

1008 Ping Pong PCI to CTO LCx via OM1

A 75-year-old lady was referred to us for persistent angina. She had PCI to RCA with rotablation in 2017 and a failed attempt to CTO LCx. Past medical history are single functioning kidney and former cigarette smoking.

Angiogram demonstrated a J-CTO 4 LCx lesion due to blunt ambiguous proximal cap with side branch, long lesion, failed previous attempt and calcified vessel. There were no retrograde collaterals from RCA.

Bi-radial access with 7Fr EBU3.5 into LCA and 6Fr JR4.0 into RCA, with subsequent 6Fr EBU3.5 (Ping pong into LMS).

PCI strategy was initially attempted with AWE. Wired down distal AVCx with Turnpike LP and Sion Blue? escalated to Fielder XT, however difficult to locate and penetrate proximal cap? hence changed back to sion blue and wired down distal AVCx? attempted IVUS guided proximal cap puncture, however unable to advance IVUS to reach proximal cap

Changed to RWE and RDR via ipsilateral epicardial collateral (LCx-OM1). Wired down OM with Sion Blue together with Caravel microcatheter changed over to Sion, able to reach distal cap.? Wire escalation, to Fielder XTA, Pilot 200? XTA retrograde knuckle.? Attempted BASE, side BASE, unable to progress anterogradely.

Set up for 6Fr Guideliner facilitated reverse CART with Ping-Pong Guide Catheter into left main with 6Fr EBU 3.5. Wired down proximal LCx with Sion Blue,? with 3.0 balloon at proximal LCx and retrograde Confianza pro 12, reverse CART was successfully and crossed into guideliner with subsequent externalisation with RG3 wire. Sion blue position maintained in distal AVCx. ?Predilated LCx to proximal OM2 with 2.0/20 balloon followed by FKB distal LCx with 2.0/20 balloons.?

Ran IVUS: proximal vessel 2.75-3mm and distal vessel 2mm, moderate calcification. Overlapping stents from OM2 to proximal LCx with 2.25/32 and 2.5/32 DES. Changed over RG3 system with antegrade Sion Blue.? Distal AVCx Sion Blue removed and rewired down OM2. Post-dilated sequentially with 2.5/15 NC and 2.75 NC balloons? Excellent final results on IVUS.

The key learning points in this case is using ipsilateral collaterals with appropriate technique and equipment.