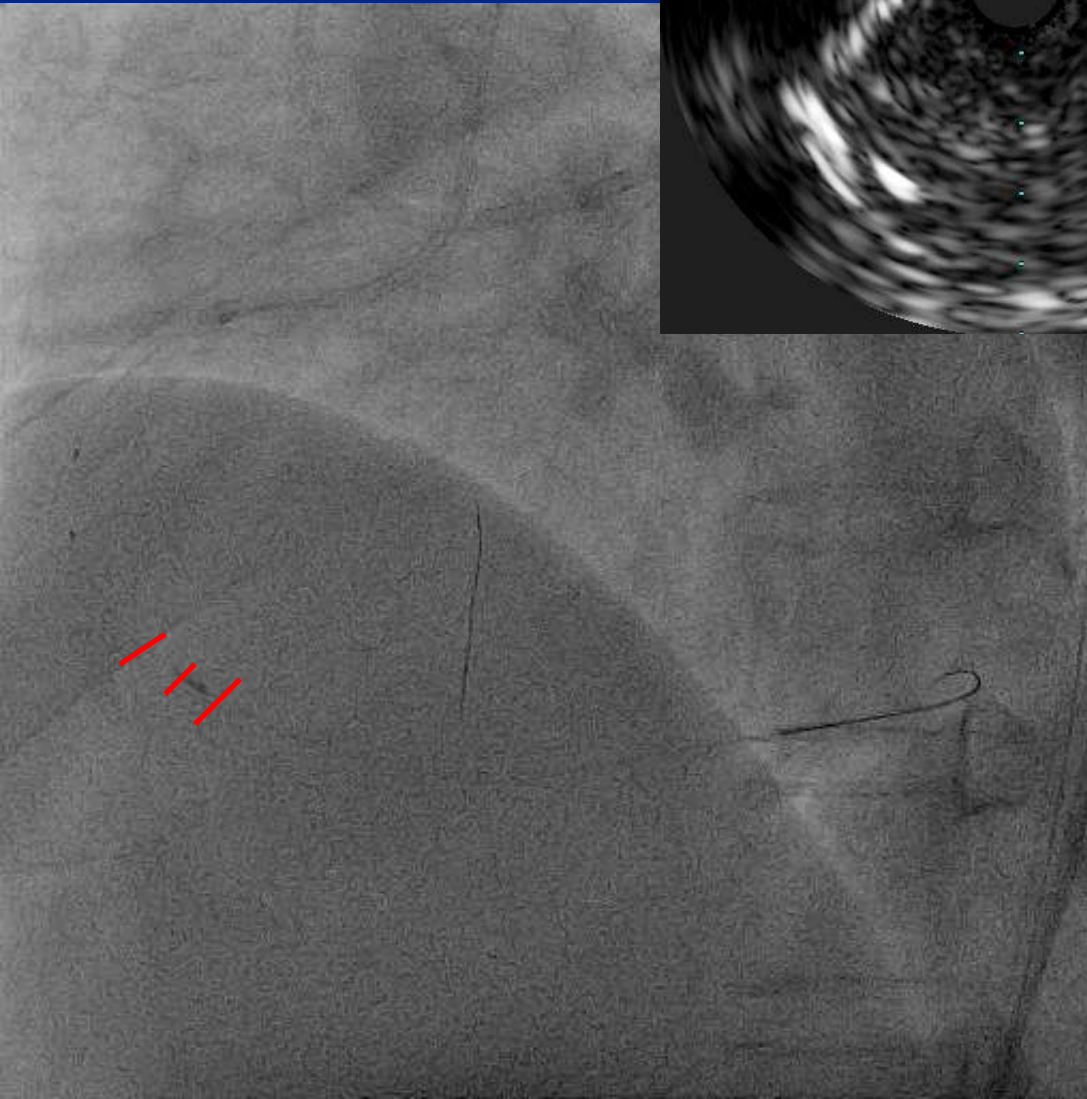
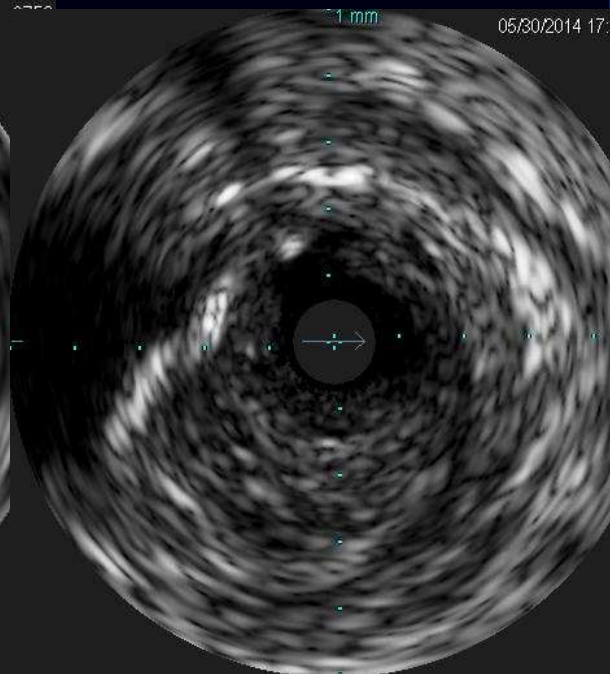
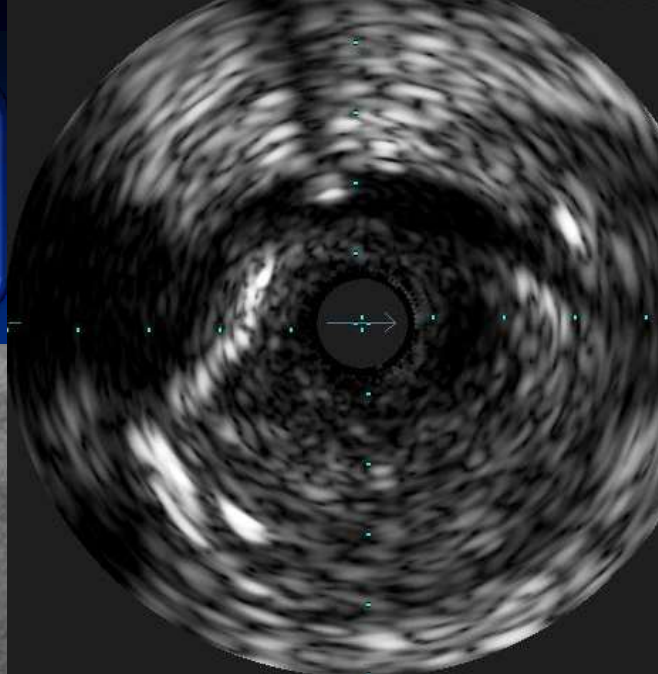


1st IVUS-guided re-entry

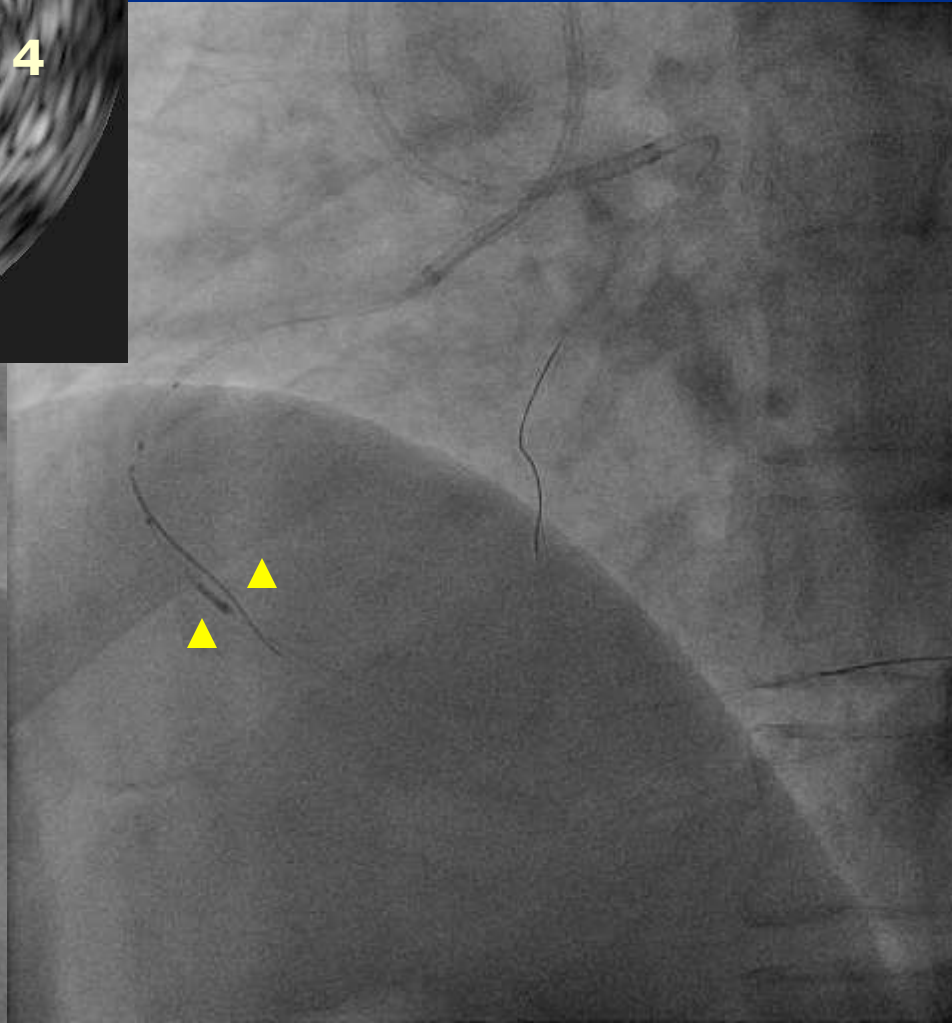
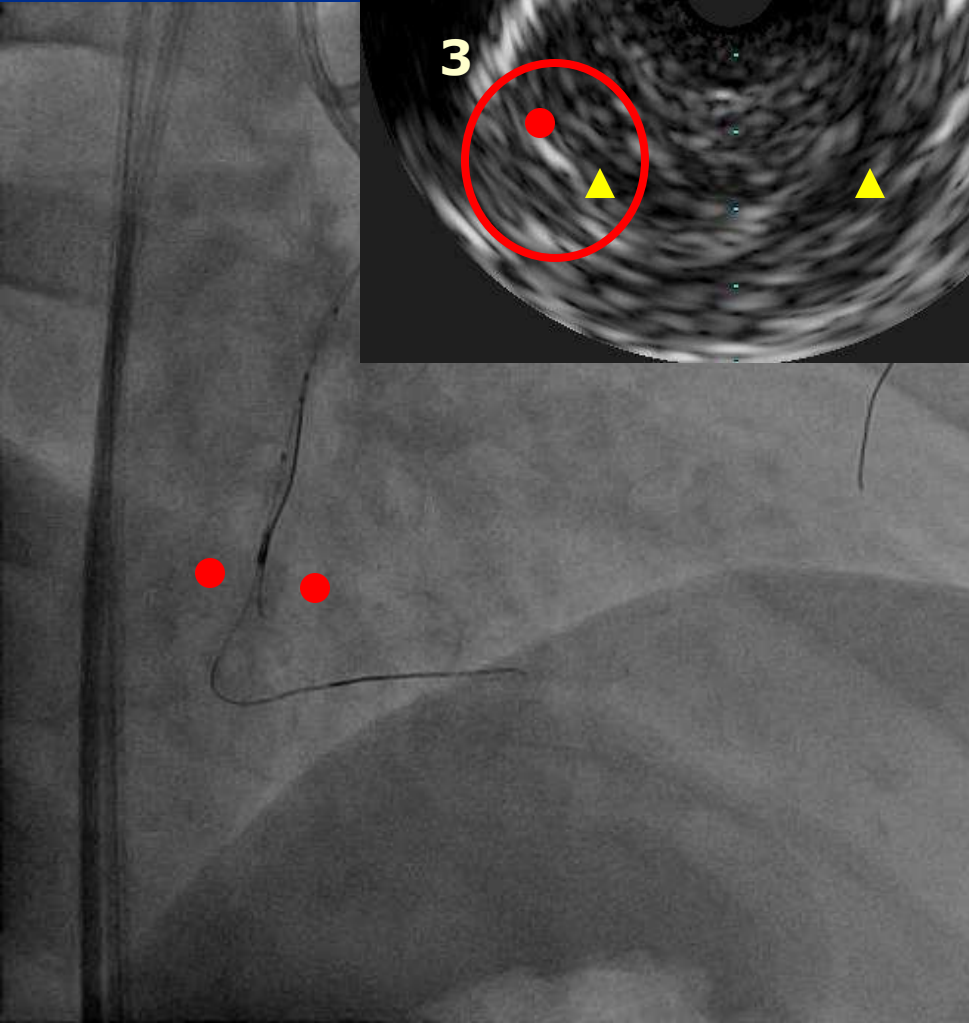
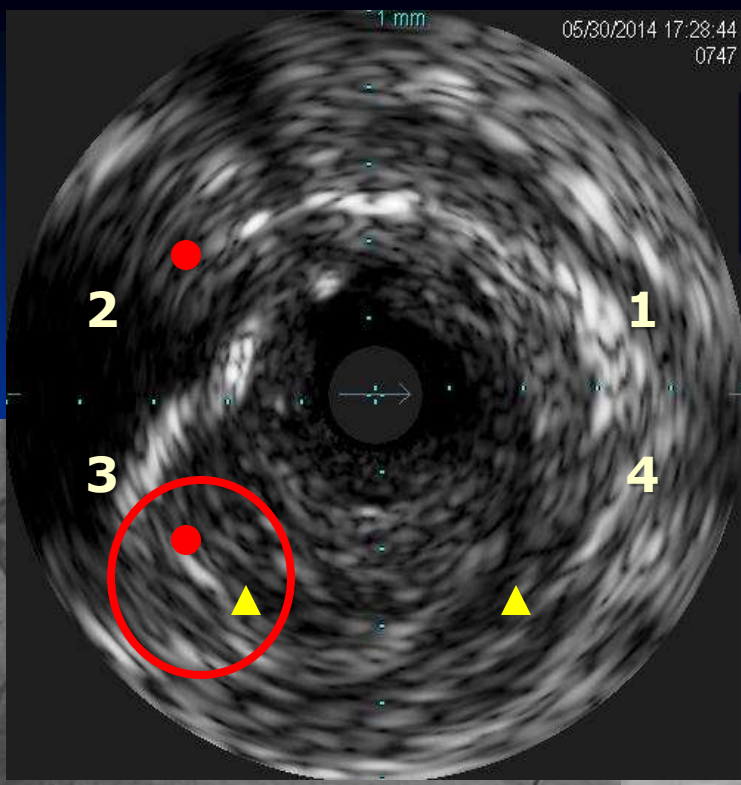




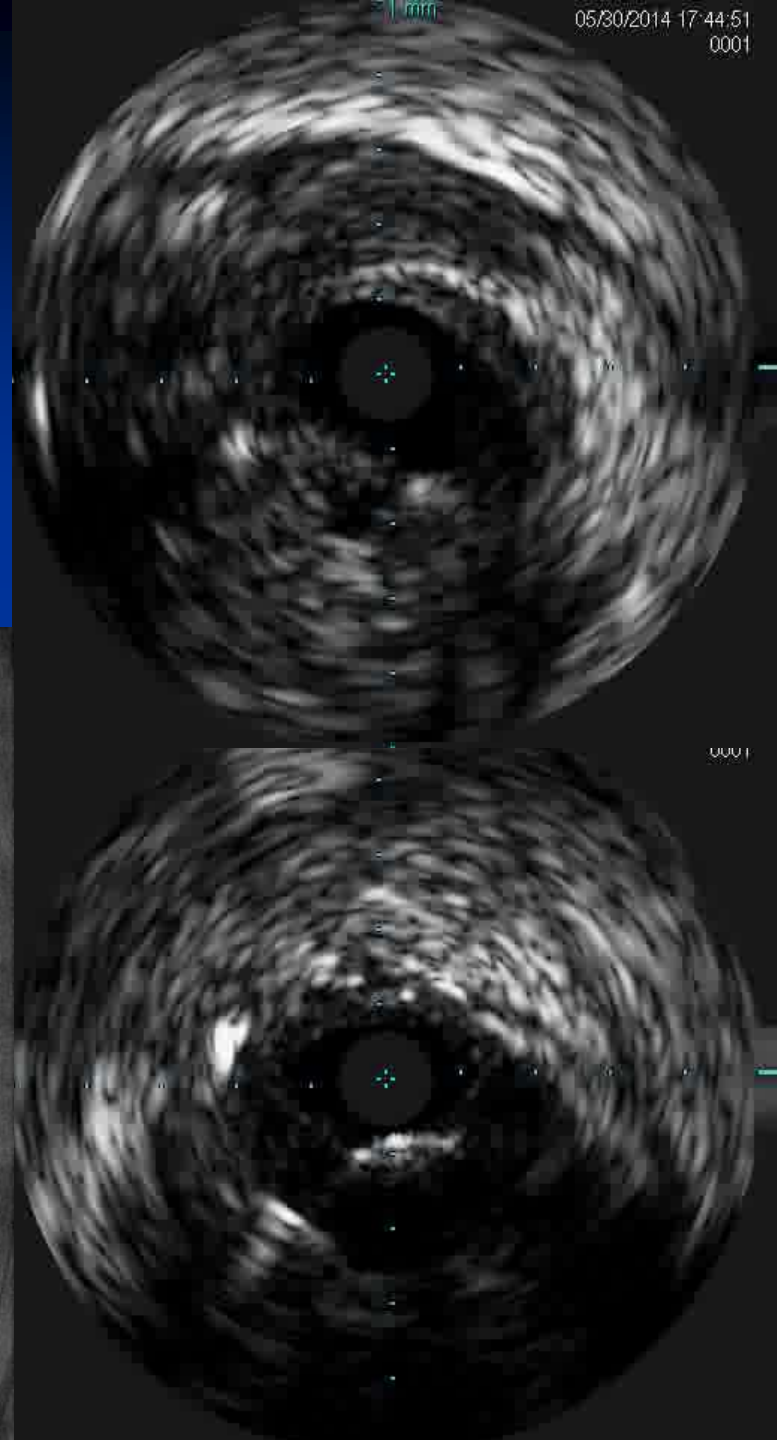
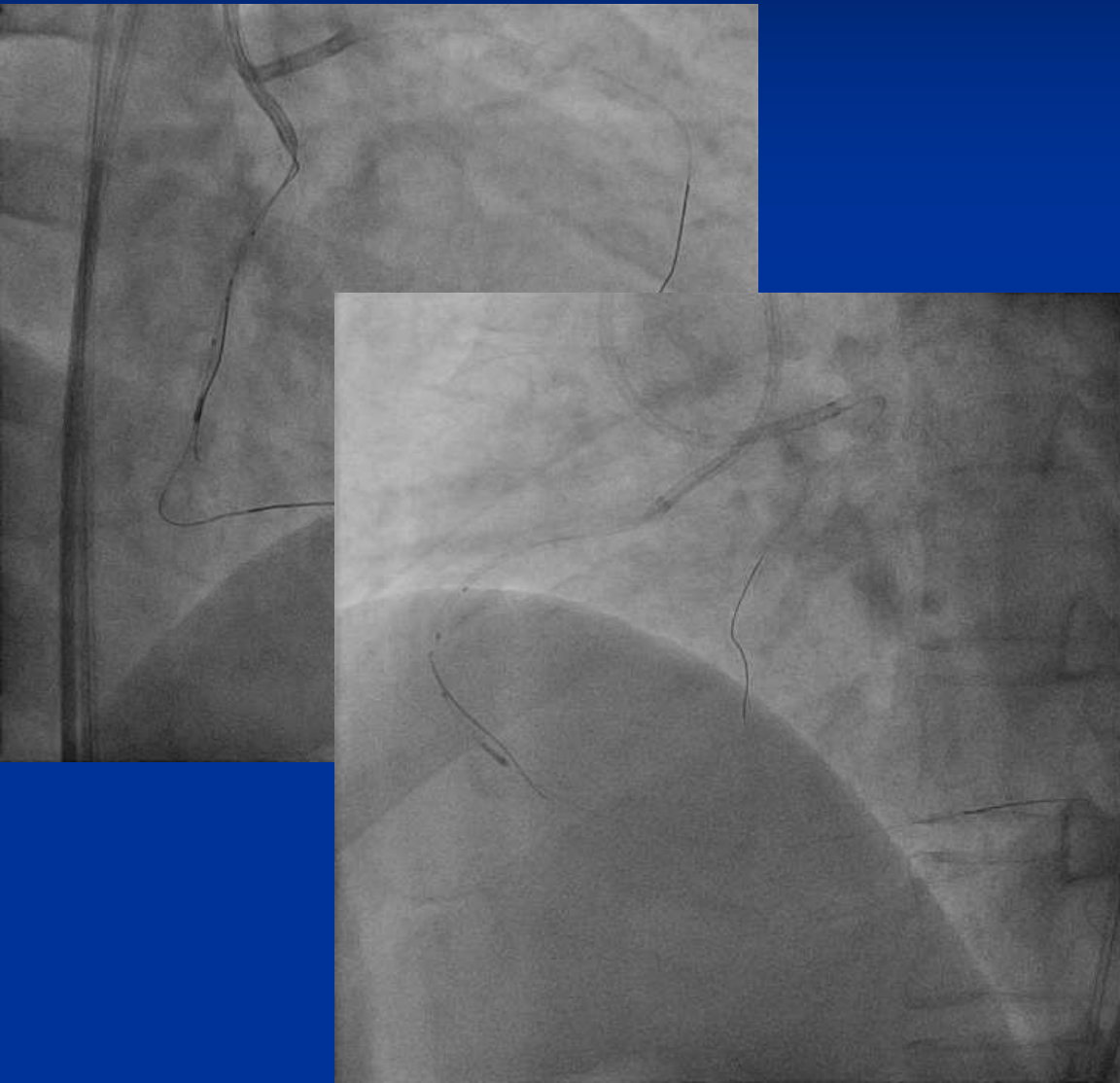
Identify the
2nd entry-point



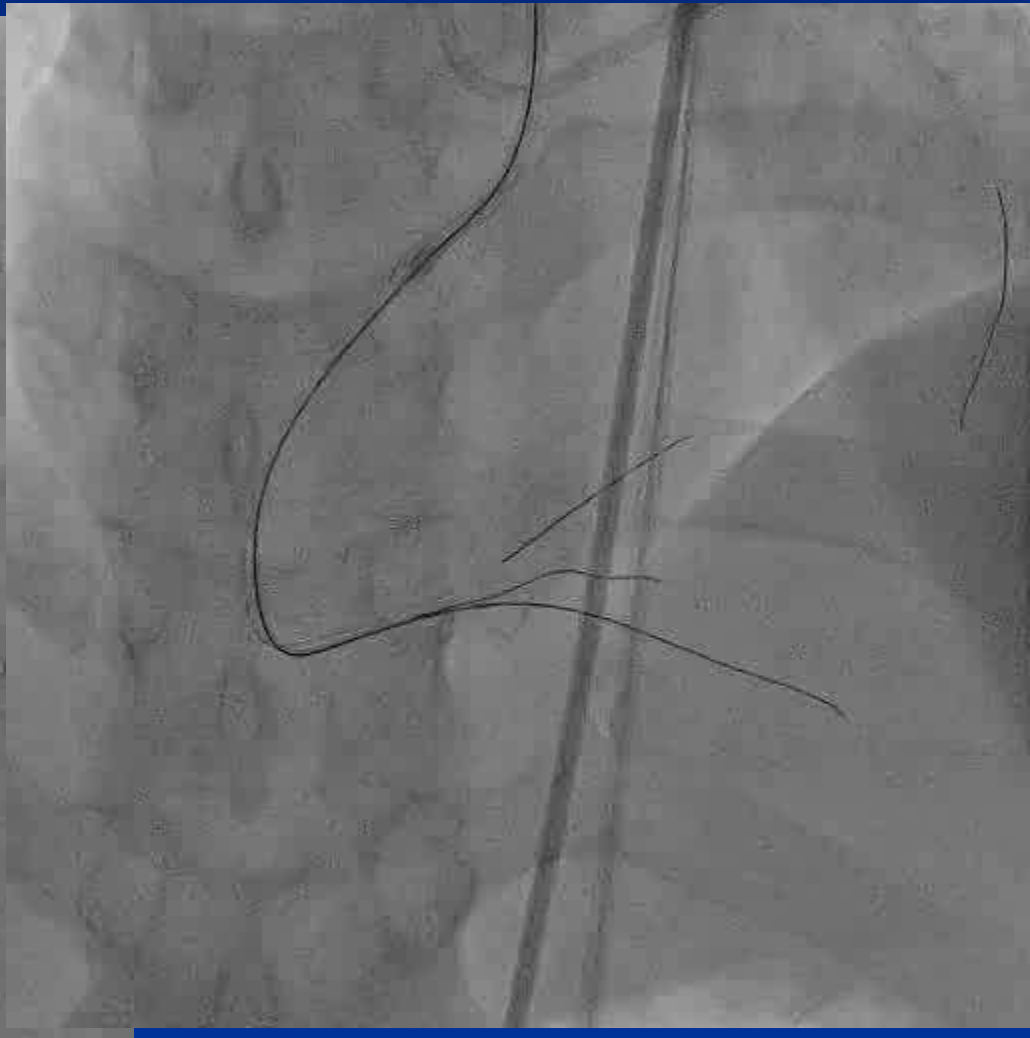
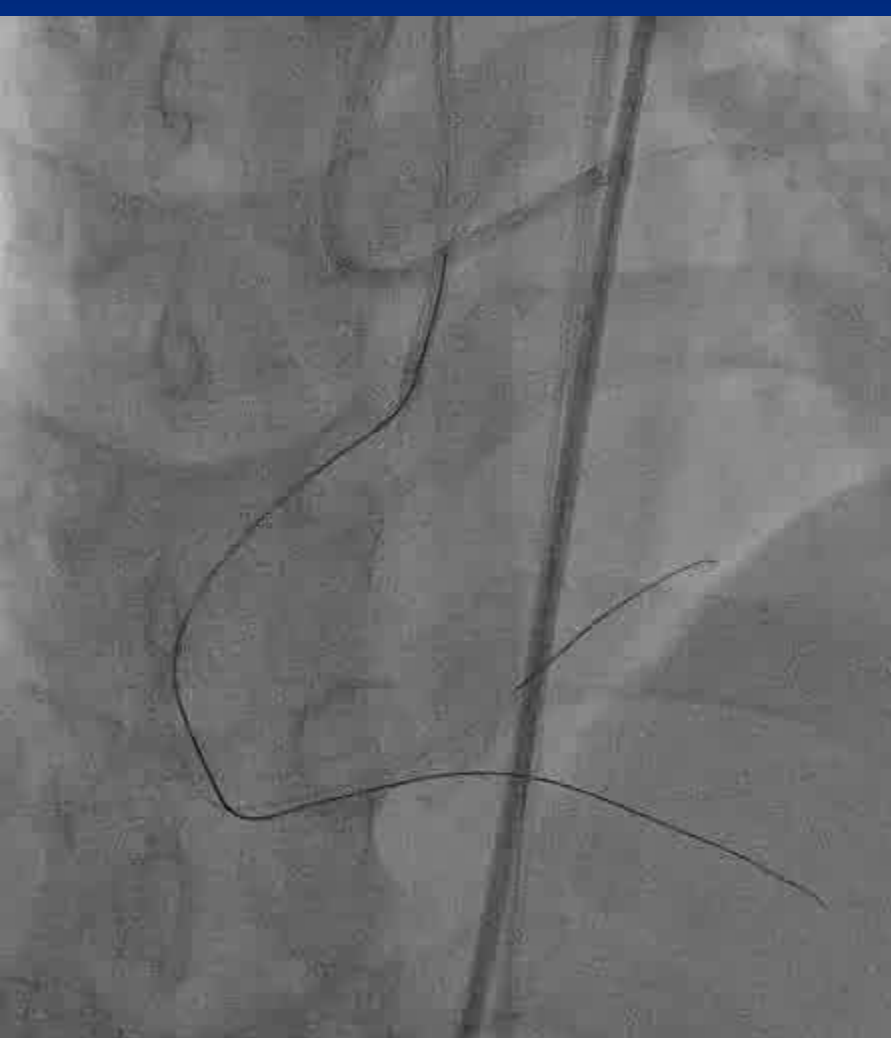
2nd IVUS-guided wire re-entry

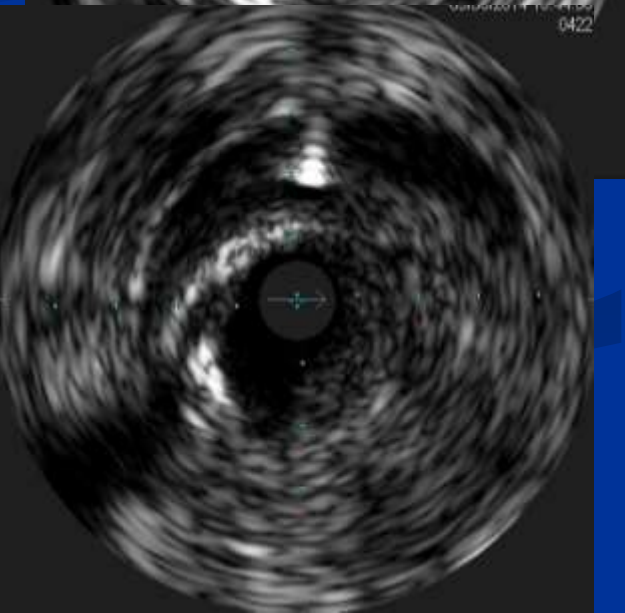
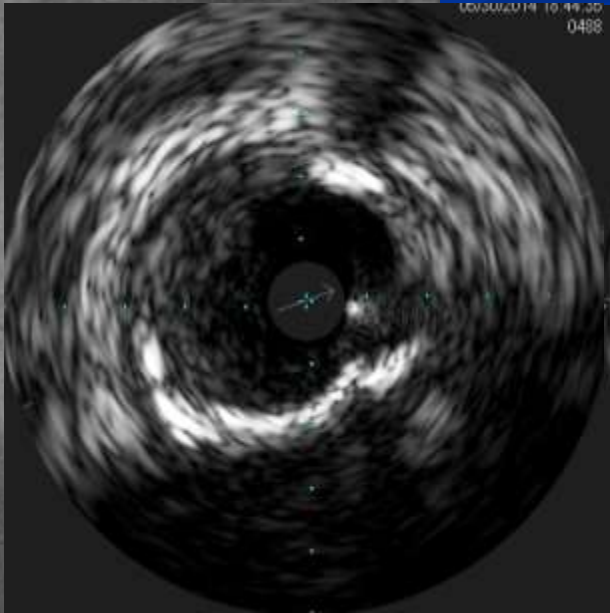
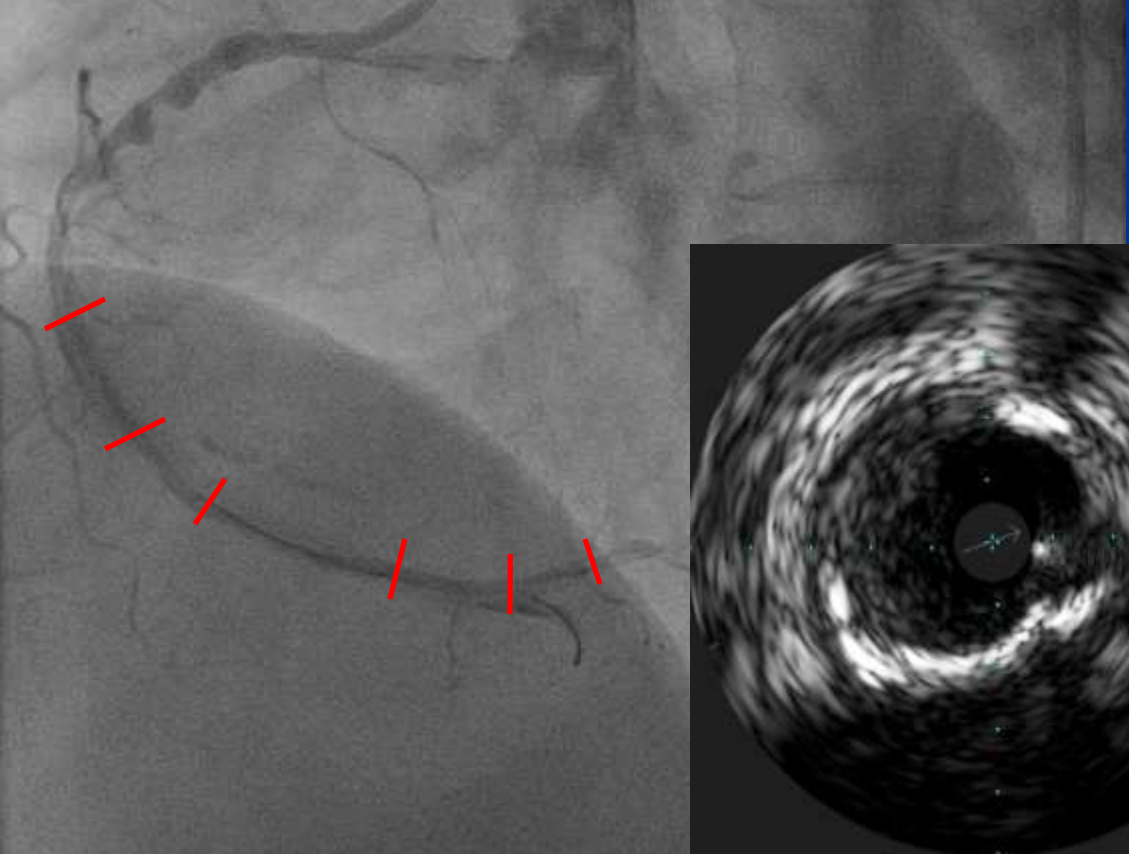
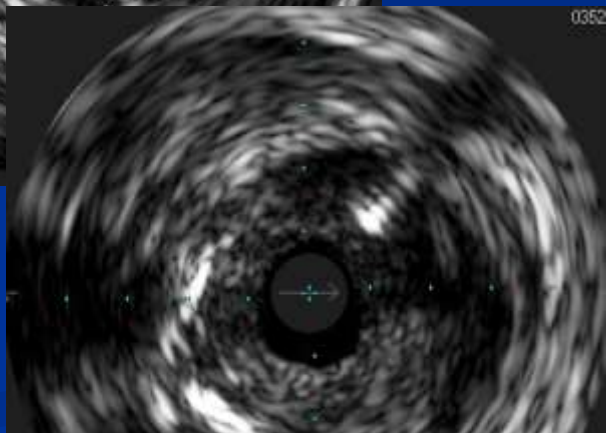
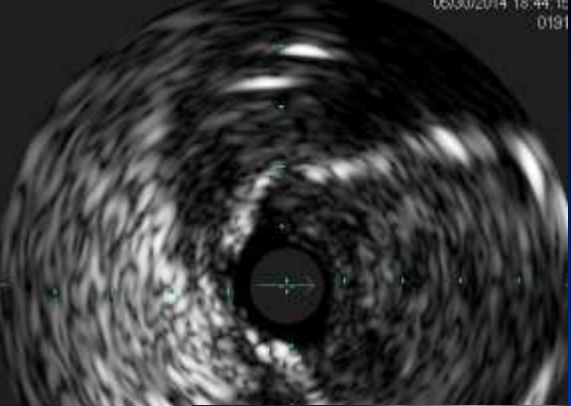
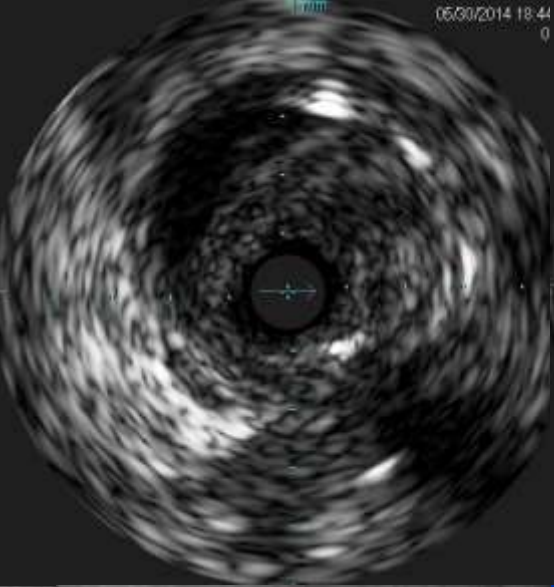
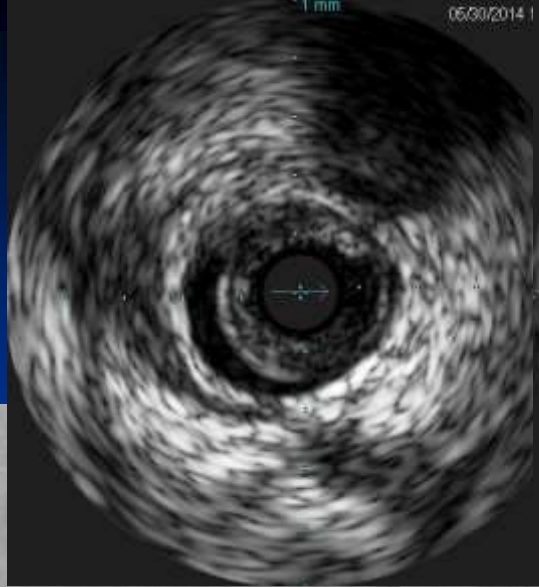


2nd IVUS-guided wire re-entry



- Confirmation of Conquest GW in the distal PDA
- Put floppy GW to PL by using crusade MC





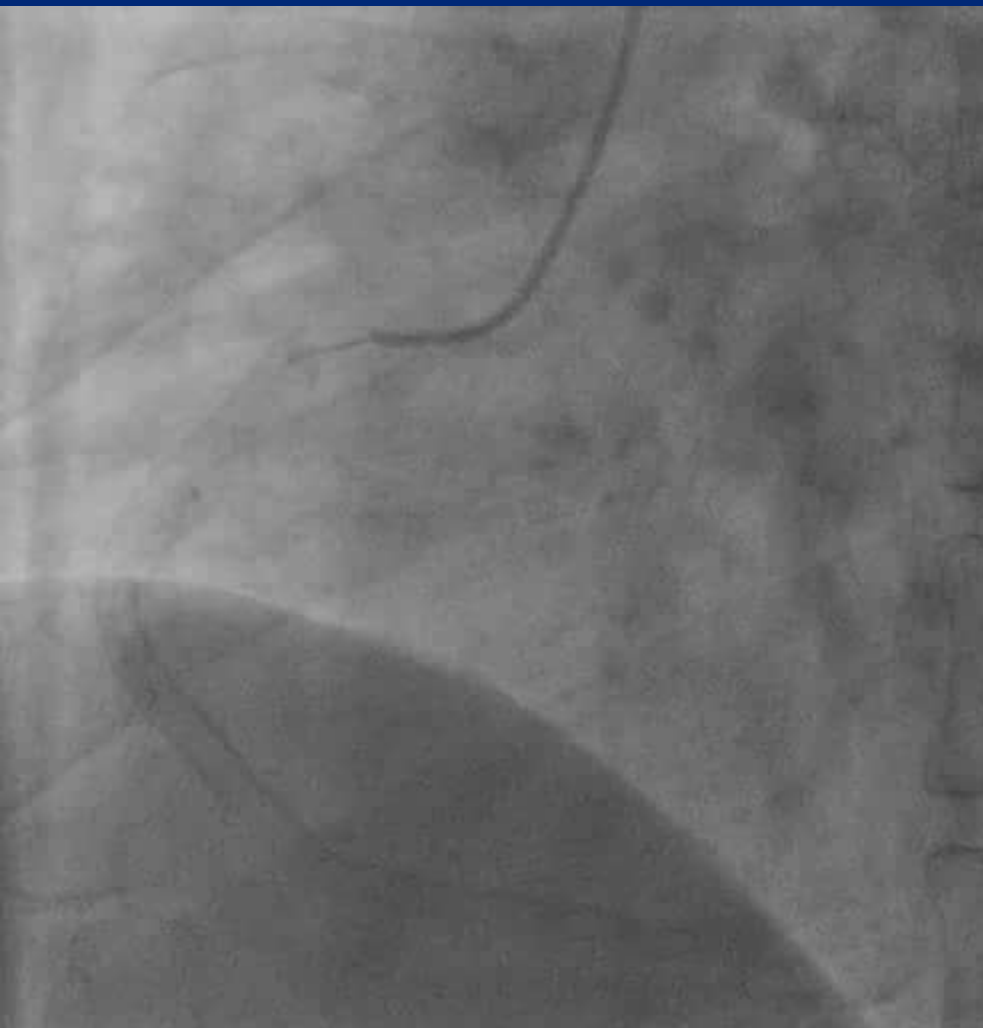
3 long DES stenting (2.75 mm, 3.5 mm, 3.5 mm)



Final angiogram



Follow-up angiogram 6 months later



Conclusions

- To increase the successful rate of CTO-PCI, we have to be familiar with antegrade approach /retrograde approach /IVUS guidance wiring, and need to be flexible (hybrid approach)
- IVUS plays an indispensable role in the treatment of tough CTO, and may be helpful in keeping “true lumen tracking”

