1134　Unexpected cardiogenic shock due to sinus node artery occlusion

[Target lesion] mid RCA CTO

[Strategy] Primary antegrade approach

A 7Fr AL1.0SH guiding catheter was engaged into RCA and a 7Fr EBU3.75SH guiding catheter was engaged into LCA. Antegrade approach was performed at first. However, we had to switch to retrograde approach, because the antegrade wire could not cross to the distal true lumen. A retrograde wire and a micocatheter was successfully passed into the septal channel from LAD to RCA. Retrograde wiring started with a XT-R. The retrograde XT-R wire directly crossed to the proximal true lumen and finally into the RCA guiding catheter for externalization. A DES was implanted at the CTO site of mid RCA. After a while, he complained of chest pain with cardiogenic shock of hypotension and bradycardia (disappearance of P wave). It might result from decreased coronary flow of RCA, but RCA flow was normal. LCA angiogram revealed dissection at the proximal LAD probably due to the injury by the tip of guiding catheter, which might result in cardiogenic shock. Bail-out stenting was performed at the left main trunk to proximal LAD. However, his hemodynamics had not been recovered even after bailout for pLAD. RCA angiogram was re-checked and it showed the occlusion of sinus node artery. We tried to regain sinus node artery, but failed.

[Final Result] His hemodynamics was gradually improved only by drug support and he regained his P wave in two days. Sinus node artery occlusion by stenting or retrograde procedure may have more adverse effect than we expected.