

1121 A case which complete revascularization was achieved by performing PCI in stages while performing ischemic evaluation on severe three-vessel lesions including CTO.

The case was a 70-year-old woman with a history of hypertension and dyslipidemia.

She had previously recognized dyspnea on effort but did not visit a clinic.

About two months before the hospital visit, symptoms began to appear in normal walking, and even in indoor walking a few days ago symptoms appeared.

Coronary angiography was performed with a diagnosis of Worsening effort angina.

The RCA was completely occluded at # 2,

The LAD had severe stenosis in # 6 to # 7, and the LCX had severe stenosis in # 11 and # 14.

First, I performed PCI of 99% lesions of LCX # 11.

Then, before PCI of RCA CTO, we performed PCI of LCX # 14 and LAD # 6.

During selective angiography of collateral circulation to RCA CTO, GW proceeded to the pseudolumen and vascular dissection appeared, and blood flow restriction of LAD appeared.

GW proceeded true lumen by a dual lumen catheter, and added PCI of LAD#7.

In PCI to the RCA# 2 CTO, GW SUOH03 passed the lesion antegradely with MC caravel, referring to imaging of collateral circulation from LCA.

However, the PCI system failed due to the poor backup of GC.

SUOH03 never passed through the lesion again.

When the GW was changed to XT-R, the wire was advanced to the distal pseudo cavity, so we attempted to pass the lesion using dual lumen catheter with parallel wire operation with GaiaNext 1 but failed.

Furthermore, the RCA ostium was dissociated by GC.

Abandon PCI completion in the antegrade approach and move on to the retrograde approach.

We passed the Septal channel with GW Sion and SUOH 03 and returned to the antegrade approach procedure again.

GW Neo 3 was passed to the distal, the 2.0 / 15 mm balloon was expanded at # 2, and Reverse CART was established using GW XT-R and Sionblack.

Then, after externalization, I passed GW into RV branch and performed kissing balloon dilatation.

However, when I performed stent placement for # 2 and # 1, RVbranch became slow flow.

The procedure was finished after confirming the vital stability.

After PCI, NSVT and heart failure occurred for a while due to right ventricular infarction, but it improved only by conservative treatment.

At the time of angiography one month later, the flow of the RV branch was improved.

On the same day, the stenosis in the ostium of LCX was evaluated by pressure wire, and since it was positive for ischemia, PCI was performed.

The symptoms have not recurred until now.

This case was severe three-vessel lesions including RCA CTO.

There was also a part of the ostium lesion, and it was possible to achieve complete revascularization by performing PCI in stages while performing ischemia evaluation.

In addition, at the time of PCI of RCA CTO, there was a problem that the wire which passed by Antegrade gotten out by the lack of GC-backup.

If we use guide extensions or anchor balloon techniques, it is thought that we could have performed the procedure more safely and more easily, and we should reflect on it.