

1056 Making Back-up Support is the only useful procedure (method) for PCI to Native LAD via LIMA

A 80 year-old male with CKD on HD presented with EAP. Echocardiogram showed diffuse severe hypokinesia with EF 49%. His had CABG with a LIMA to LAD. CAG via transfemoral artery revealed total occlusion at mid-LAD and significant disease in mid- and distal-LAD beyond patent LIMA insertion. We decided culprit lesions mid- and distal-LAD beyond LIMA insertion and performed ad-hoc PCI via LIMA. LAD was wired by Sion blue with use of 6Fr JR-4 GC. DES delivery to target lesions was very difficult in short length of stent shaft because of tortuous LIMA and tortuous iliac artery with poor back-up support in the Arch. We adopted mother-and-child technique using 5.5Fr Guideliner and Dio aspiration catheter with the help of anchor balloons in distal LIMA. But our attempts failed. Finally, we were able to implant stent (2.25x38mm) for only mid LAD with use of 5.5Fr Guideliner advanced in distal LIMA. For achieving complete revascularization, we decided to treat all lesions in seg.8 and seg.9 in second session. This time, we used 90cm length long sheath transfemorally to straighten tortuosity of iliac artery and placed Grand slam as a buddy wire along the subclavian artery to enhance back up support to JR-4 GC. Then, we could dilate the distal Seg.8 lesion by POBA (1.5x15mm) with stent-like result and deployed 2.5x22mm stent at Seg.9 successfully. To make the length to target lesion short and making back-up support strong are very important for treating distant anatomical lesions successfully.