

IVUS guided CTO PCI

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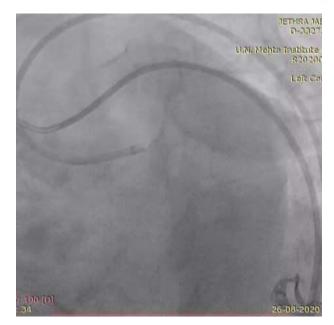
History

- 48-year-old male, non-diabetic, hypertensive
- H/O CSA- 1.5 years, progressed from class II to class III
- CAG 1 year back: LAD CTO
- PTCA attempted outside year ago: Unsuccessful, ambiguous proximal stump
- Presented again with worsening angina
- Normal LV Function, J-CTO Score: 3





Dual injections showing proximal LAD 99
percent calcified lesion
with mid LAD CTO with ambiguous
proximal cap, distal vessel filling via
epicardial collaterals from LCX-OM







Procedure Plan

- J CTO score 2: Long length and ambiguous proximal cap
- Proximal heavily calcified lesion, no good septal collaterals
- Antegrade approach: 7fr EBU guiding, IVUS run from septal to identify proximal cap
- Retrograde attempt in case of antegrade cap puncture unsuccessful



PTCA



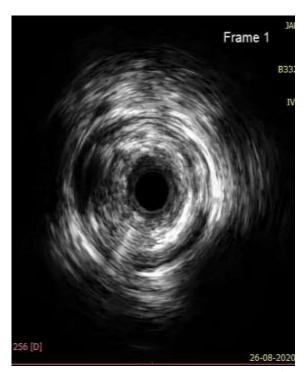


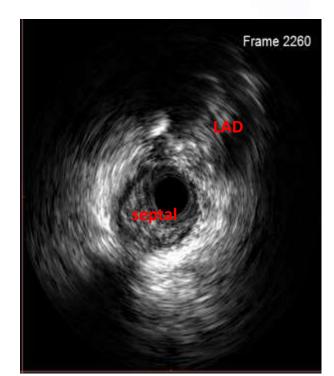


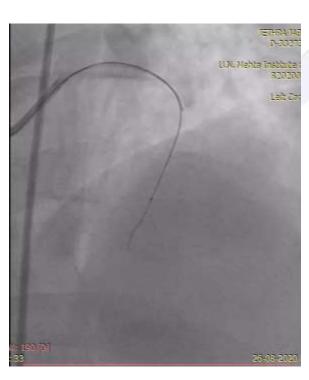
Initial probing done with pilot 50 wire over finecross, wire repeatedly slid into the septals, proximal balloon dilatation done to facilitate advancement of microcatheter to lesion site, cap engagement attempted with Gaia 2nd, unsuccessful



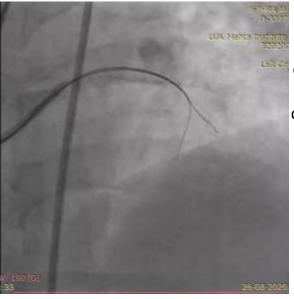
IVUS run from septal to LAD



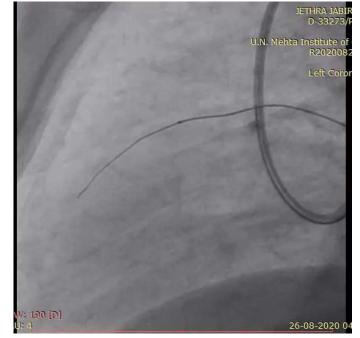


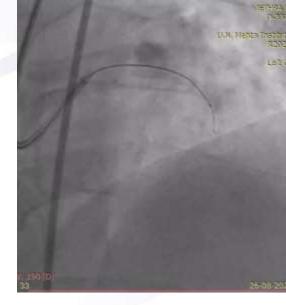


IVUS run from septal identified the site of proximal cap, cine angiogram taken at the site with IVUS catheter tip at Cap site



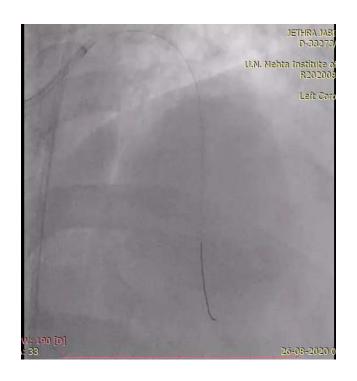
Cap puncture reattempted successfully at the purported site with Gaia 3rd over finecross, wire de-escalated to fielder XT, manoeuvred into distal LAD

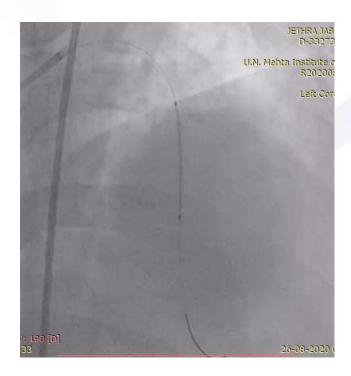






PTCA

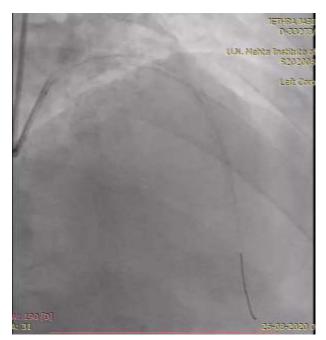




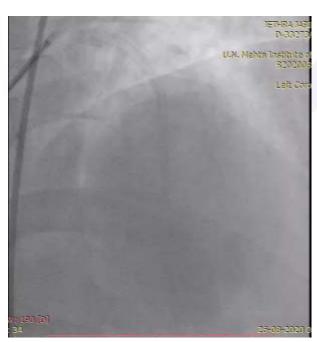
Balloon dilatation and stenting done with 2.5*38 and 3*38 stents, ivus guided stent optimization done



Final Result









Conclusion and take home message

- Post procedure course uneventful, discharged next day
- Doing well at 3 years follow up
- IVUS: Helpful in solving proximal cap ambiguity in selected cases
- Wire escalation and de-escalation integral part of antegrade wiring
- Final sizing and optimization with IVUS crucial for good long term outcomes



Thank you