MLCTO ACADEMY
RESEARCH · EDUCATION

My worst complication

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55 yr old male patient, S/P PCI to LCx and mid – distal RCA to PLV 2015.

Effort angina class 2 worsening to class 3 despite medical management.

CAG : Patent LCx stent, RCA instent long segment occlusion, PDA fills retrogradely by septal collaterals

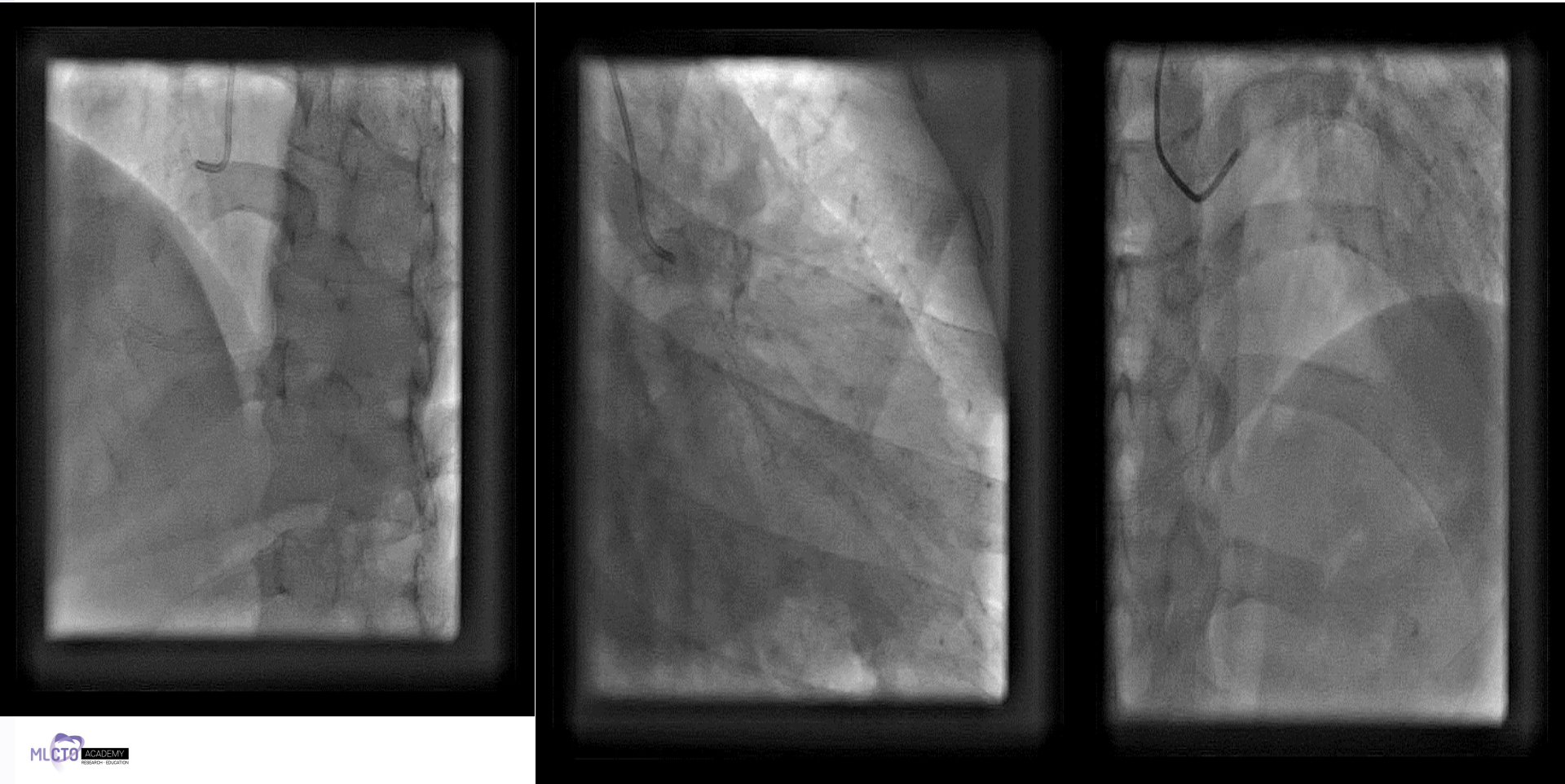
LAD mid segment CTO, CTO length > 20 mm, no calcification/ tortuosity, septal to septal Homocollateral, epicardial collaterals +, bifurcation at proximal and distal cap, JCTO score 1

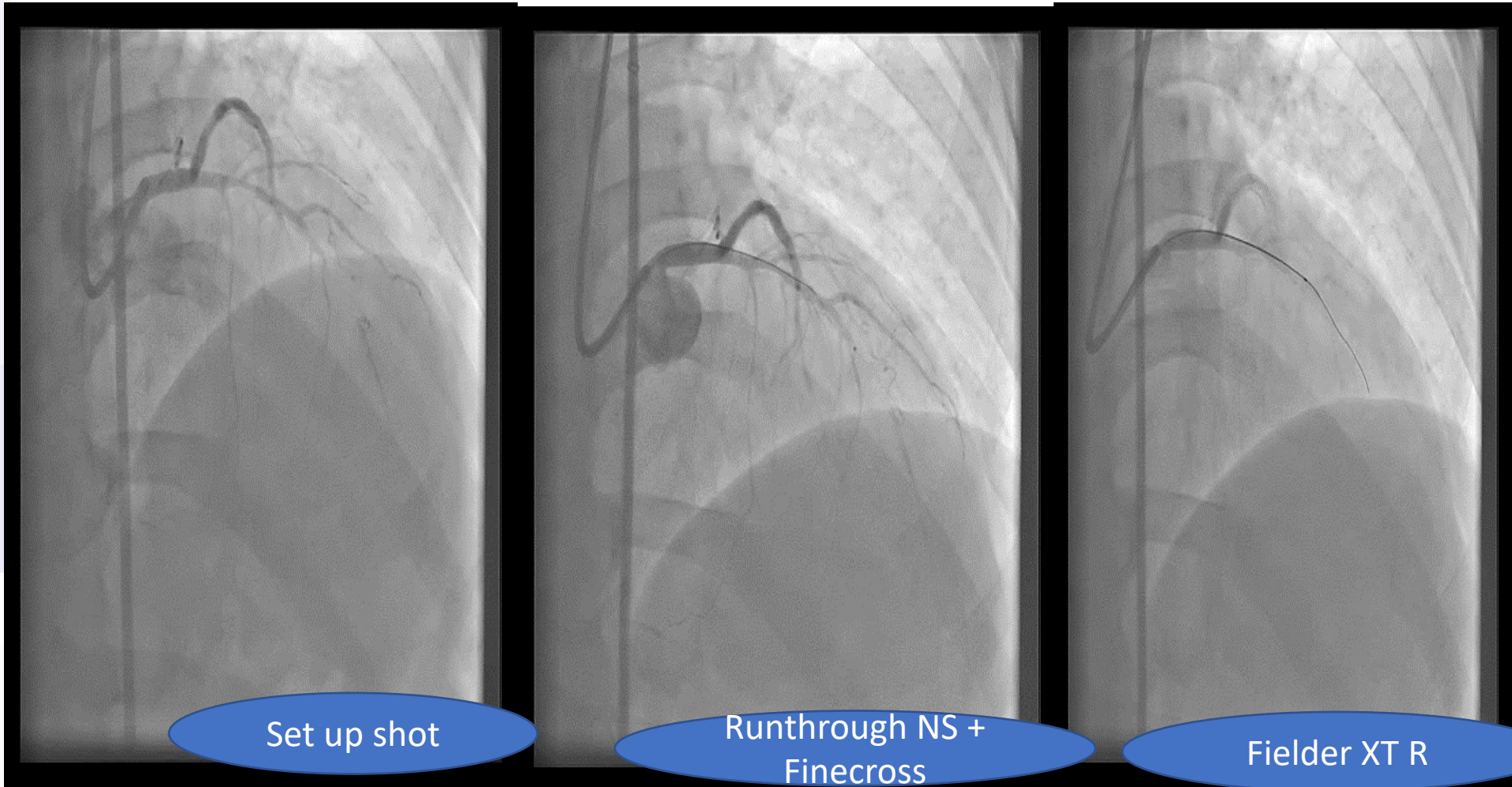
Plan : Antegrade wire escalation for LAD CTO

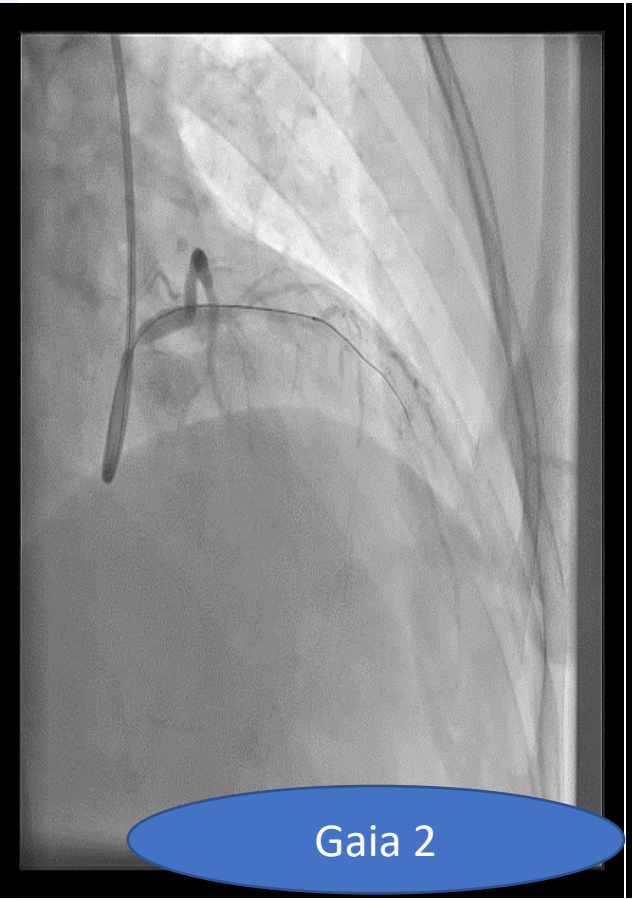
Set up : Right femoral artery 7F XB guide catheter, finecross with Runthrough NS to Park MC to Proximal cap , probe with fielder XT R , escalate to gaia and further as per requirement.

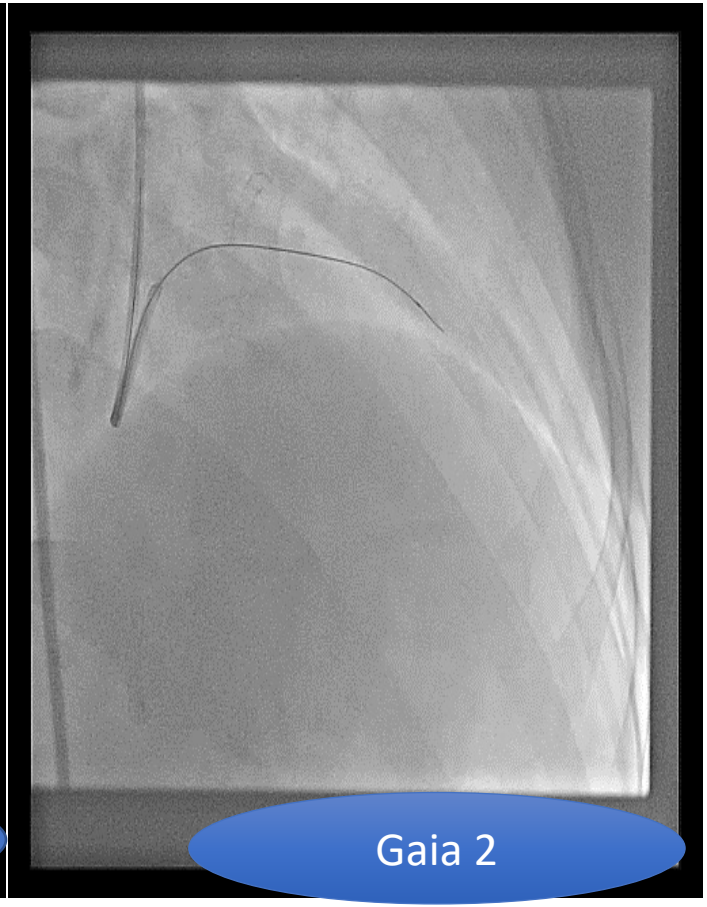
Second micro if required to visualise through septal to septal collaterals.

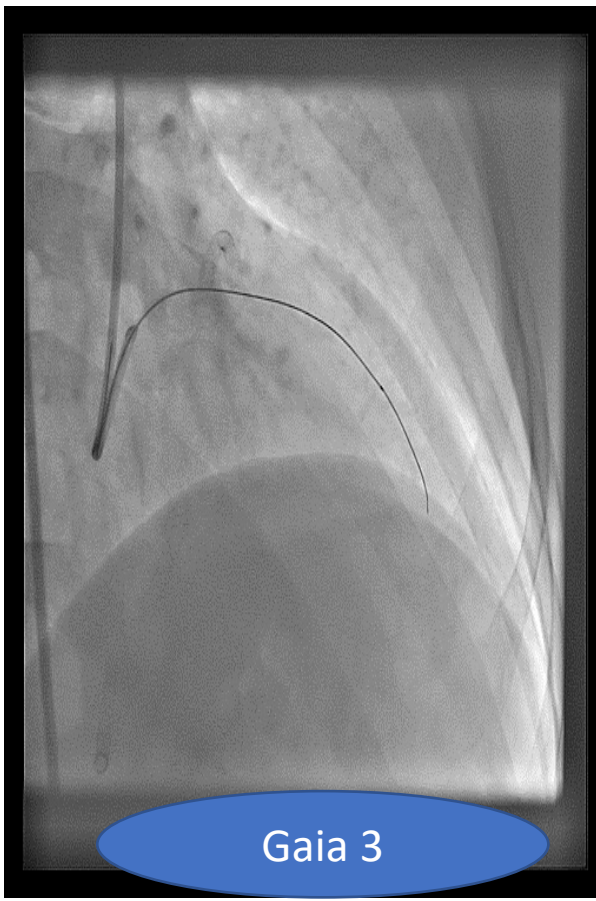
Diagnostic coronary angiogram

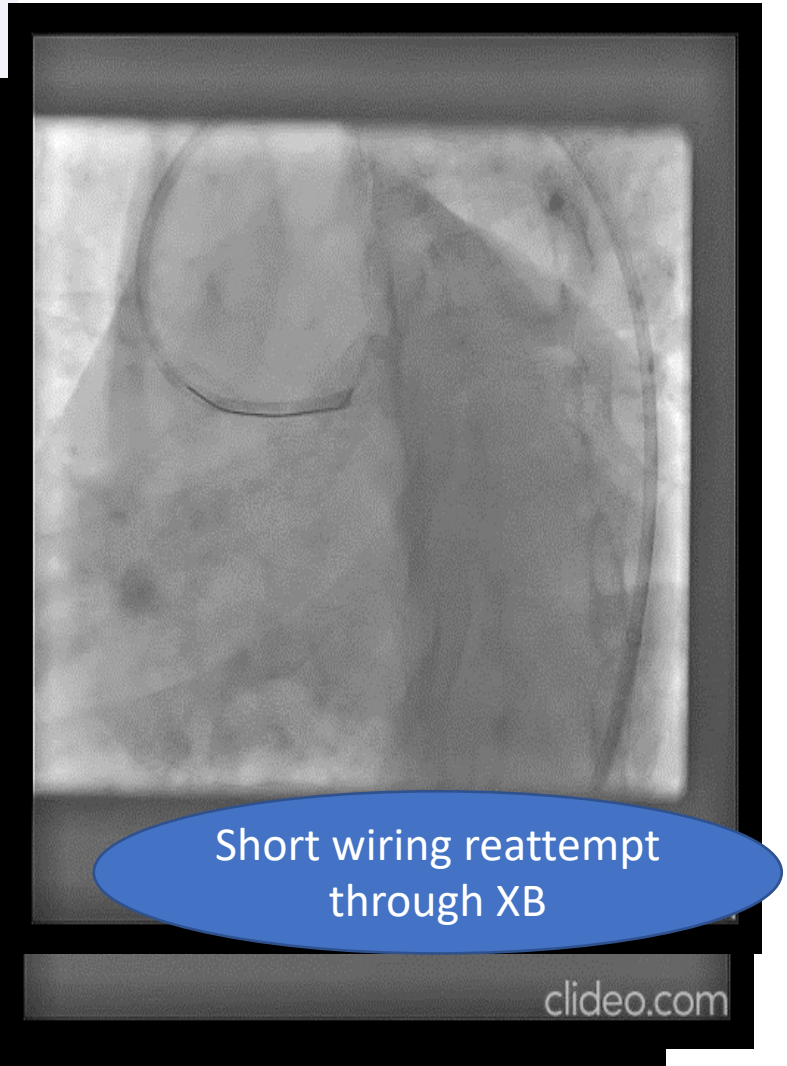


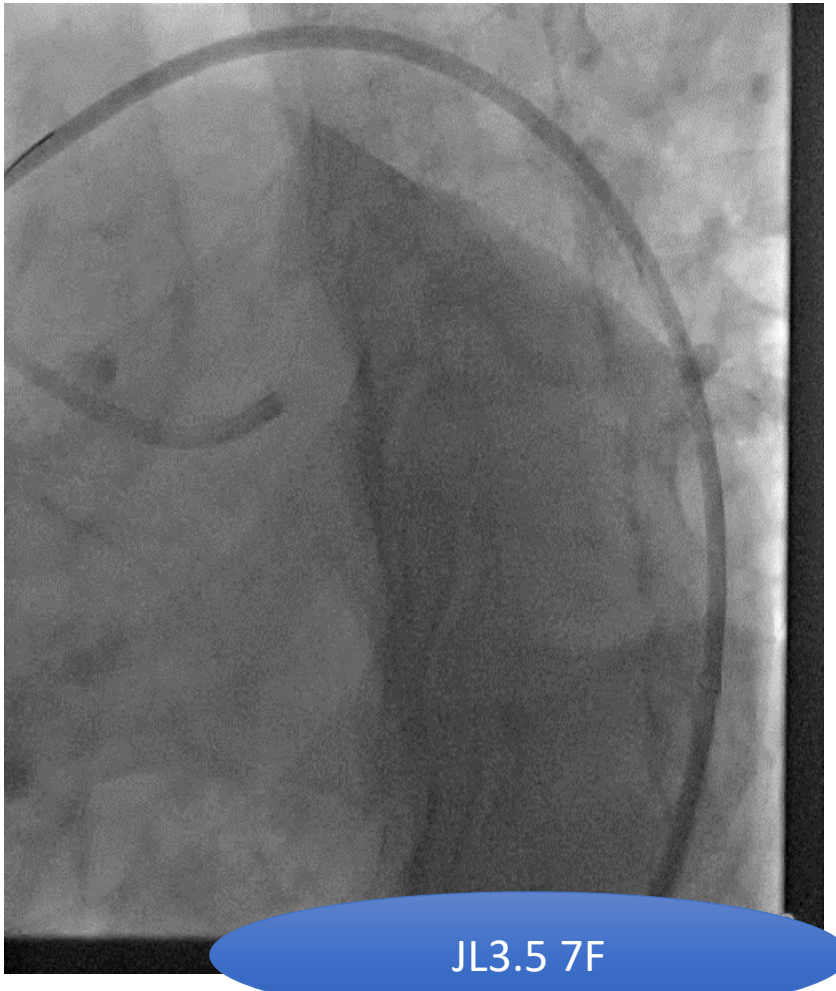

Set up shot
Runthrough NS + Finecross
Fielder XT R

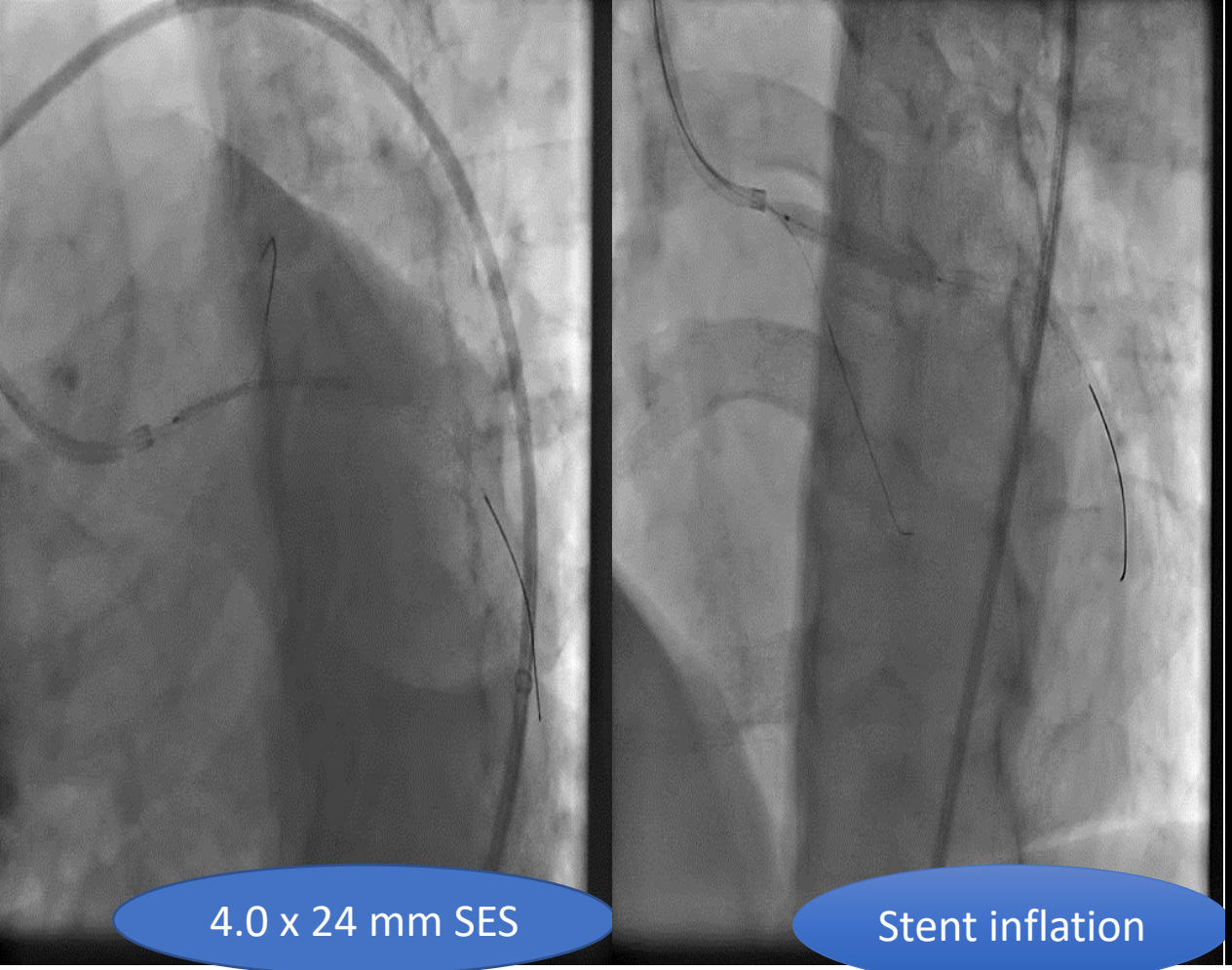

Gaia 2


Gaia 2

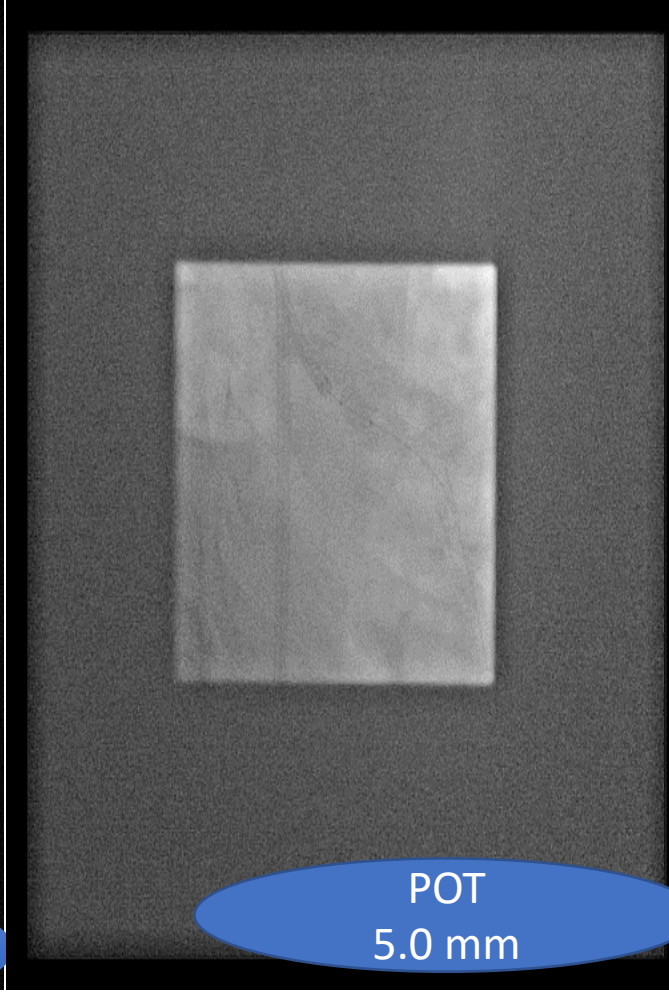

Gaia 3

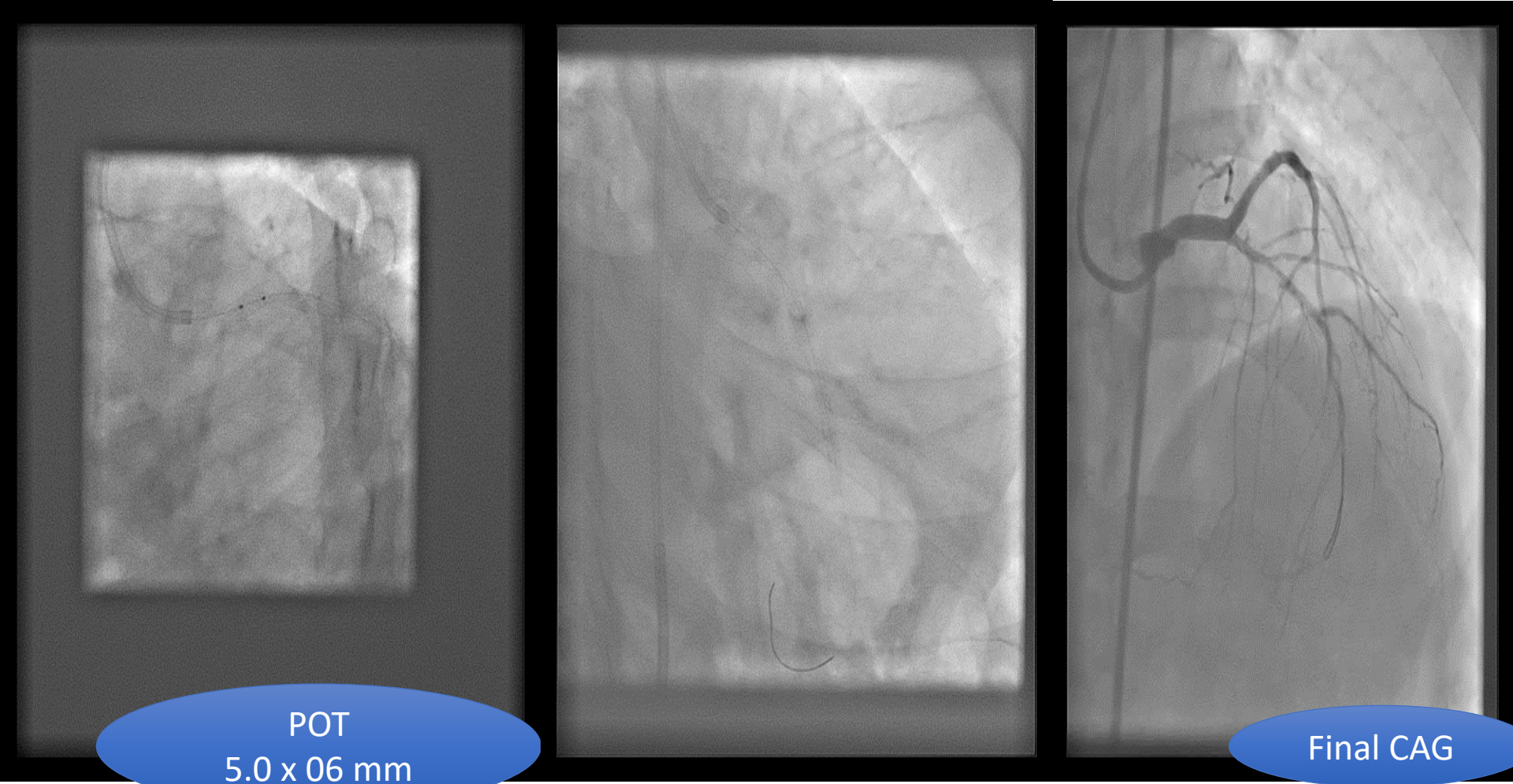

Short wiring reattempt through XB
clideo.com


JL3.5 7F


4.0 x 24 mm SES

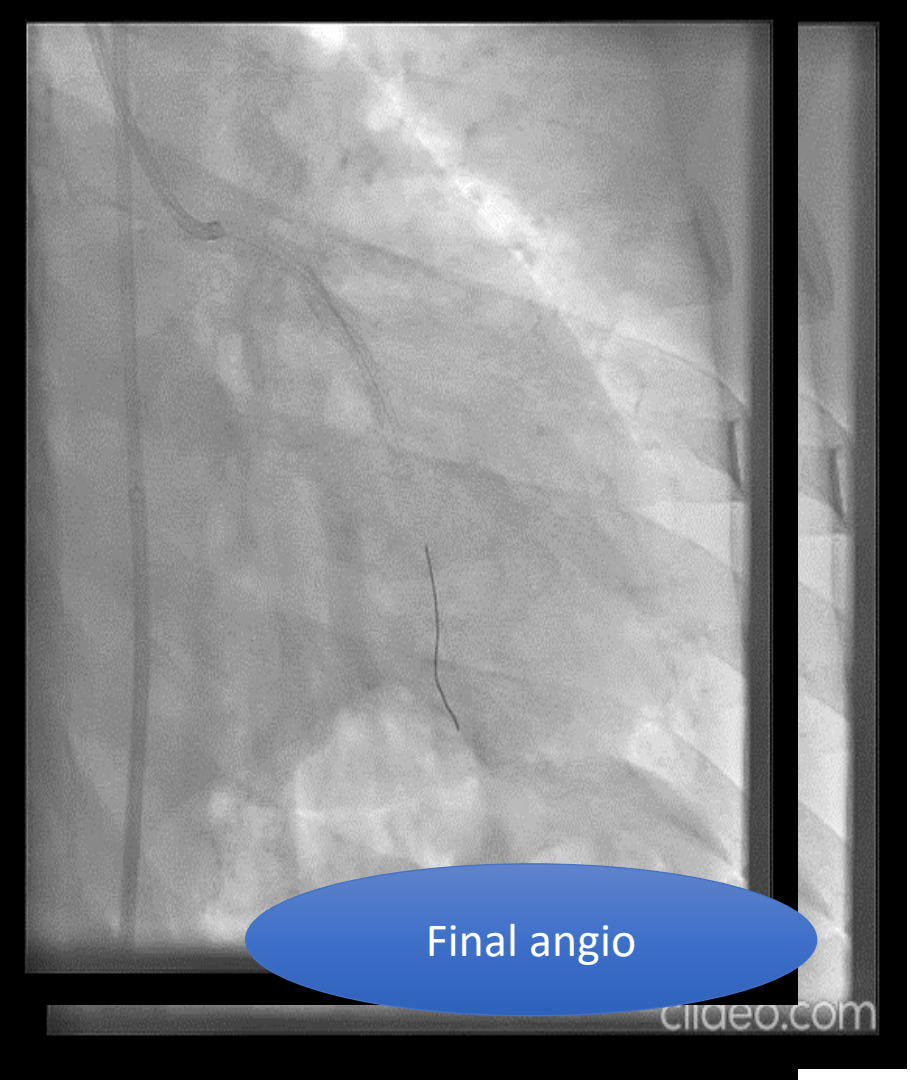
Stent inflation

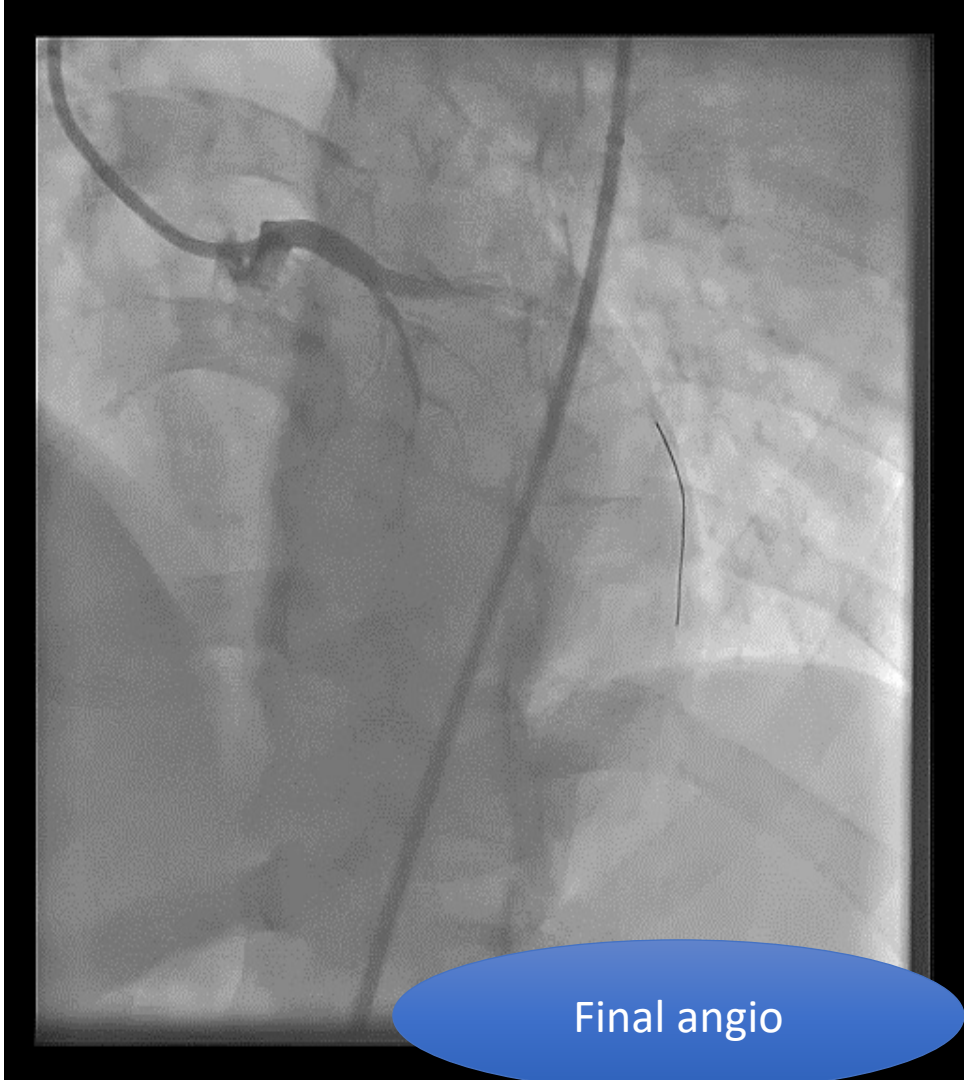

POT
5.0 mm



POT
5.0 x 06 mm

Final CAG


Final angio
clideo.com


Final angio

Conclusion and take home message

Guide induced aorto ostial dissections should be avoided specially while we are working with aggressive guides during CTO PCI and in sole surviving vessel.

Hemodynamic instability occur in flash in these scenarios

Cool head of the leader and confidence to handle crisis forms the backbone of the treatment.

Prompt sealing of inlet (LMCA / RCA ostia) forms mainstay of treatment.

Never inject once dissection is noted as it propogates it further.

Wire in such scenario is LIFELINE, NEVER LOOSE IT IN WHATEVER CIRCUMSTANCES.