Complication of retrograde CTO PCI

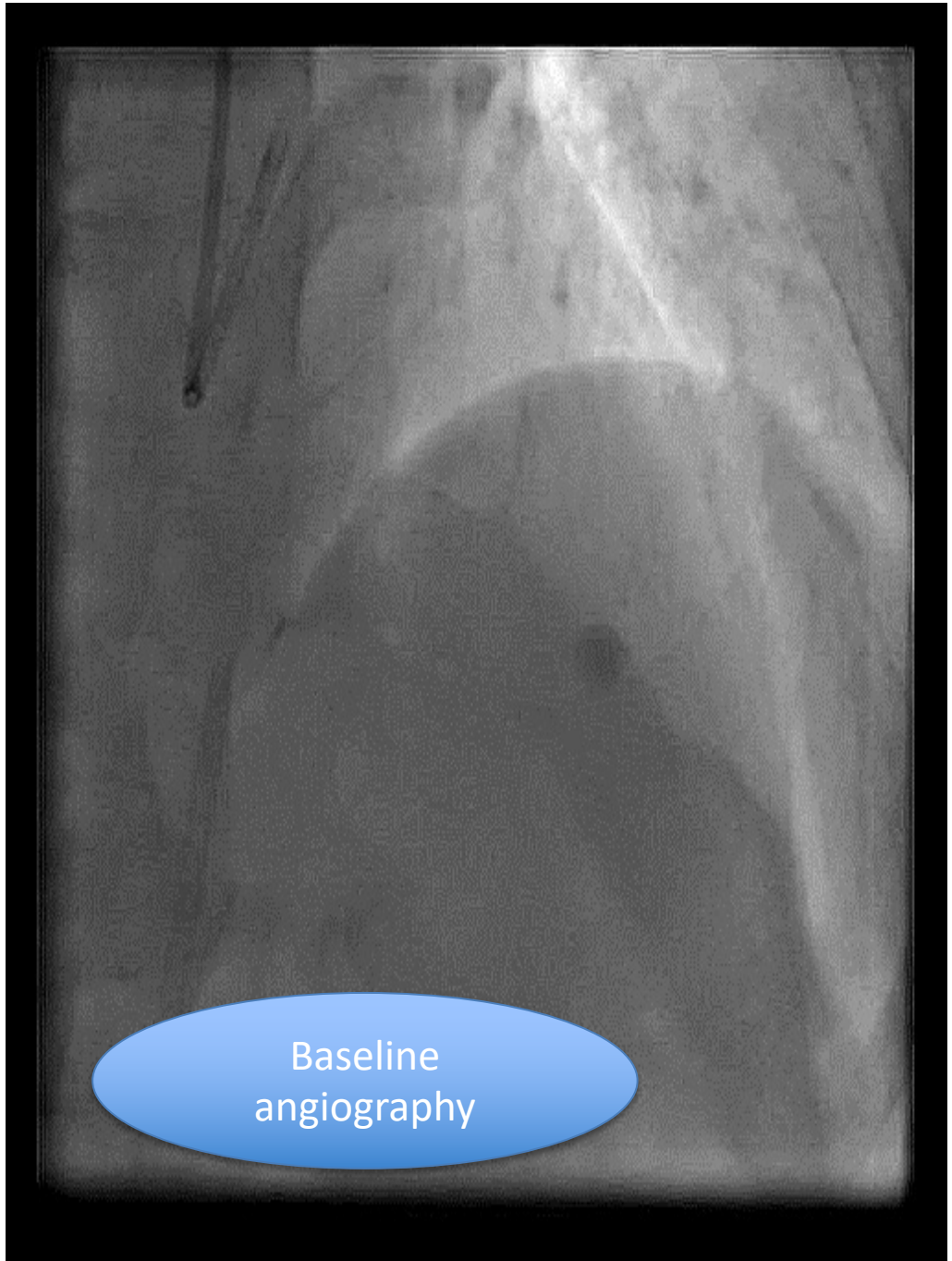
Dr Arvind Sharma
Rhythm heart institute
Vadodara ,Dahod, Banswada

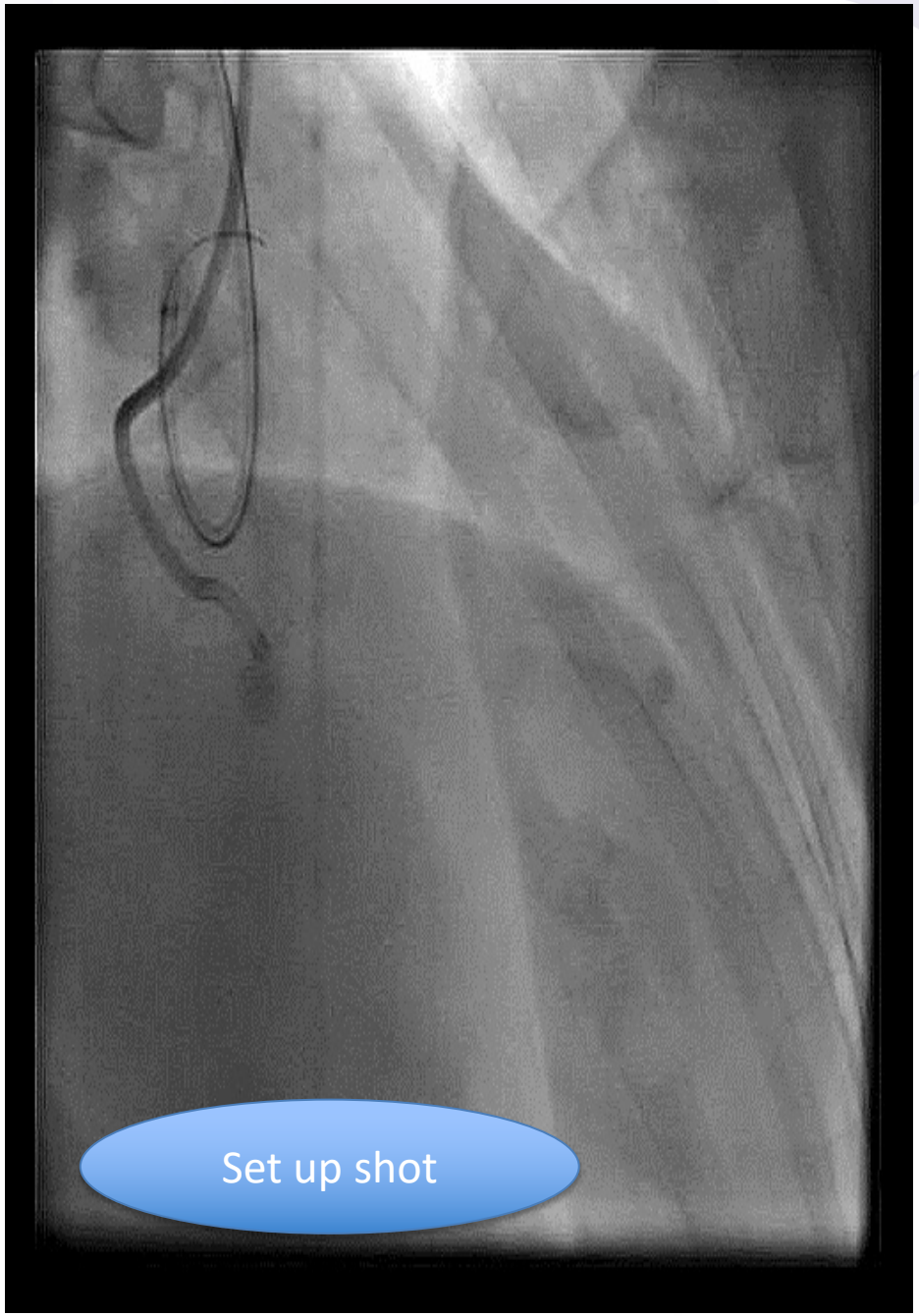
History and Coronary angiography

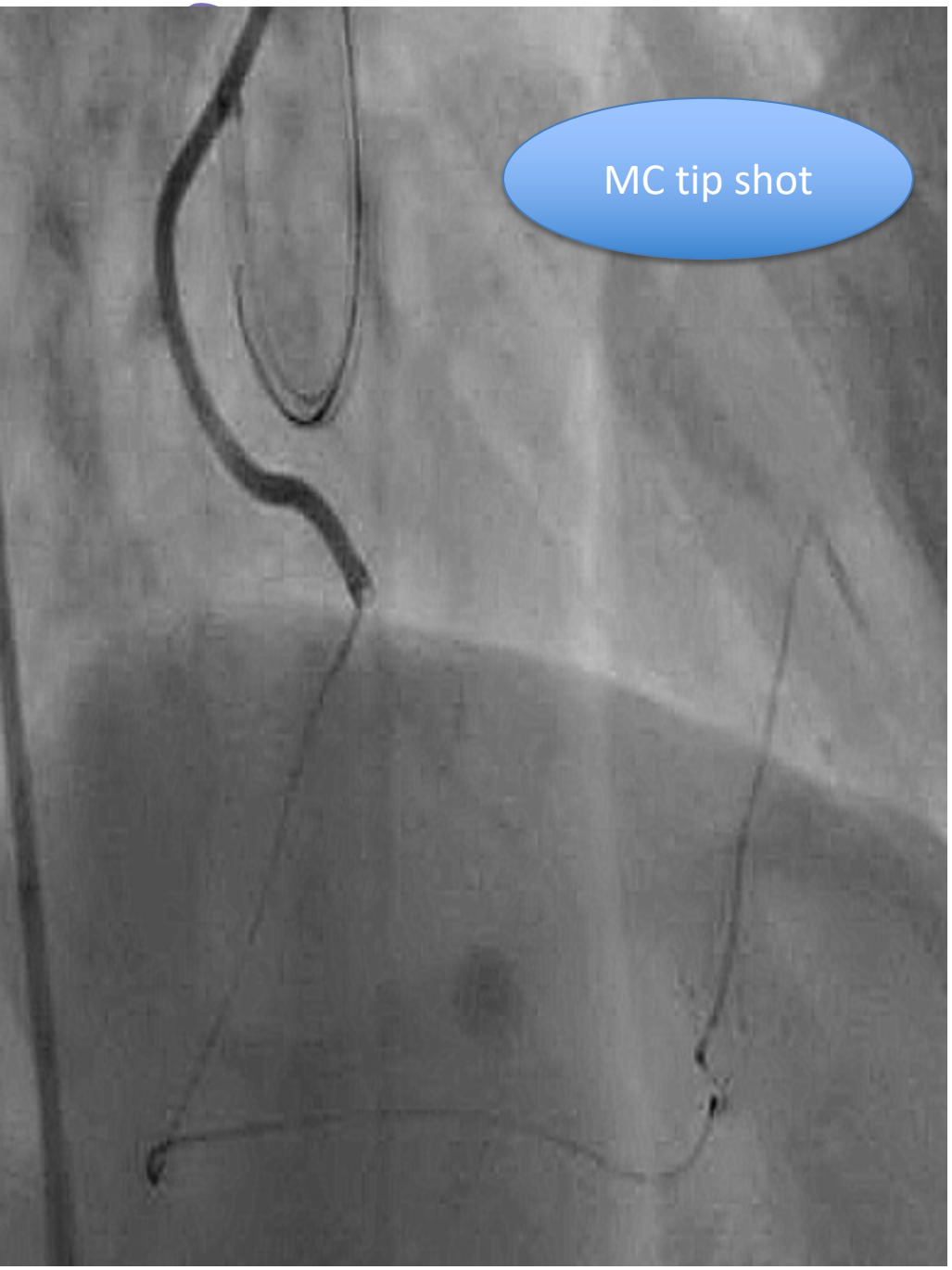
- 50 Yr old female patient
- Prior AWSTEMI (3 yrs back) , DM, Smoker - conservatively managed
- Effort angina, class 2-3, On incremental doses of Medical therapy including betablockers, Notrates, nikorandil, trimetazidine, ranolazine, ACE inhibitors, high dose statins.
- LV EF : 55% , No obvious scarring on Echo.
- CAG : Single vessel disease, LAD proximal segment CTO : CTO length >20 mm , Blunt and illdefined proximal cap, Grade 2 werner collaterals from Septals, no calcification, tortuosity +,bifurcation at distal and proximal caps. JCTO 2

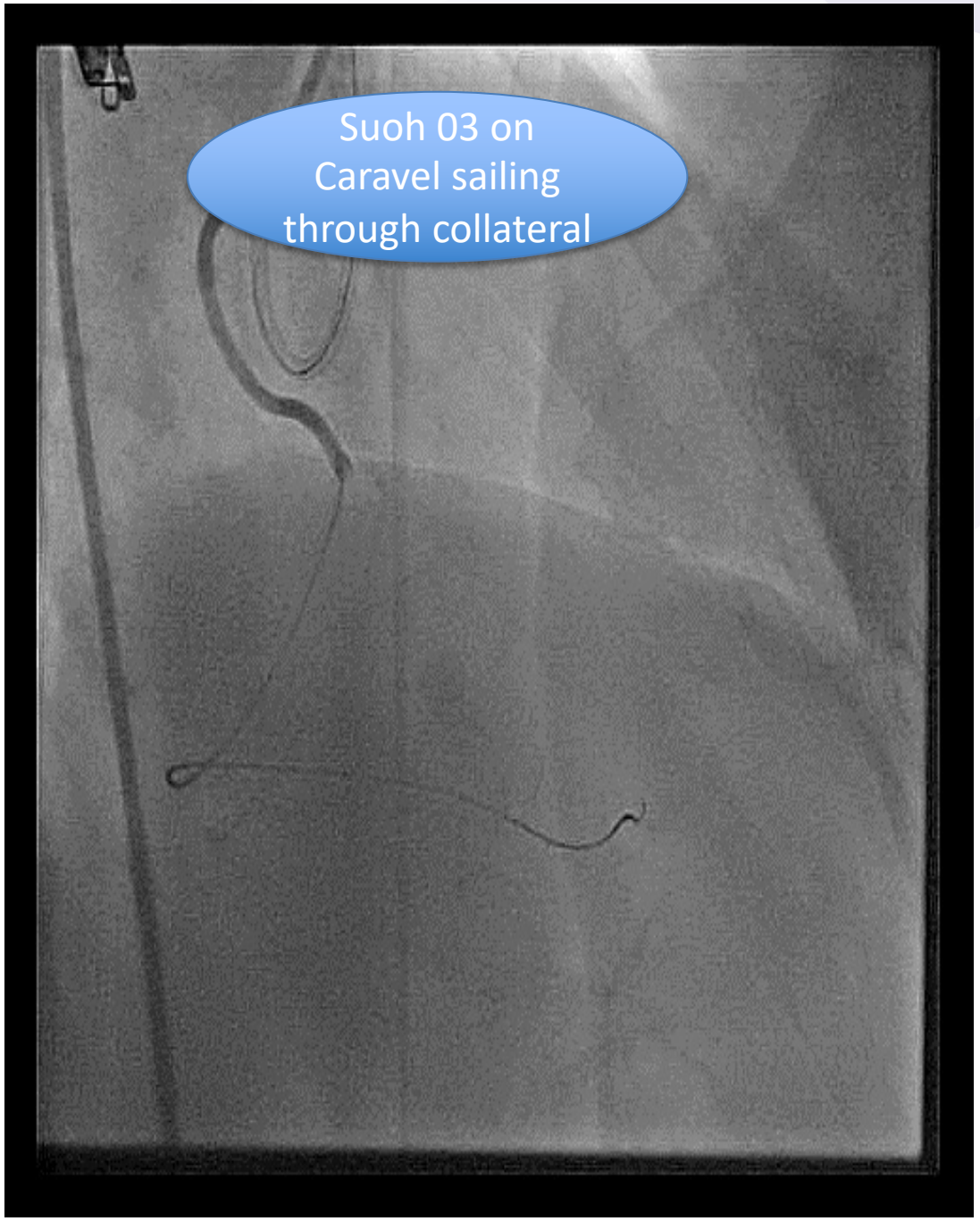
Set up and planning

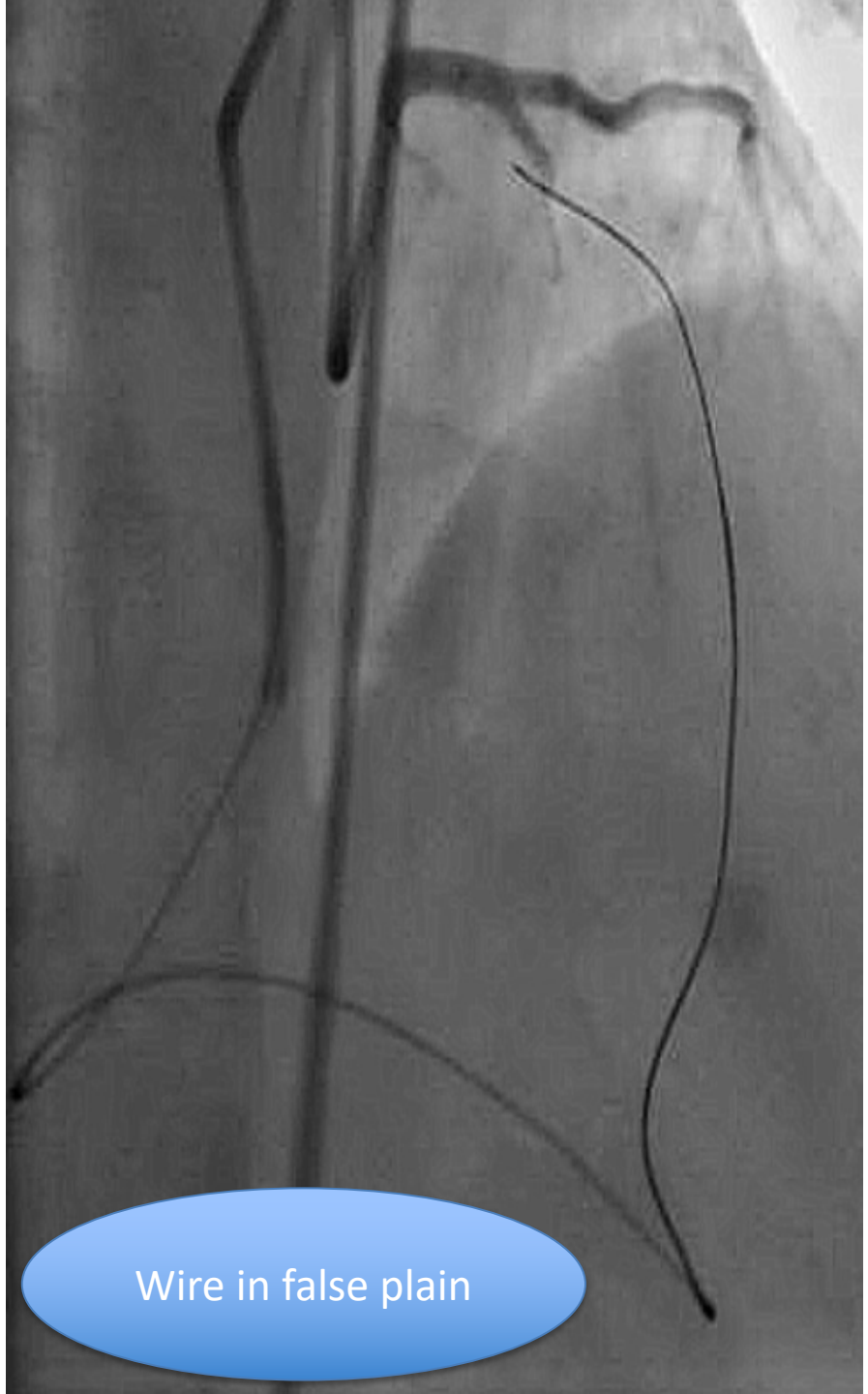
- Set up : Right femoral artery 7F long sheath, Left distal radial 6→ 7 slender sheath terumo
- EBU 7F from Radial artery and AL 1 from right femoral artery.
- Sion blue on Coarsair pro → sion → Suoh 03.
- Fielder XT- R, Gaia 2
- IVUS guided checking of true lumen entry keeping IVUS in Diagonal

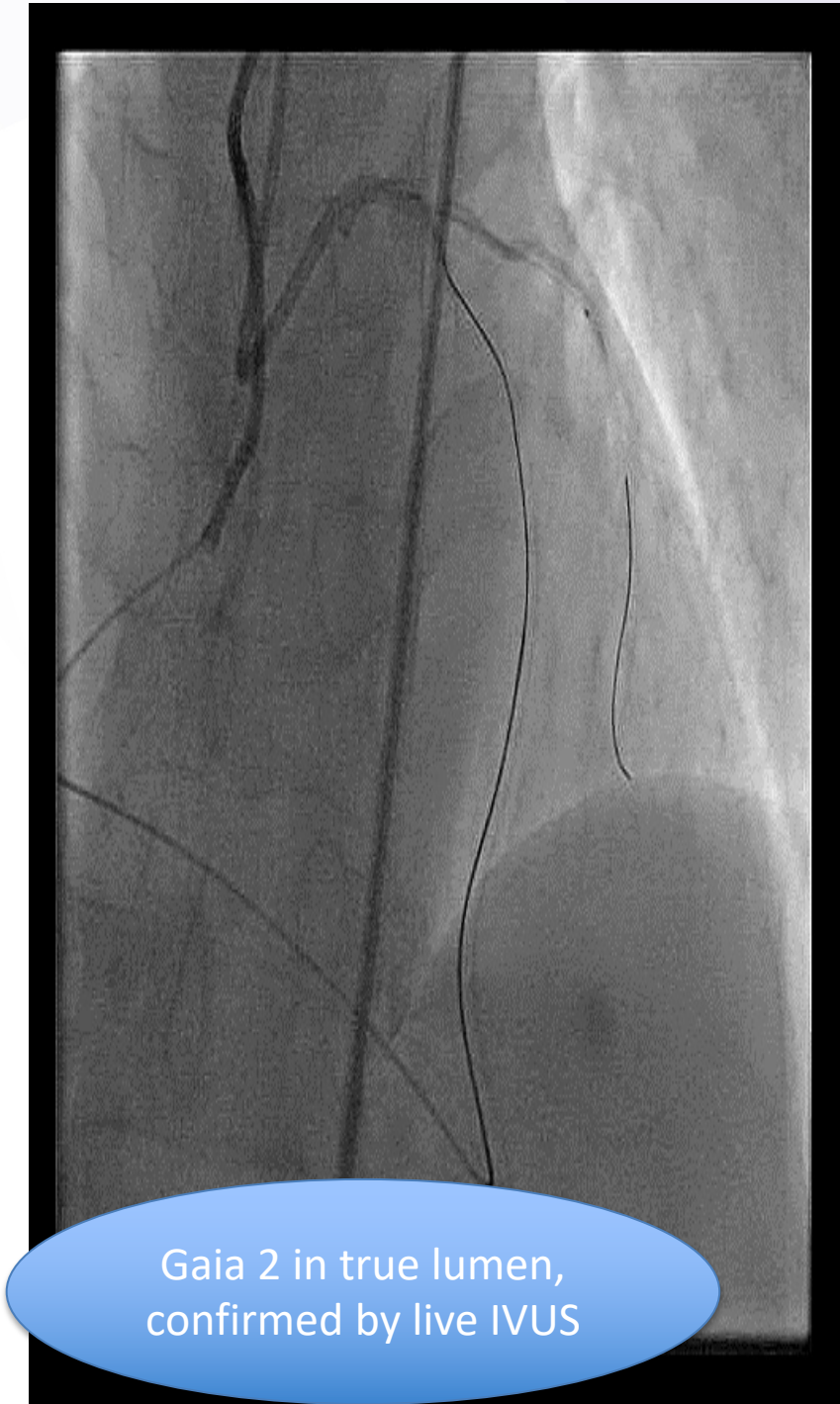

Baseline
angiography


Set up shot

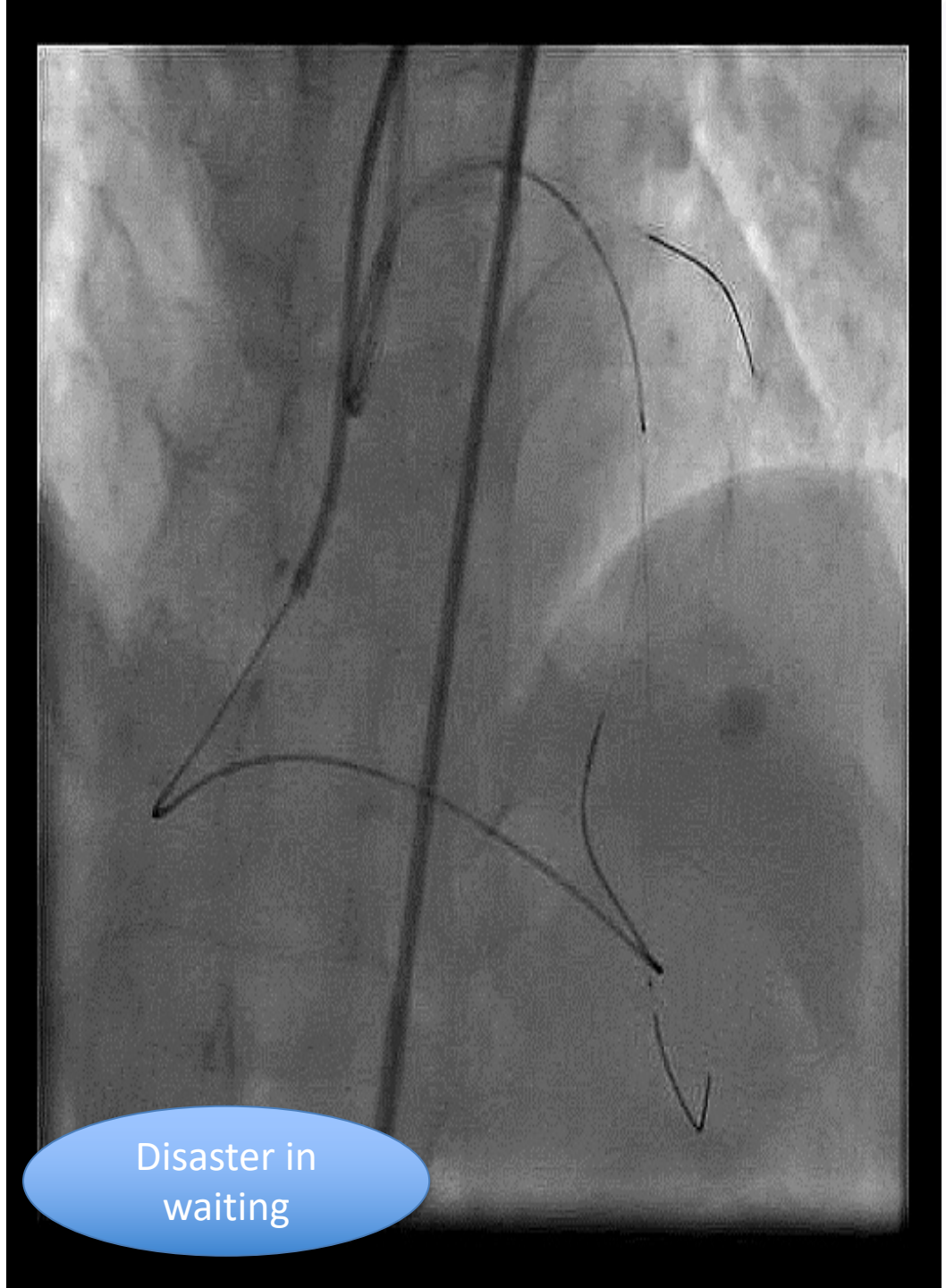

MC tip shot

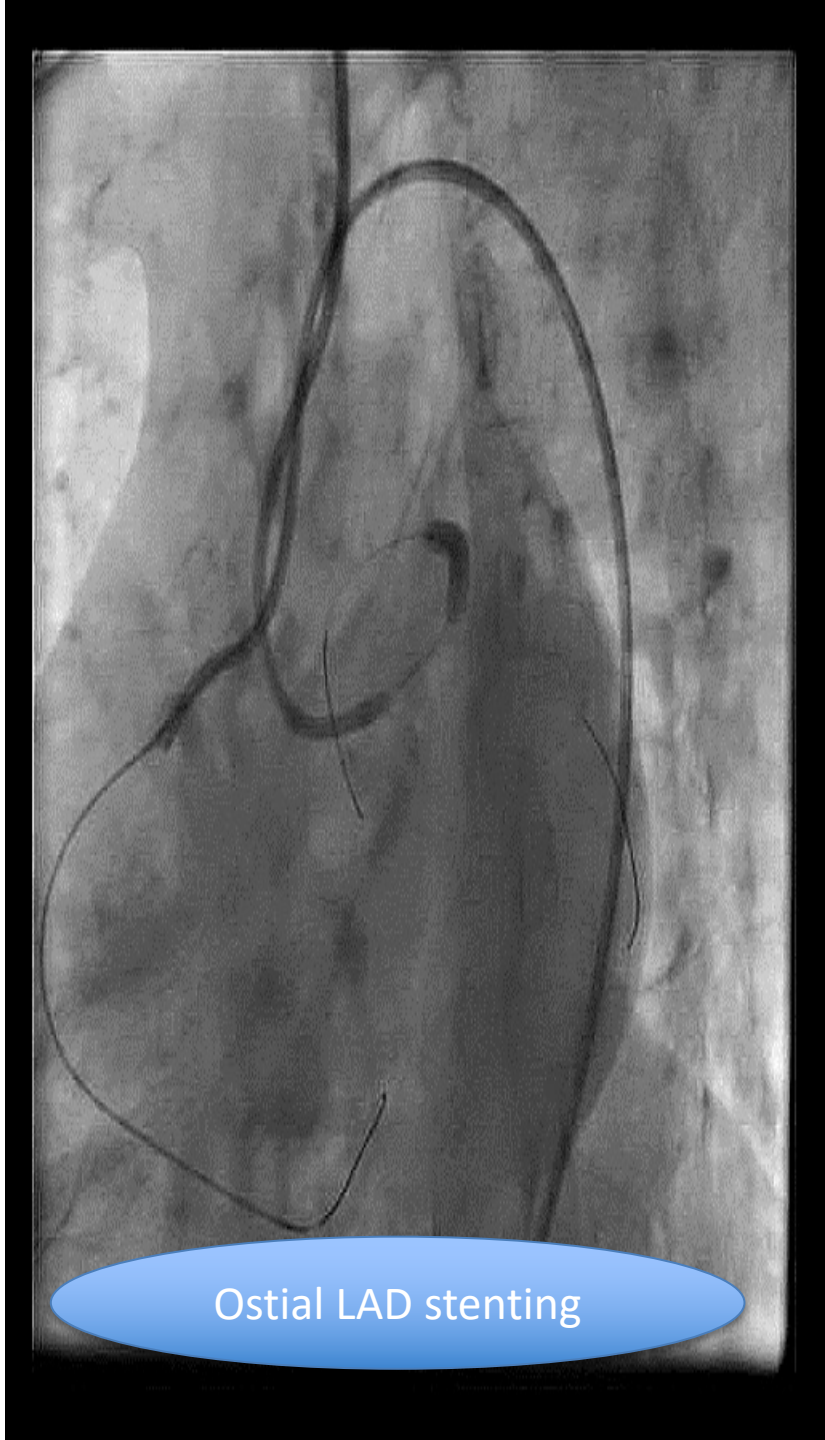

Suoh 03 on
Caravel sailing
through collateral

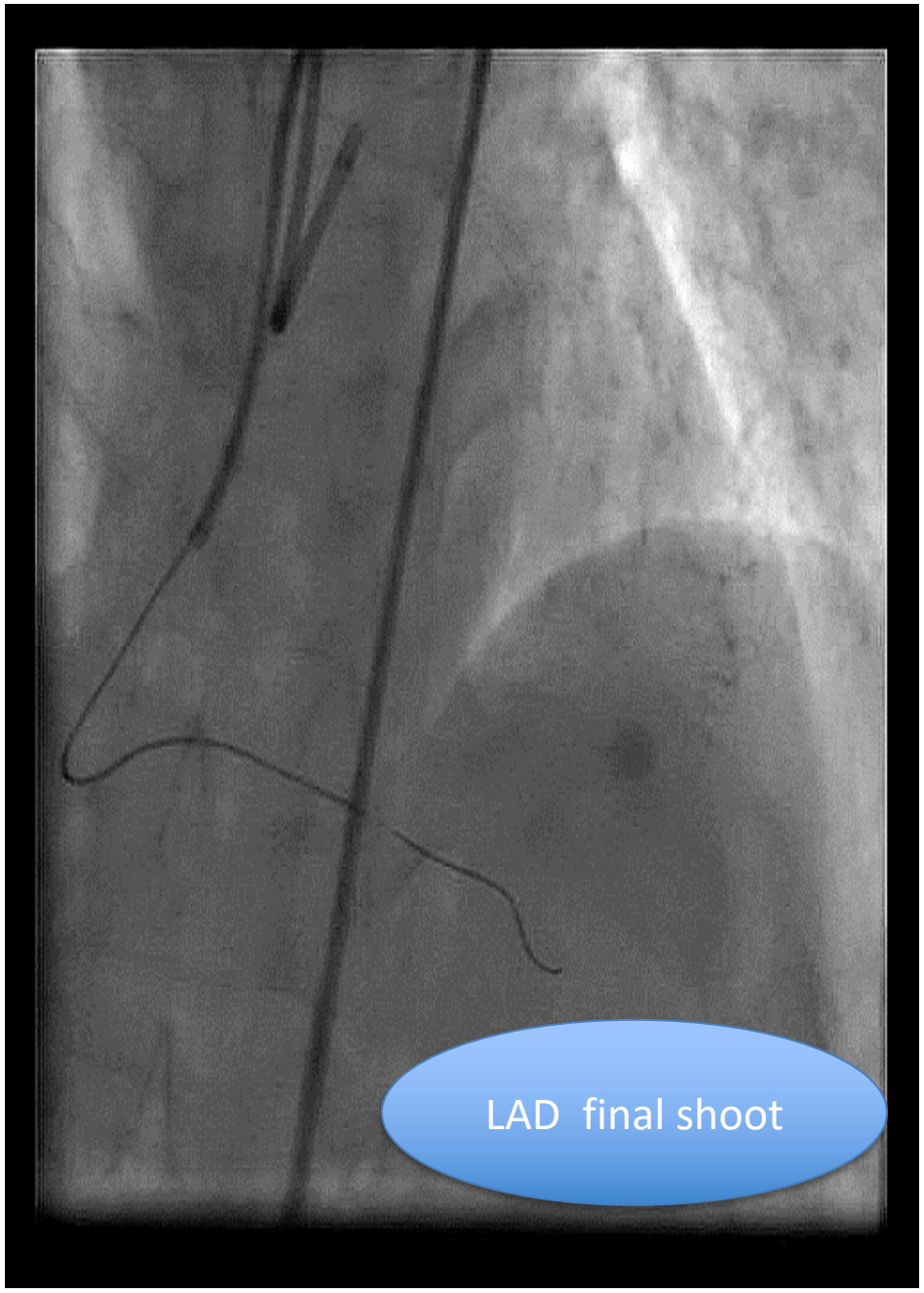

Wire in false plain

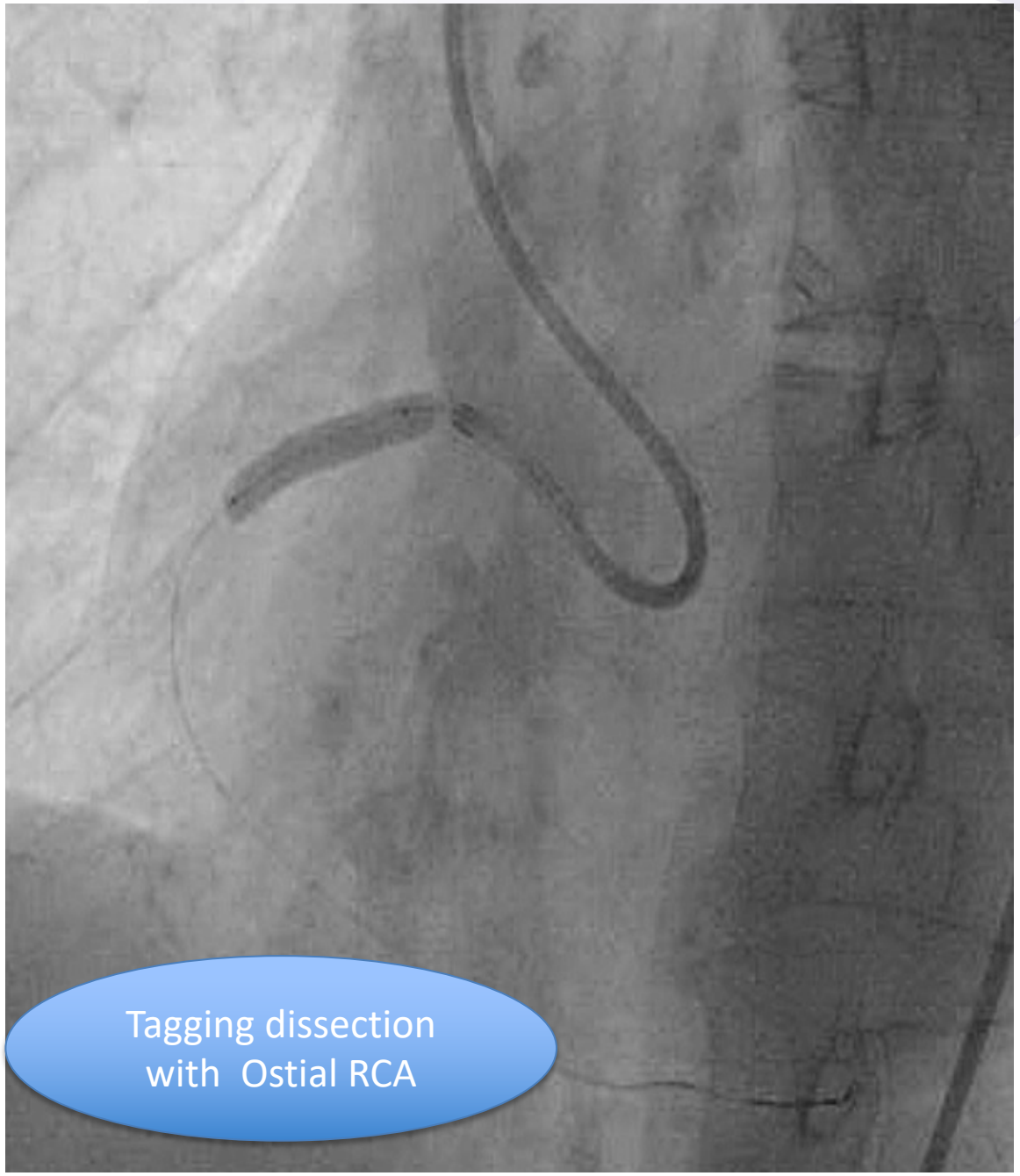

Gaia 2 in true lumen,
confirmed by live IVUS

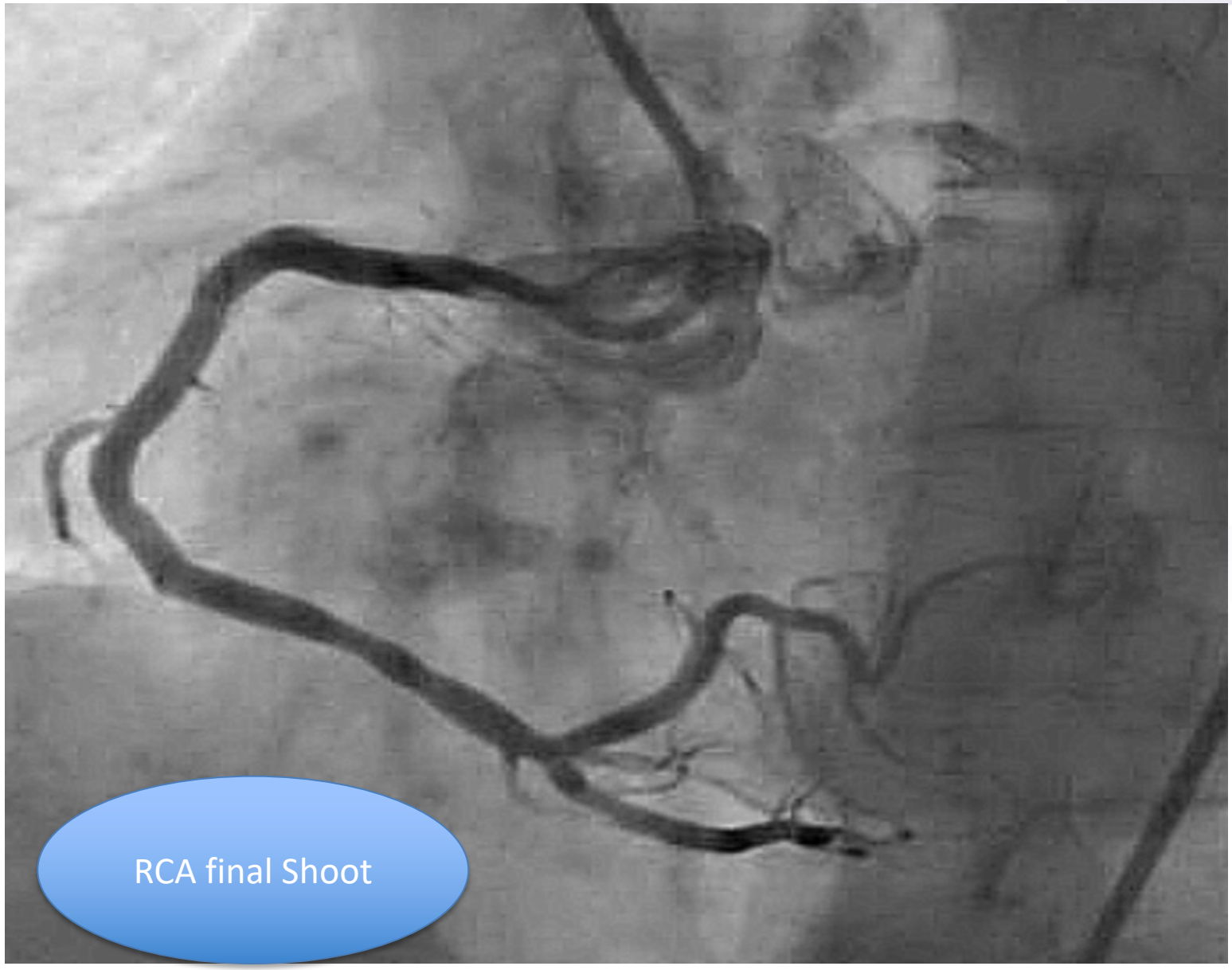
MLCTO ACADEMY
RESEARCH · EDUCATION






LAD final shoot


Tagging dissection
with Ostial RCA


RCA final Shoot

LESSIONS LEARNT

- Donor artery dissections can be disastrous complication of retrograde CTO PCI .
- Prevention is better than cure, pull or preferably disengage your guide during manipulations of retrograde gear.
- Quick restoration of dissection is the key to prevent major catastrophe.