An ajar door will solve the case...

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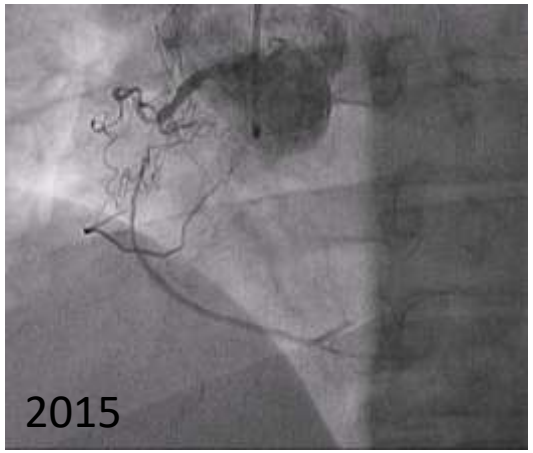
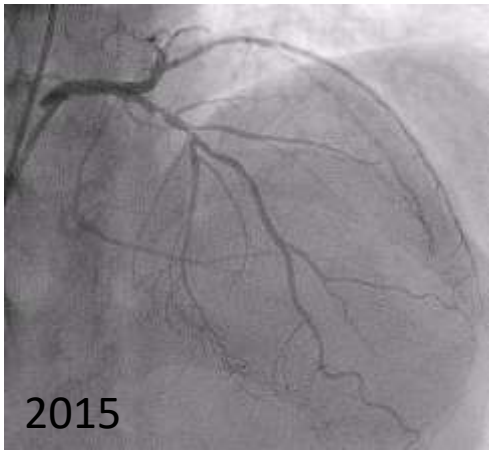
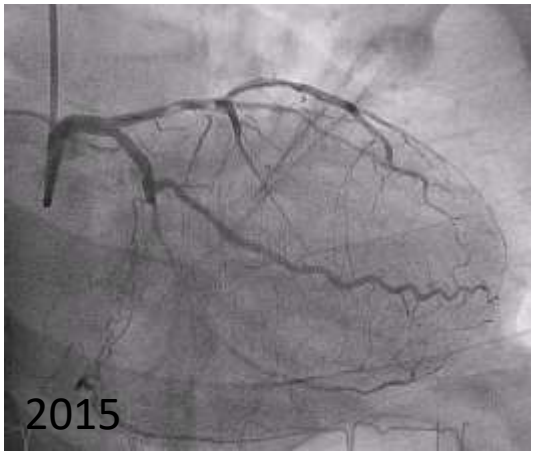
The patient…

54 y.o. male patient (young)

Sent for CABG in 2025 for 3VD:







Now comes in the ED with unstable angina

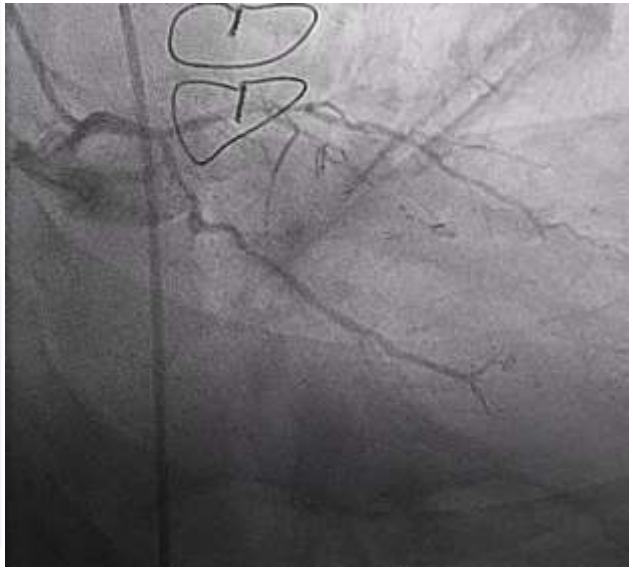
Severely symptomatic

hs-Troponin T: 142/+, preserved EF (50%)

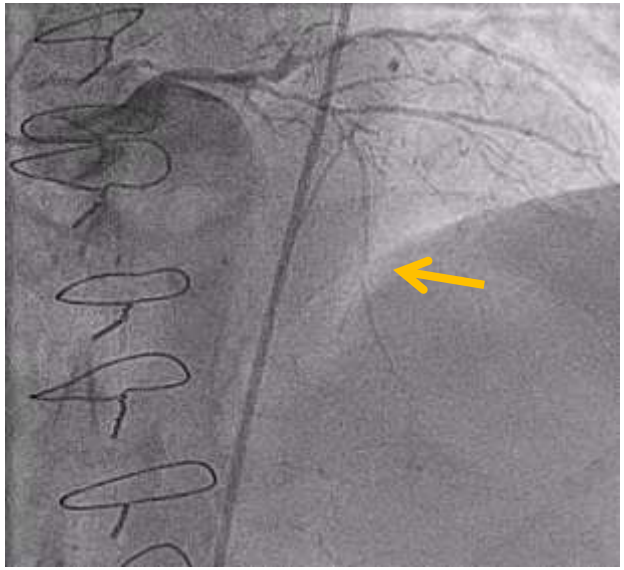
M. Scintigraphy last week: inducible ischemia on the inferolateral wall (compared to normal scan in 2021)

Current angio

All veins closed, open LIMA

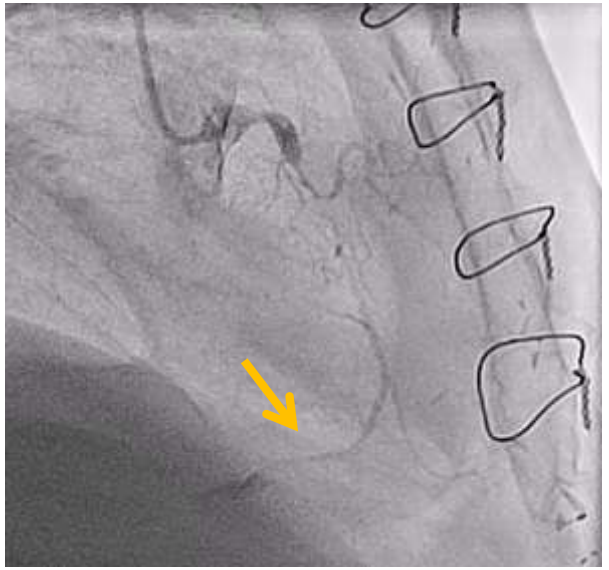


Significant progression



LAD still open?

(Competitive flow)



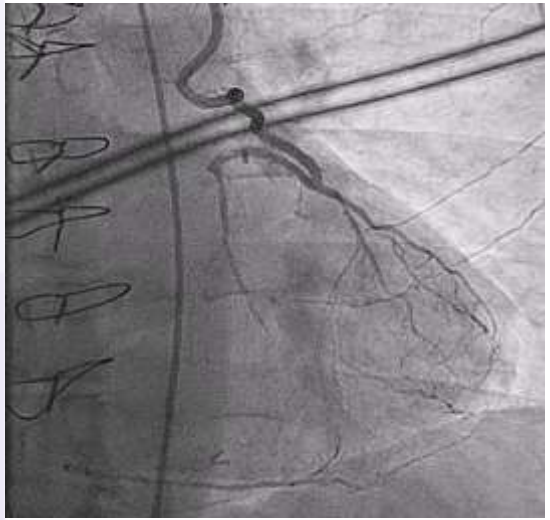
RCA ambigous

Poor antegrade filling

(Island mid segment)

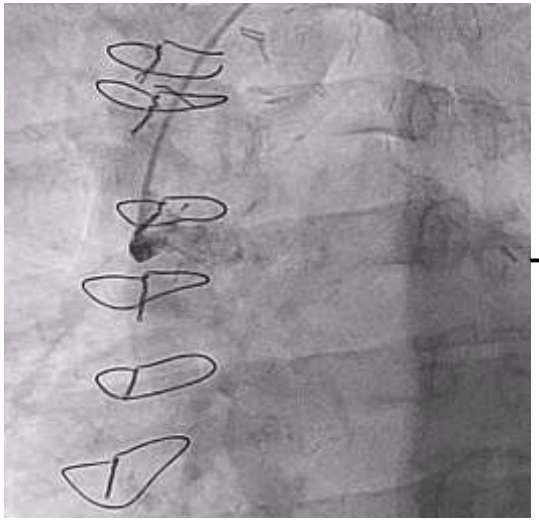
Current angio

All veins closed, open LIMA



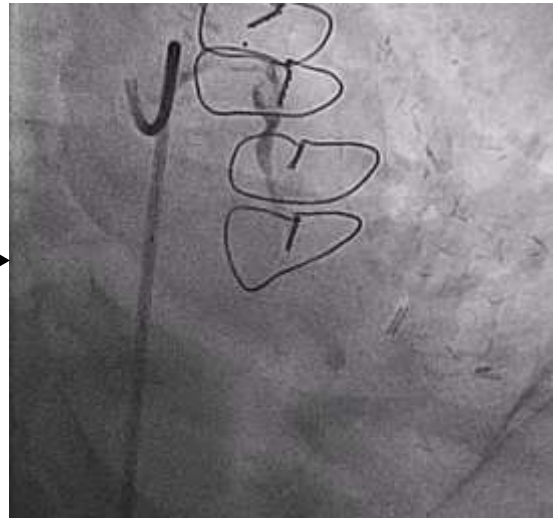
LIMA fills distal RCA

Good septals?



RCA vein considered culprit

Ad-hoc
attempt



Failed

Dissected the graft

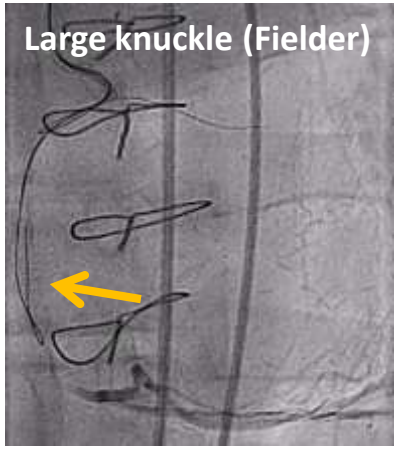
2 hours AWE with no flow

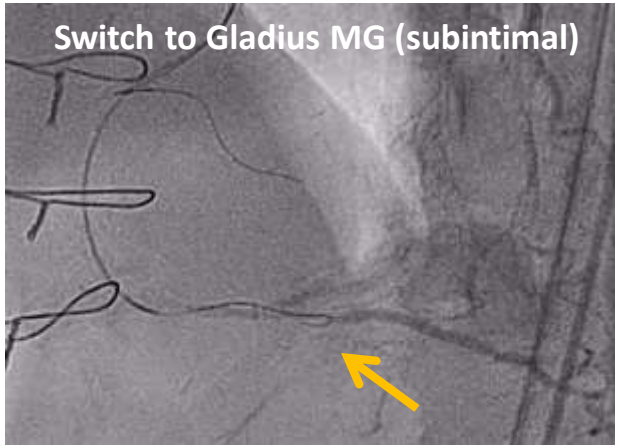
2nd attempt...

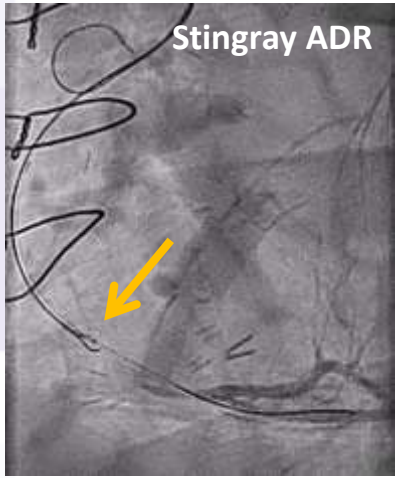
Antegrade native RCA CTO

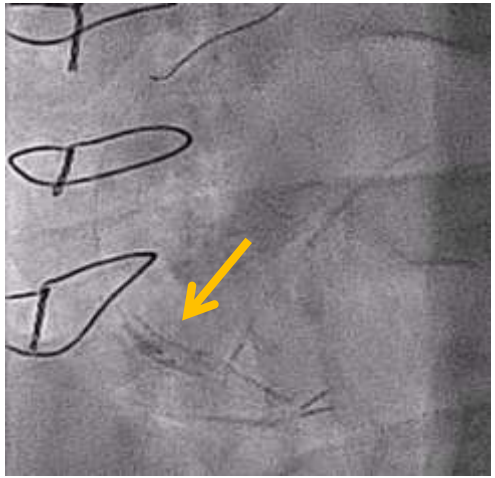
AWE failed

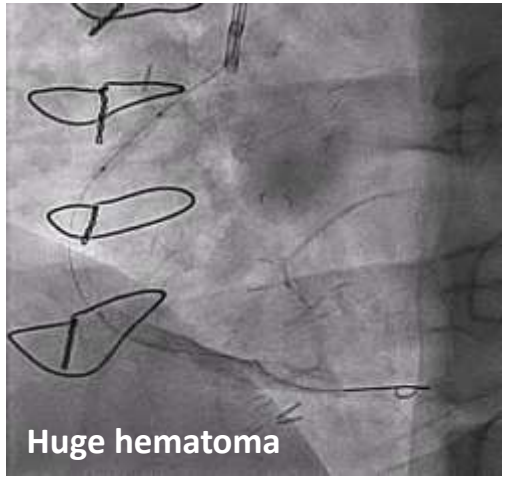
ADR failed

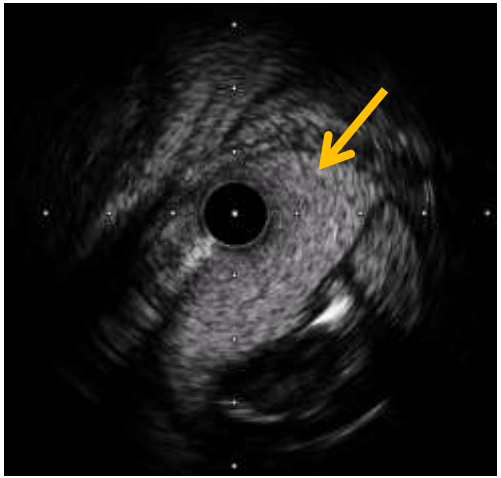












3rd attempt – after 4 months (patient very symptomatic, he cannot even walk)

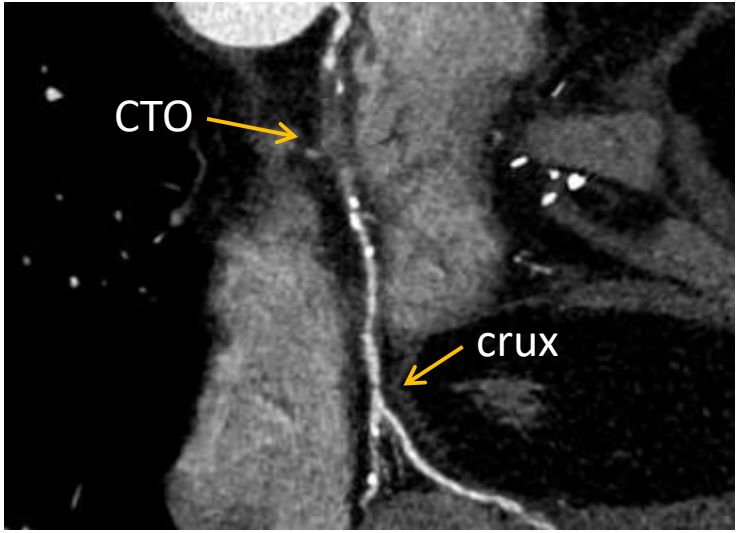
We need to go **retrograde** now… But from where?

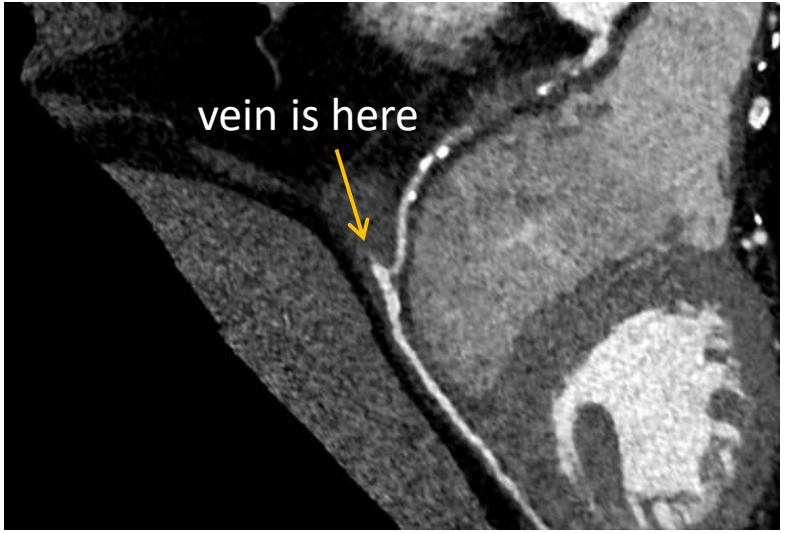
- Vein graft was dissected / failed / no evident connection
- Via LIMA almost impossible (extremely symptomatic only when cannulating / injecting)
- Via native LAD? (it may be a channel…)

But we need then 3 accesses?

- Should we just try again antegradely?

Let's do a CT:



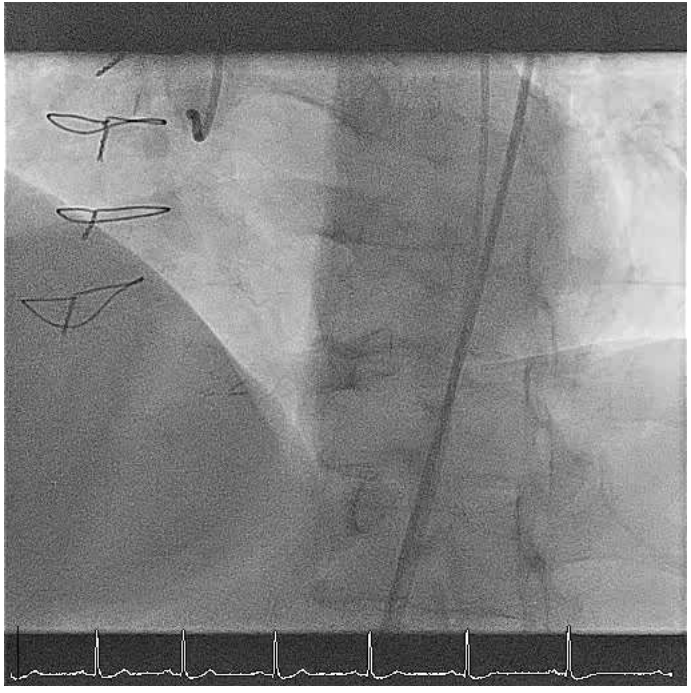


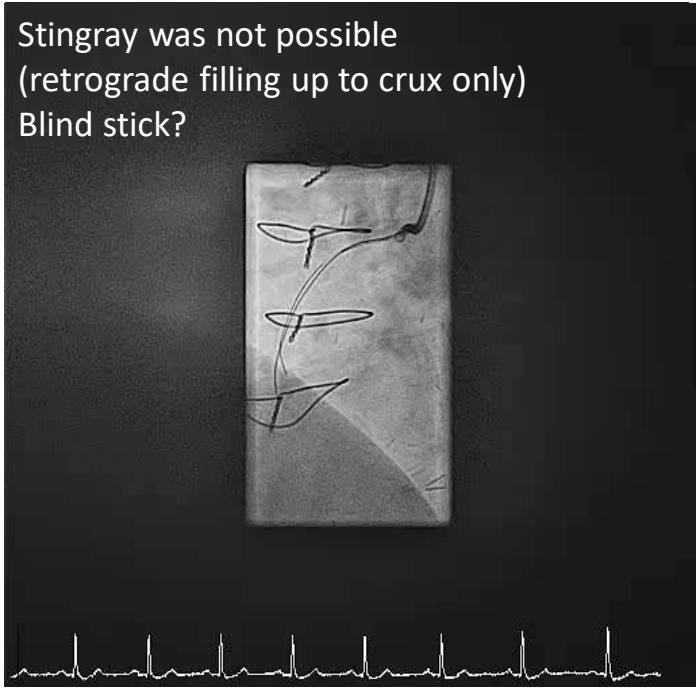
Our plan:

1. AWE + parallel wiring using ReCross (10 mins)
2. Try again ADR Stingray BUT much earlier (before hematoma formation) (10 mins)
3. Go retrograde: let's try the LAD
4. STAR both PL and PD (suboptimal as we would need a 4th session)

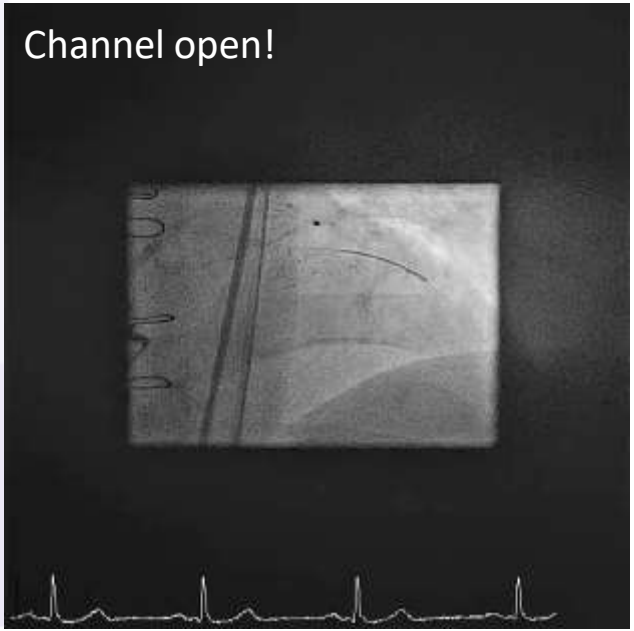
Stick with it !!!

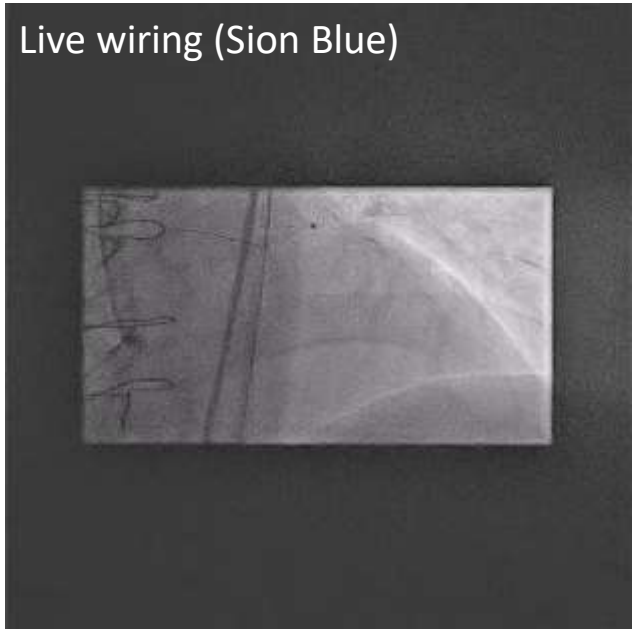
Current situation:

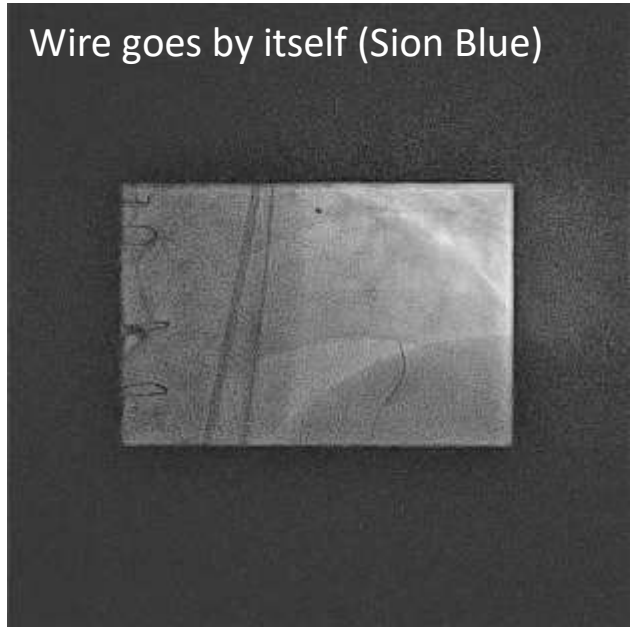




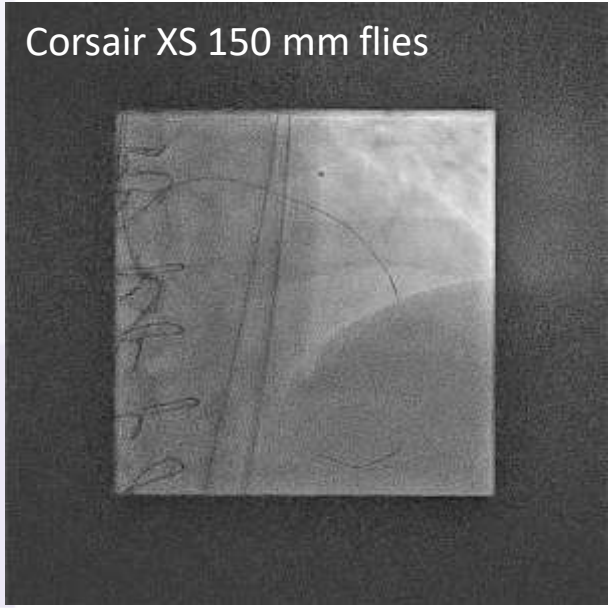
Go retrograde

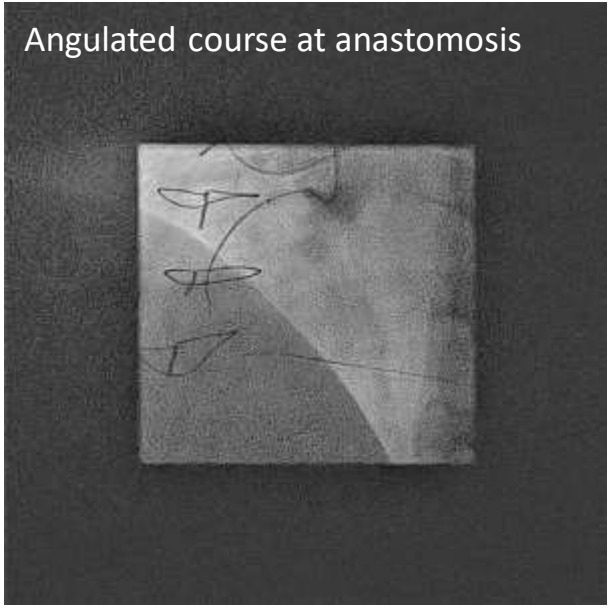


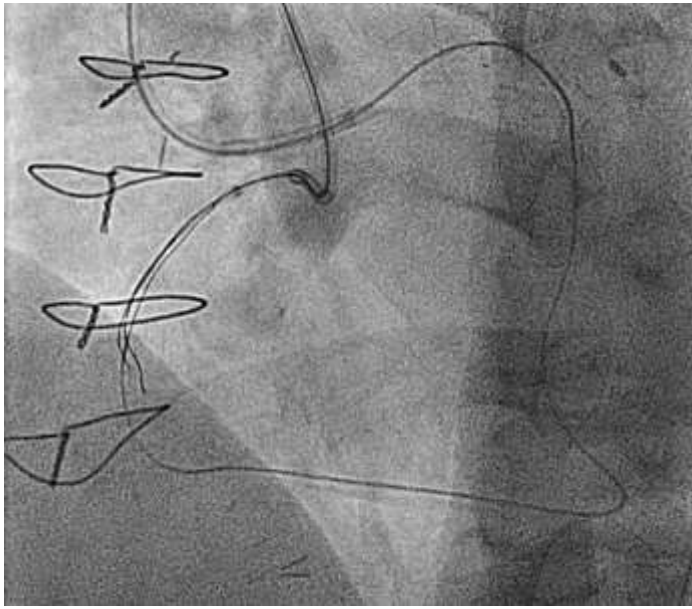




Go retrograde



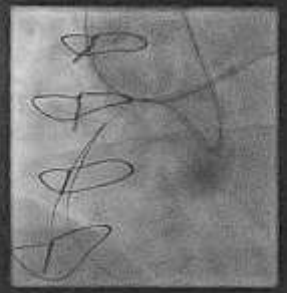




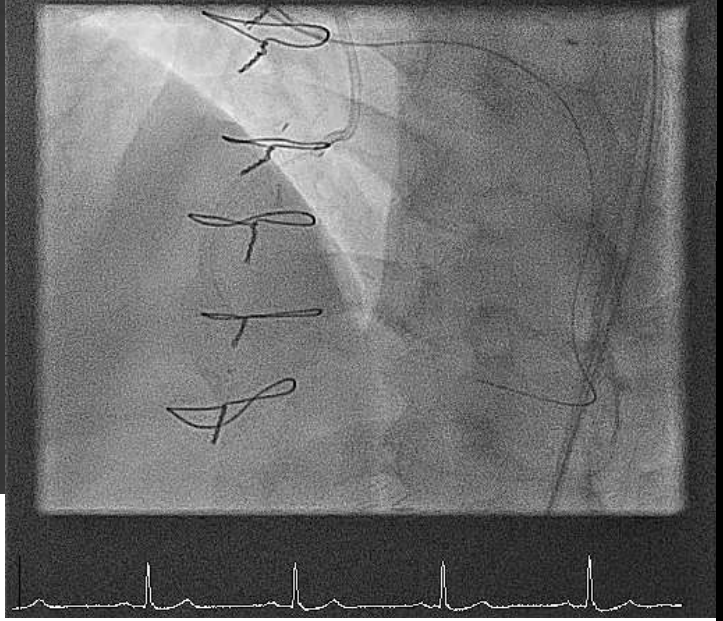
Retrograde Gladius EX cannot enter the Guideliner because of the antegr. ReCross

Final result

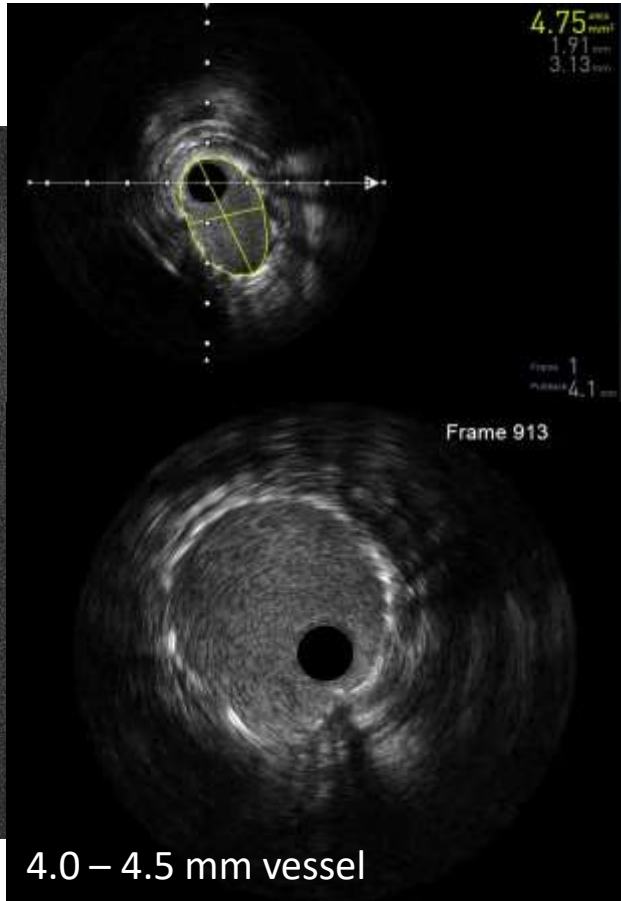
Remove the ReCross
Wire goes in



Conventional PCI on RG3
1x3.5 DES, 1x4.0 DES, postdilation 4.5



Lower and asymmetric MSA
at the level of anastomosis



4.0 – 4.5 mm vessel

Lessons

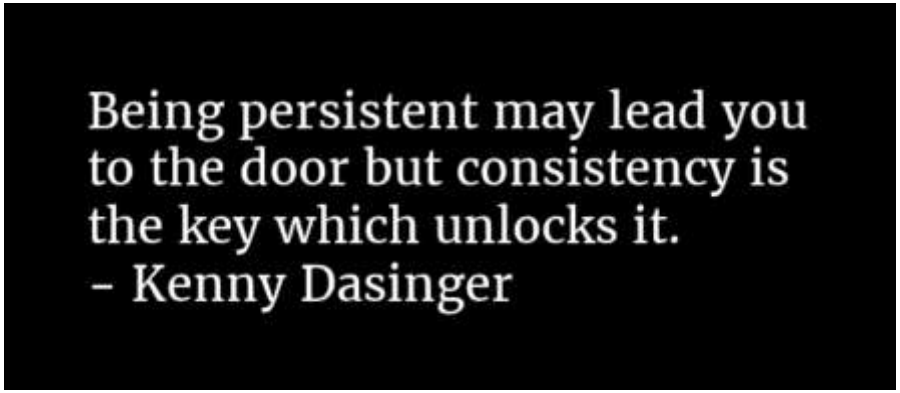
Much more efficient (total time 1.5 hours compared to the 2.5 hours failed attempts!)

Making a plan (and sticking to it) was the key

The least “attractive” door (partly opened = ajar) was the fastest

“Protected” PCI due to LIMA advantage

CT indeed helps



Thank you.