1105 Back on the right track
A 70 year-old male with diabetes mellitus, hypertension and dyslipidemia and coronary artery disease had received stenting for LCX 15 years ago. He came to our hospital for intermittent chest discomfort for one month. Coronary angiography showed LCX stent instent restenosis and chronic total occlusion with collateral supply from septal branch of LAD. RCA was small. We started with antegrade approach (EBU3.5). We tried Fielder FC, XT-R, Gaia second and finally Gaia third wire passed CTO part to OM. However, IVUS showed the wire in false lumen beyond distal edge of stent. With Crusade, we tried to wire Whisper to the proper of LCX. IVUS still showed the proper wire in false lumen. We then tried IVUS-guided puncture but still failed. Therefore, we approached from retrograde direction. Sion wire passed septal channel into Excelsior microcatheter in the other guiding catheter (another EBU3.5). We performed Rendezvous technique for recanalization. Excelsior microcatheter advanced slowly and passed the total occluded site while retrograde Finecross catheter drawback. Then, antegrade XT-R wire to distal LCX. Pre-dilatation with 2.5mm balloon. Stenting with 2.5/38mm DES at dLCX and 3.0/30mm DES at pLCX. Post-dilatation with 2.75mm NC balloon. Final IVUS showed good stent apposition and expansion.