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Complete revascularization after successful CTO PCI in triple vessels CAD improves clinical presentations of heart failure

56 year-old male was admitted to our hospital for management of CHF. Echocardiogram showed low EF(37%) with infero-posterior wall hypokinesia. CAG showed triple-vessel CAD (LAD diffuse stenosis and LCx,RCA CTOs) with collaterals from LAD. PCIs to RCA-CTO and LAD were performed in 2018. On 18.03.19, CAG showed patent stents in RCA and LAD with collaterals to OM from LAD. PCI to LCx-CTO was performed by bifemoral approach. Due to ambiguous proximal cap and existence of interventional collaterals from LAD to OM, retrograde approach was tried firstly. By using SUOH03, Caravel150 reached to exit of CTO retrogradely. Gaia next1, next2 and Conquest pro were used step by step, but those wires cannot cross LCx-CTO retrogradely due to strong LCx movement. Then, antegrade approach was started by using Gaia next1 with Sasuke support. Contrary to expectations, the wire crossed CTO entrance. Sasuke was changed to Corsairpro135. After wire crossing successfully, Ryurei1.5X10 delivery was difficult due to tortuosity. By anchor balloon (HiryuPlus3.5x15 inside LAD stent), Ryurei1.5X10 was advanced through CTO. After 1.5mm ballooning, predilatation with HiryuPlus2.5x20 was performed to Seg11 and Seg13. Resolute onyx 2.5x38 stent was deployed in Seg11 and seg13. Resolute onyx 3.0x30 stent was deployed to Seg11 additionally. After IVUS checking, postdilatation to seg11 was done with HiryuPlus3.5x15. Final result showed distal TIMI-3 flow without any complication. The patient's symptoms improved. Thus, complete revascularization after successful PCI in triple-vessel CAD including 2 CTOs improves clinical presentations of heart failure.