

# Occasionally, two is better than one

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# Disclosures

**None**

# Clinical data

## **□History:**

- 75 lady, Diabetes Mellitus II, hypertension
- Angina CCS-class II

## **□Echo:**

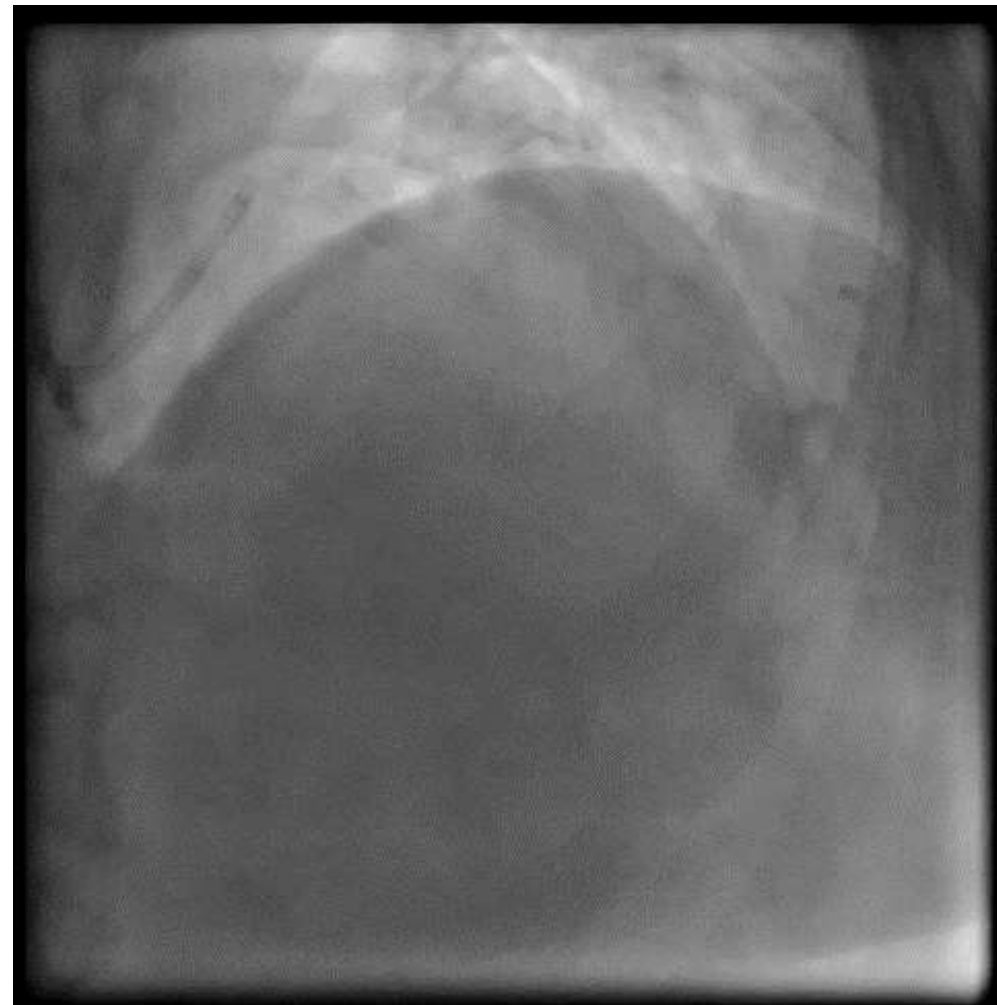
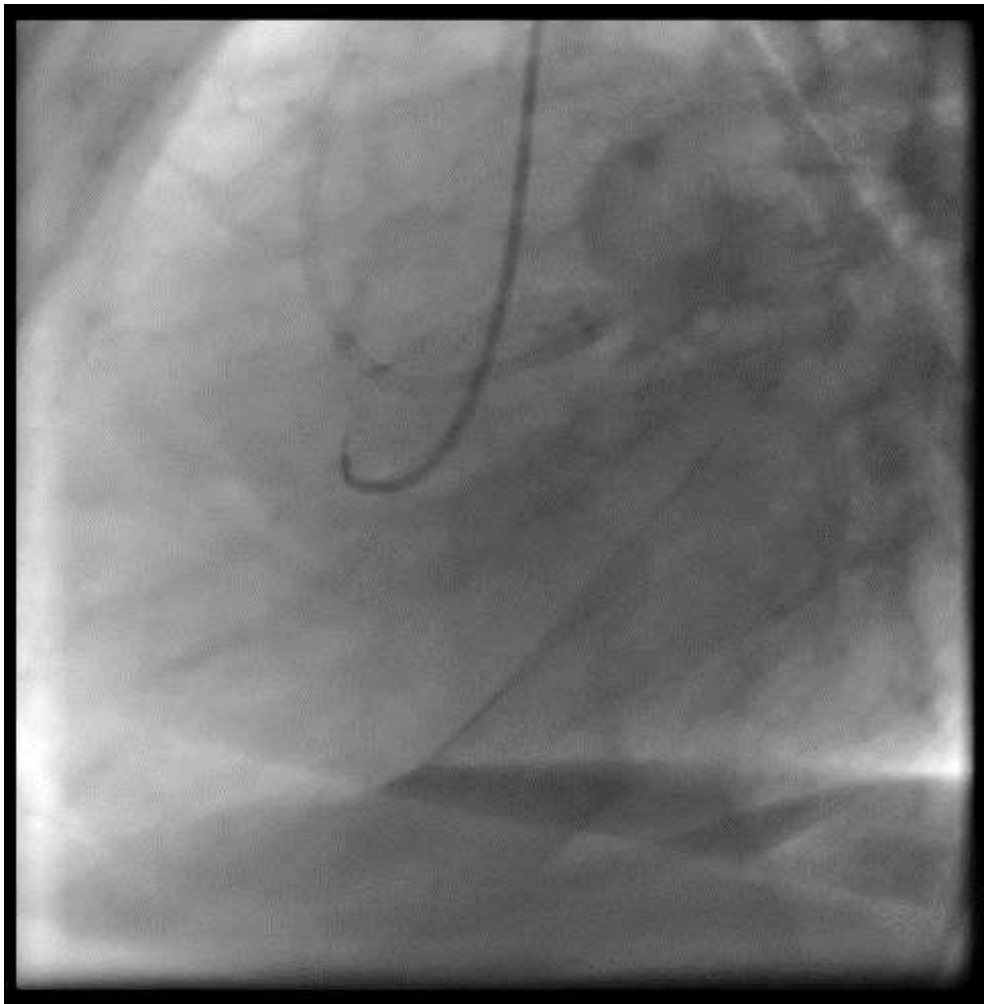
- LVEF= 35%, moderate MR.

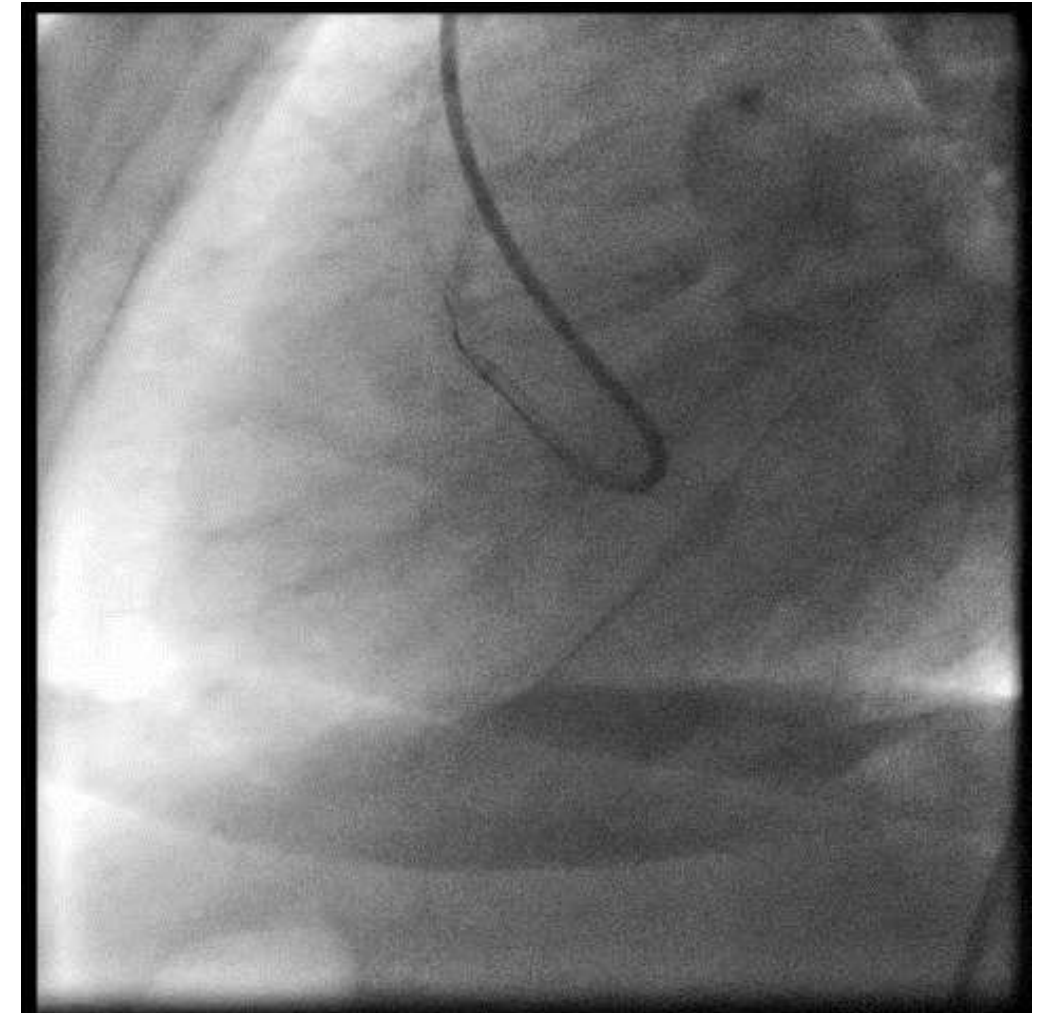
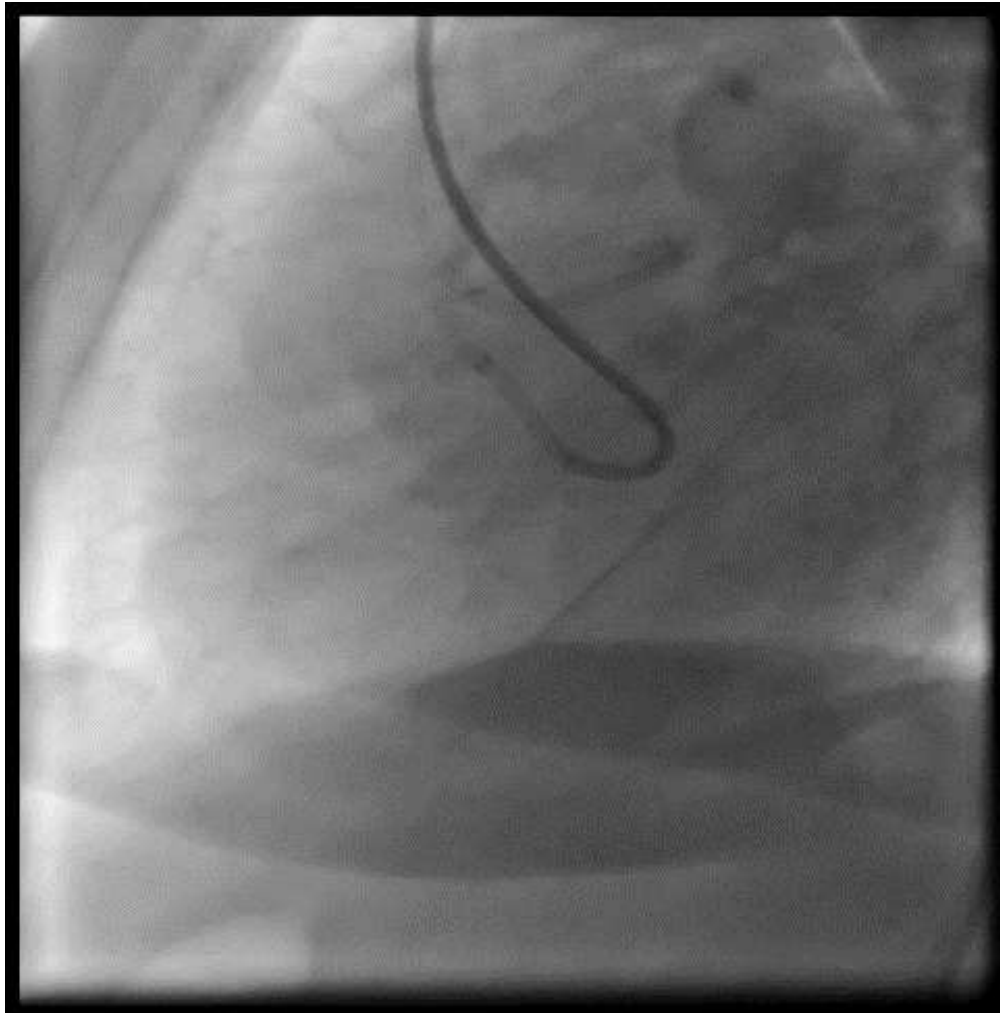
## **□Coronary angiography:**

- S/P PCI to LAD & RCA 3 years before, RCA CTO left for medical treatment.
- Failed trial of PCI to CTO RCA at another facility

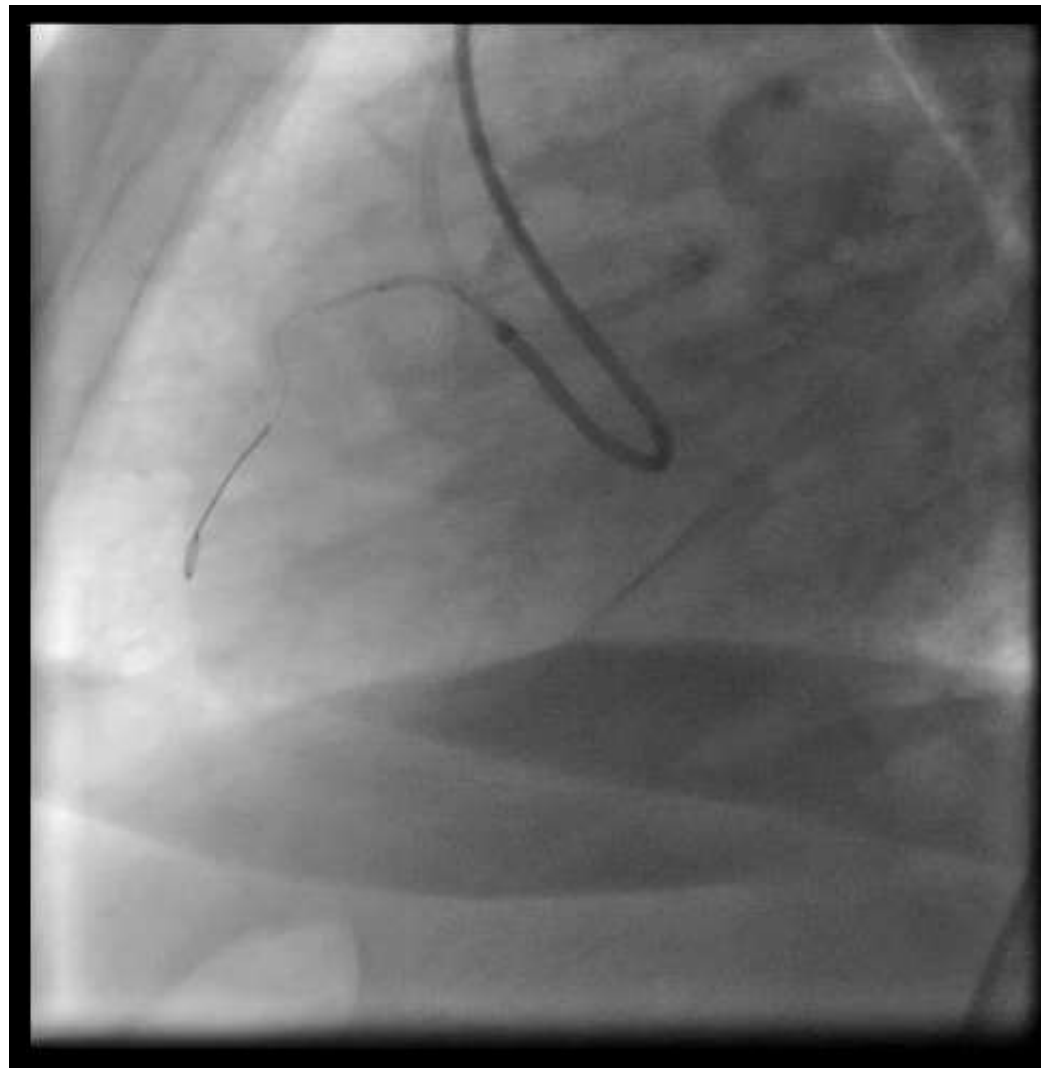
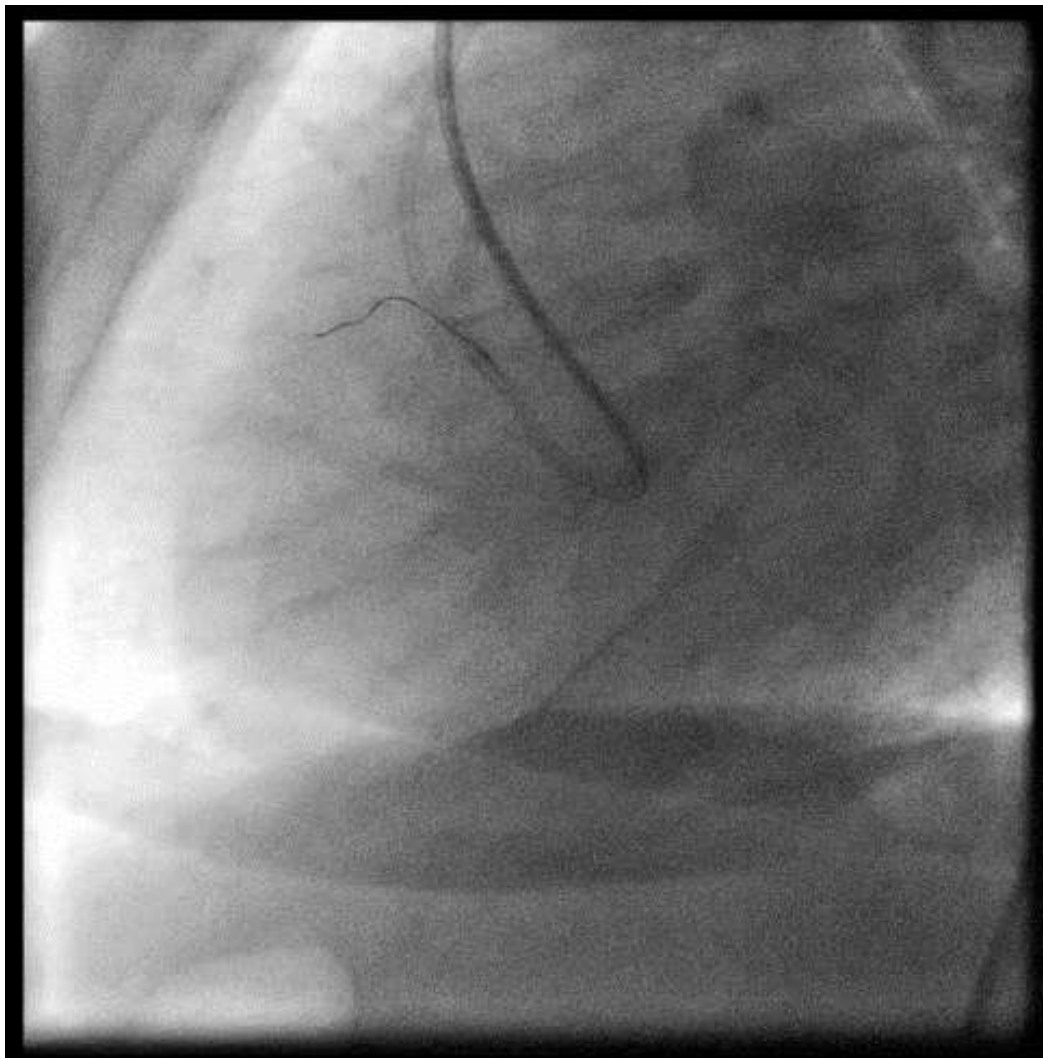


CA





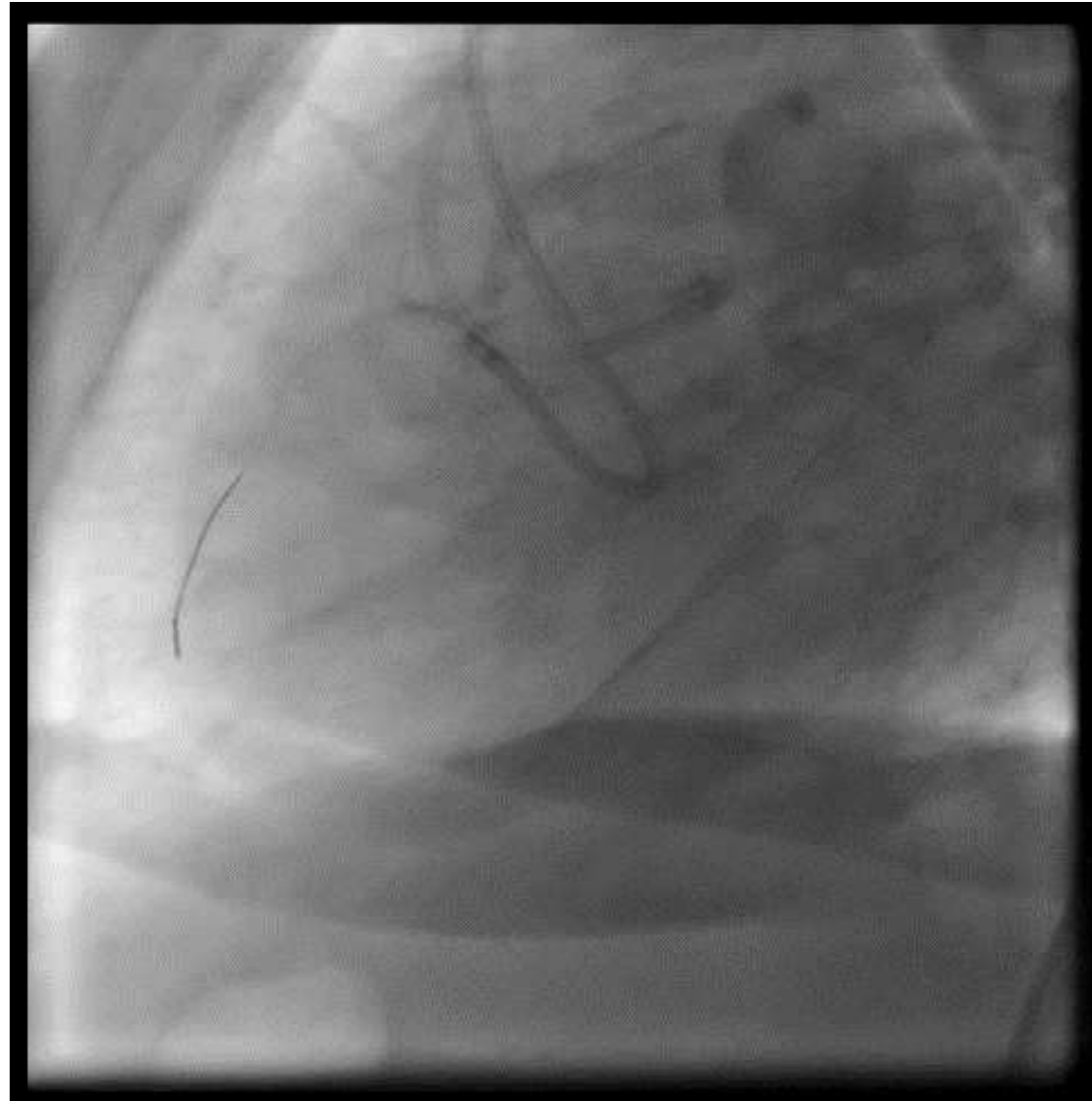
GC: A1 1   MC: Caravel 150 - GW: Sion wire to engage the ostium



PTCA (1.5 x 20 mm)

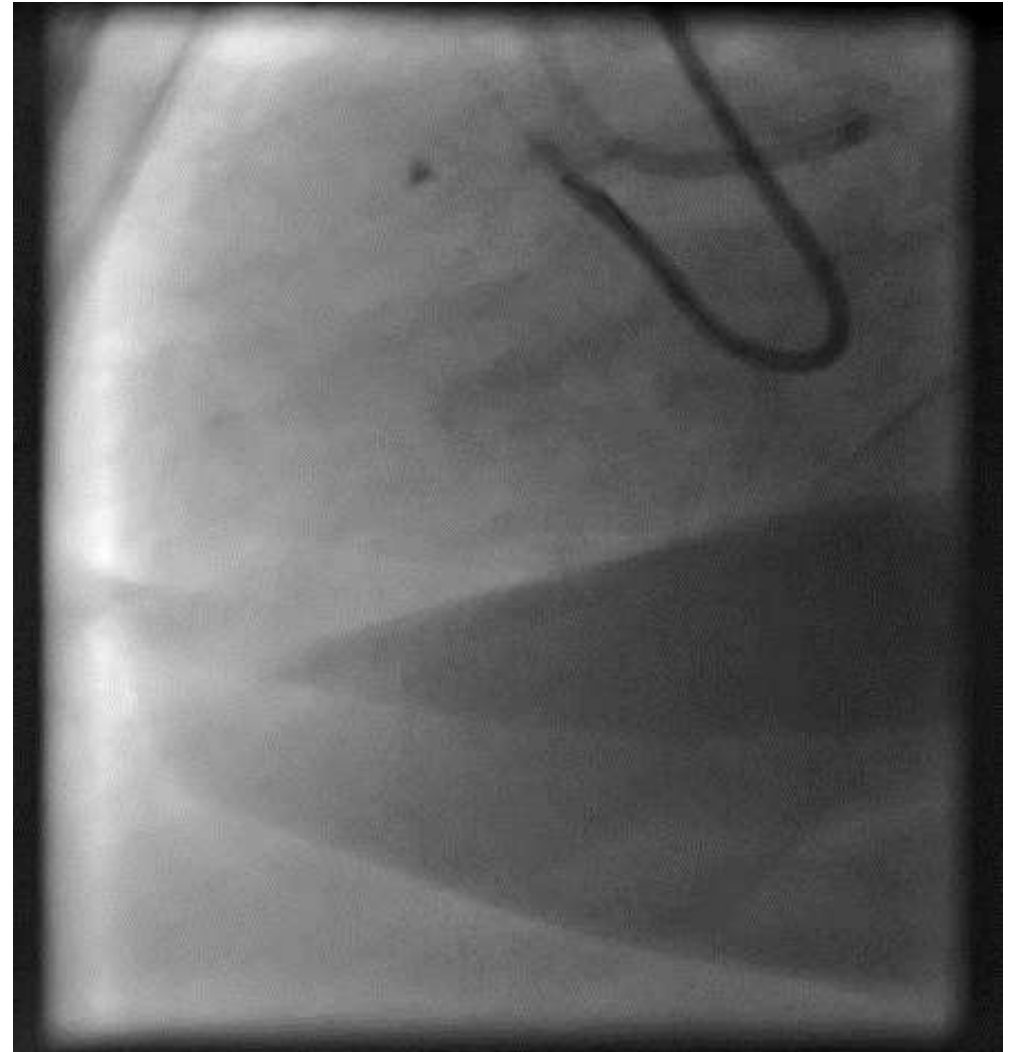
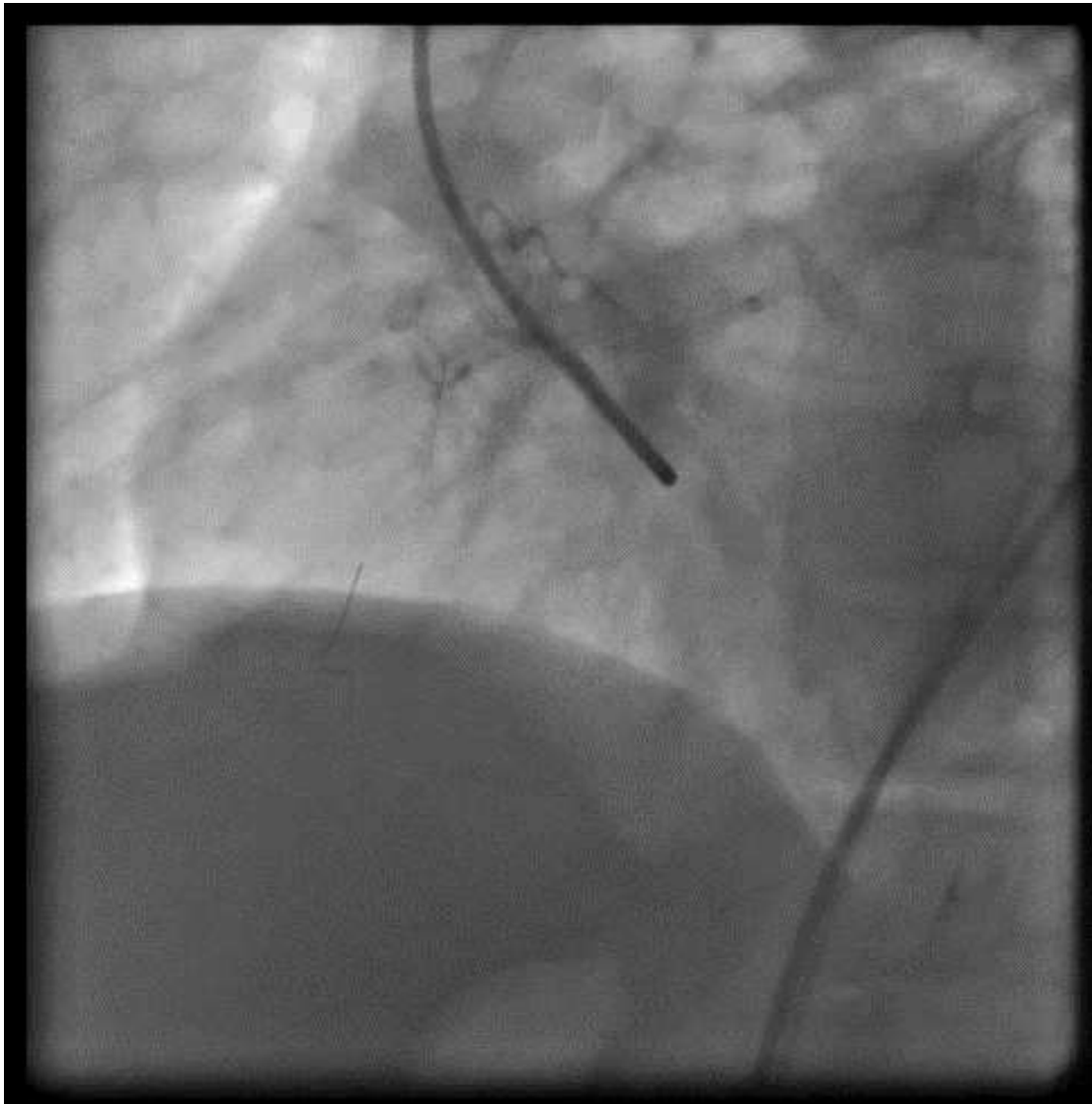
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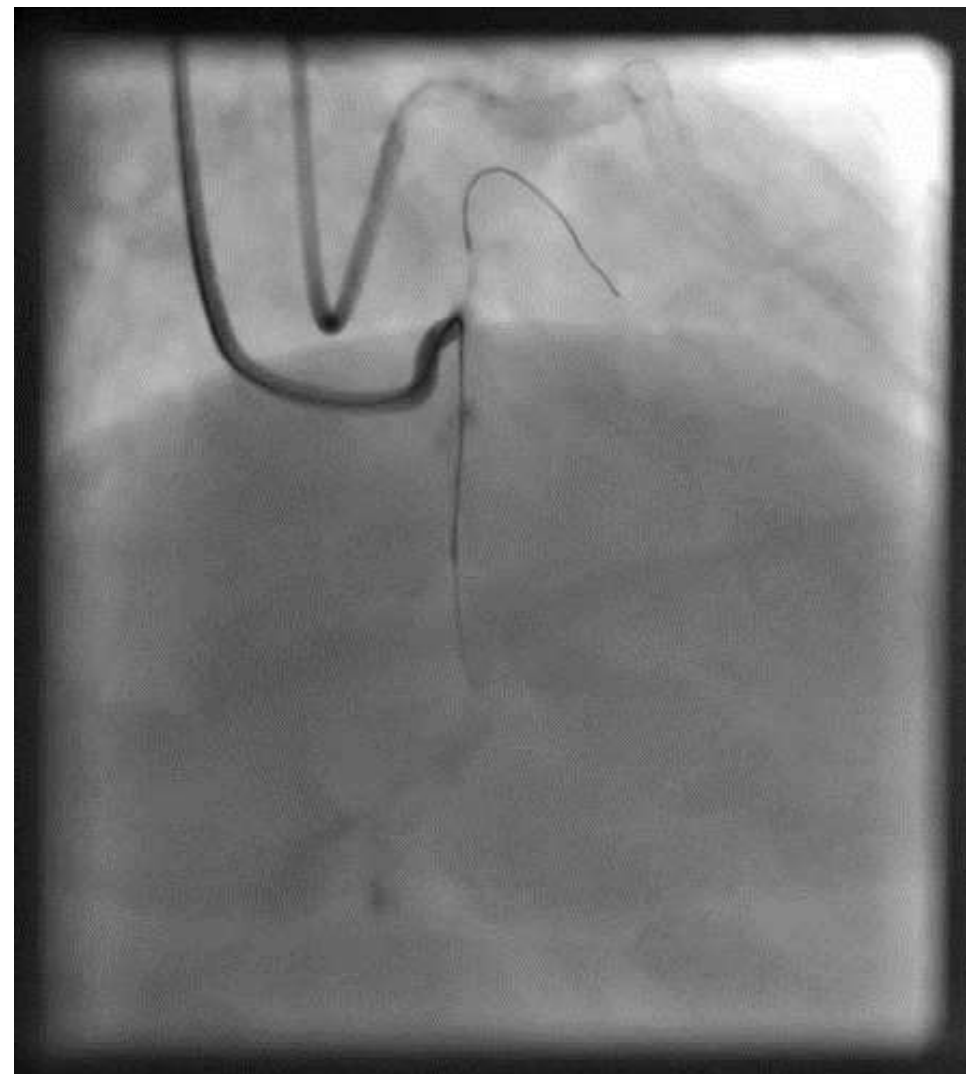
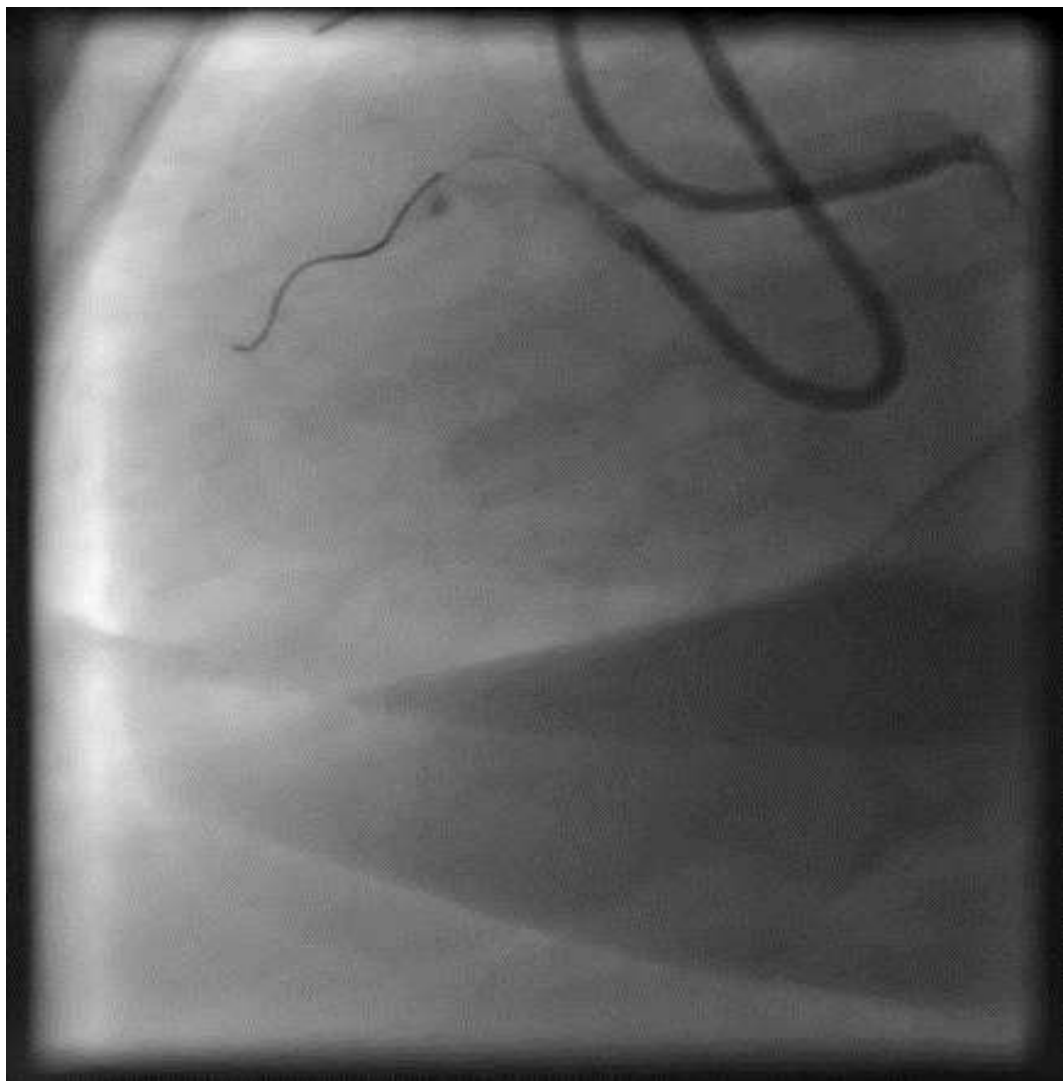
**Somewhere .. But .. where??**



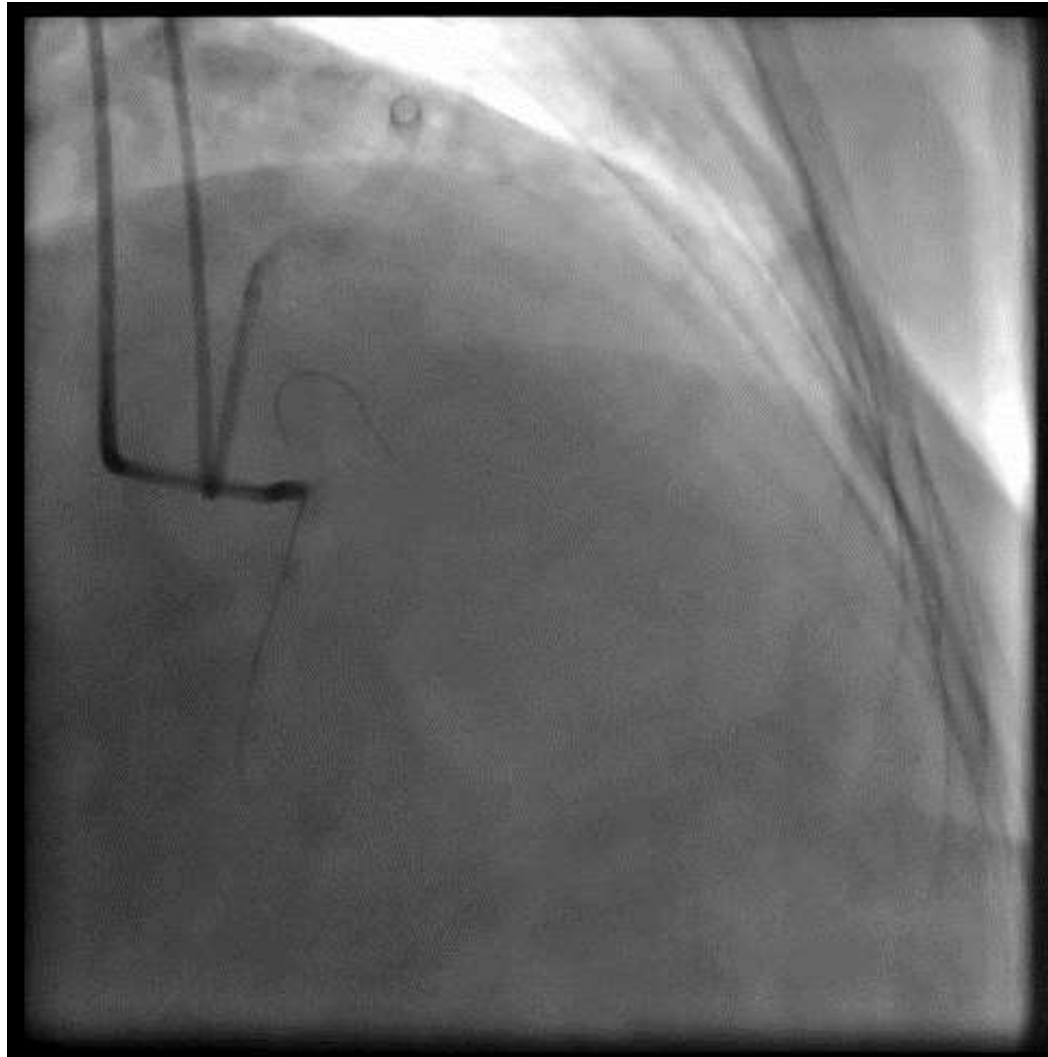


BMW wire at conal branch for better support

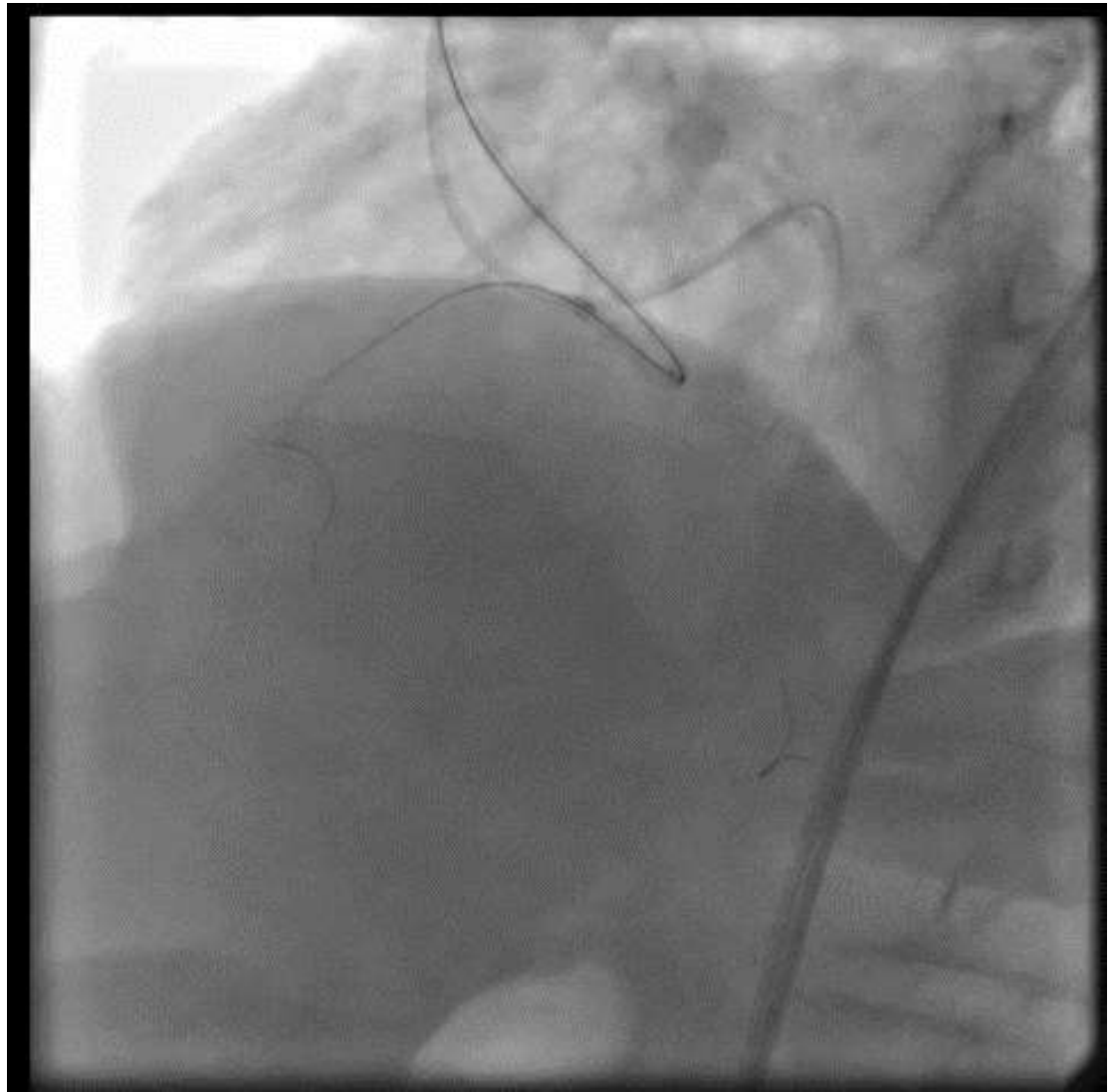




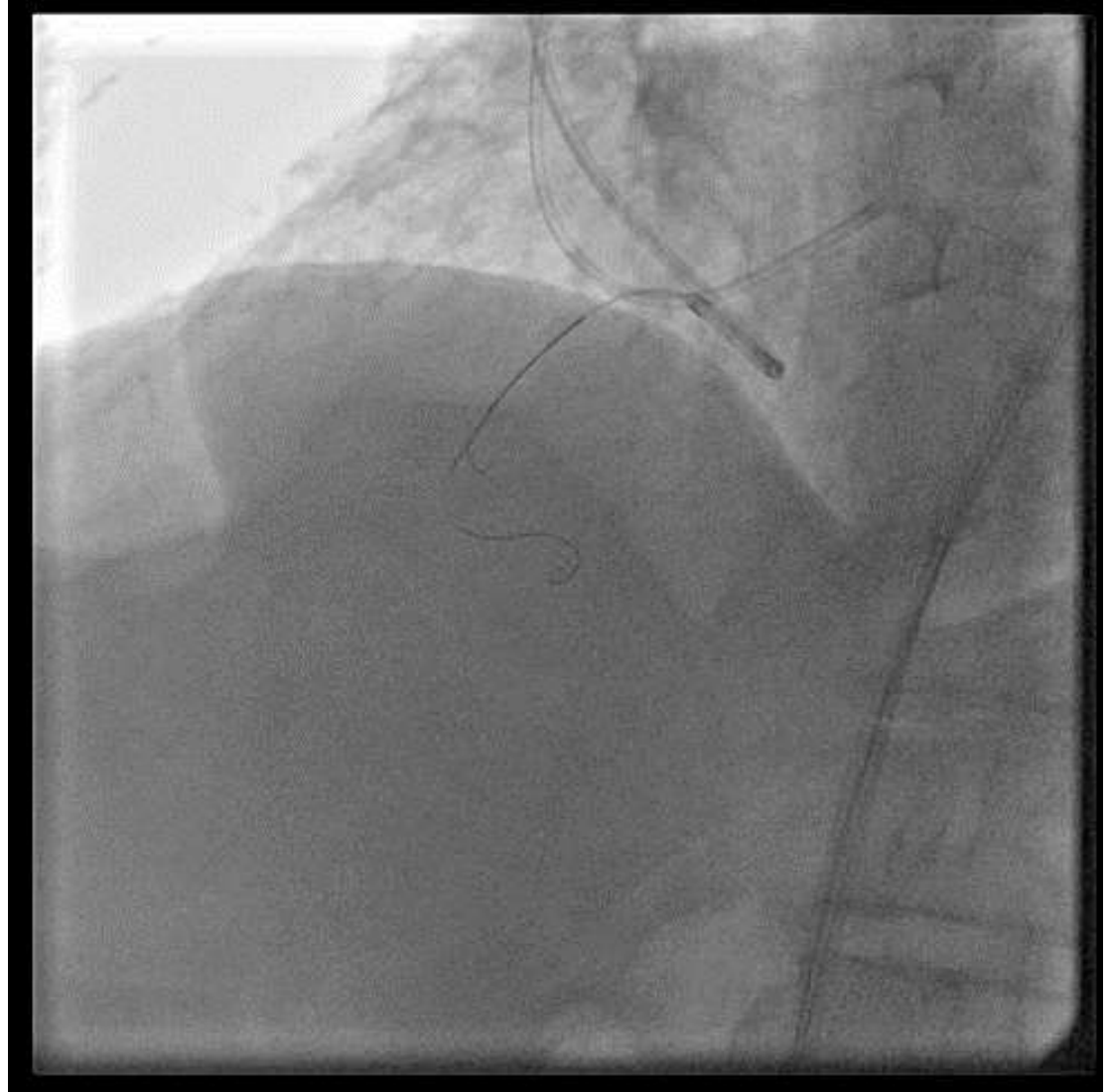
Fielder XT-A , Gaia II



Only retrograde injections .. Any further antegrade injection  
will compromise the lumen

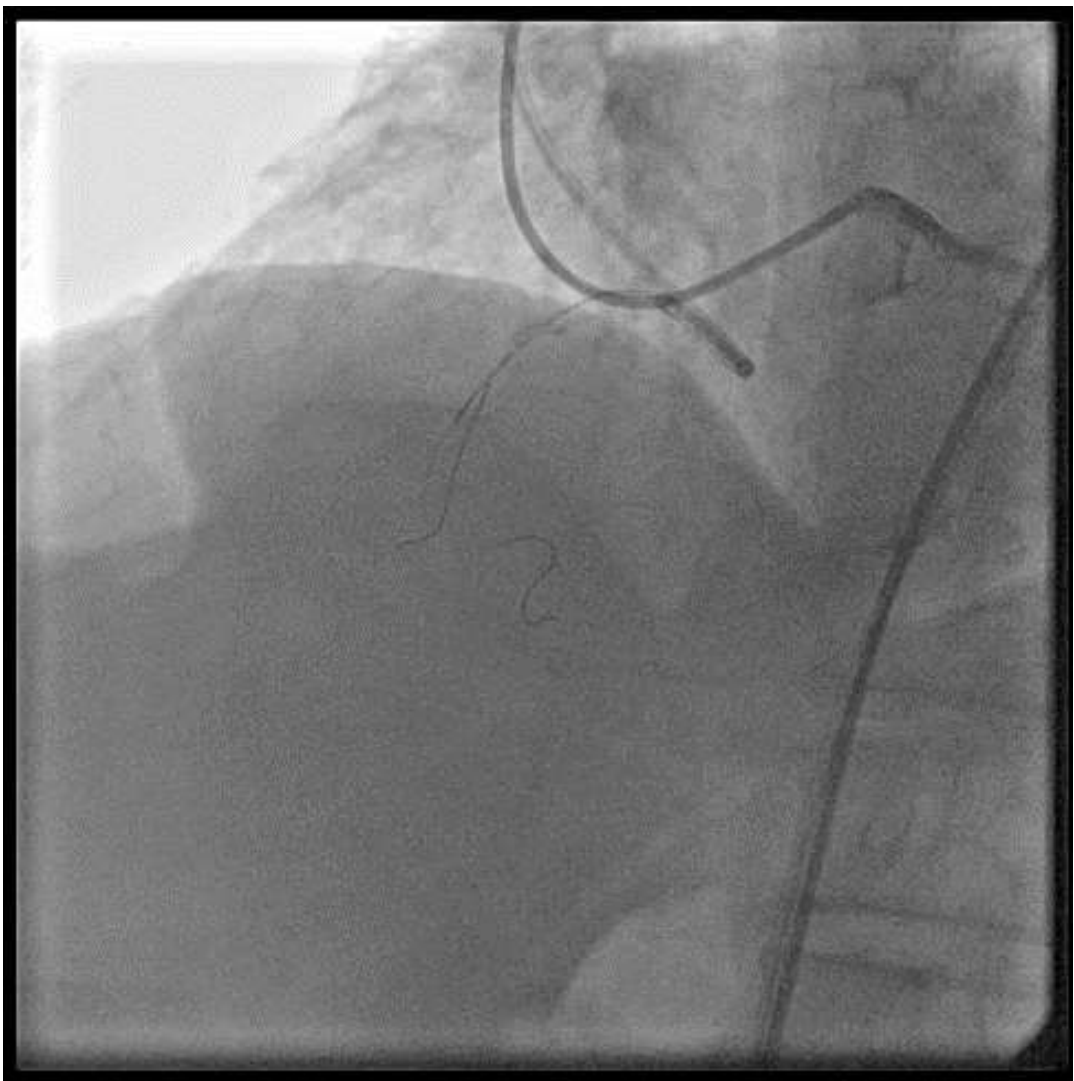


Gaia II into RV branch at the site of CTO distal cap

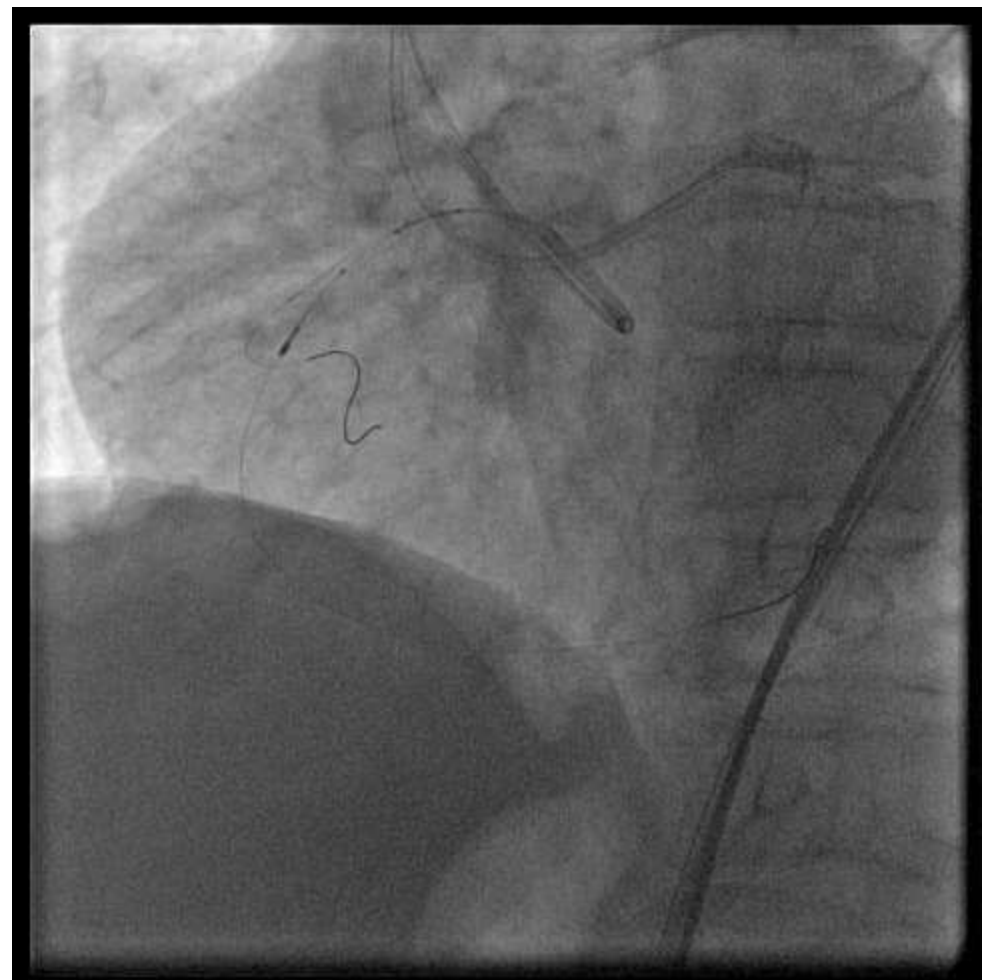
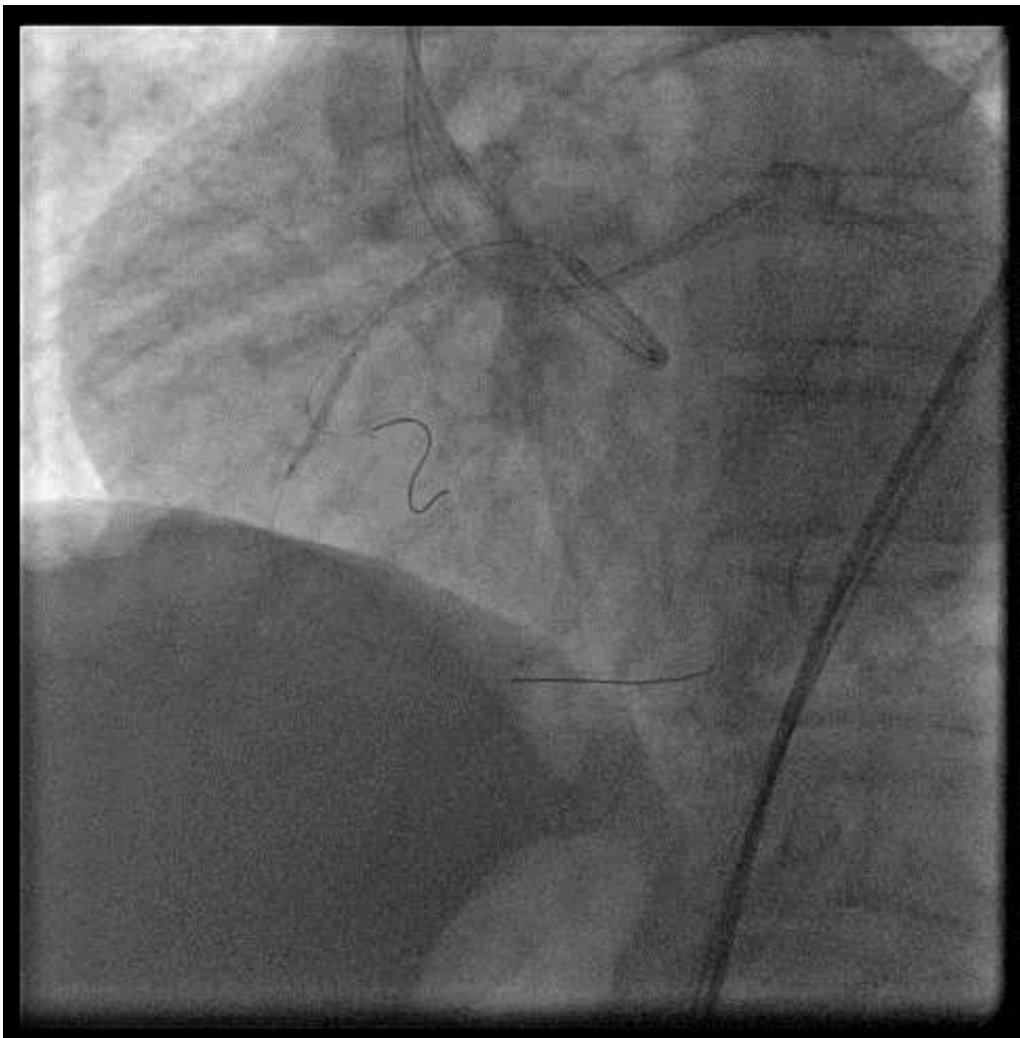


RECROSS (DLMC) .. Make sure in true lumen navigating true lumen

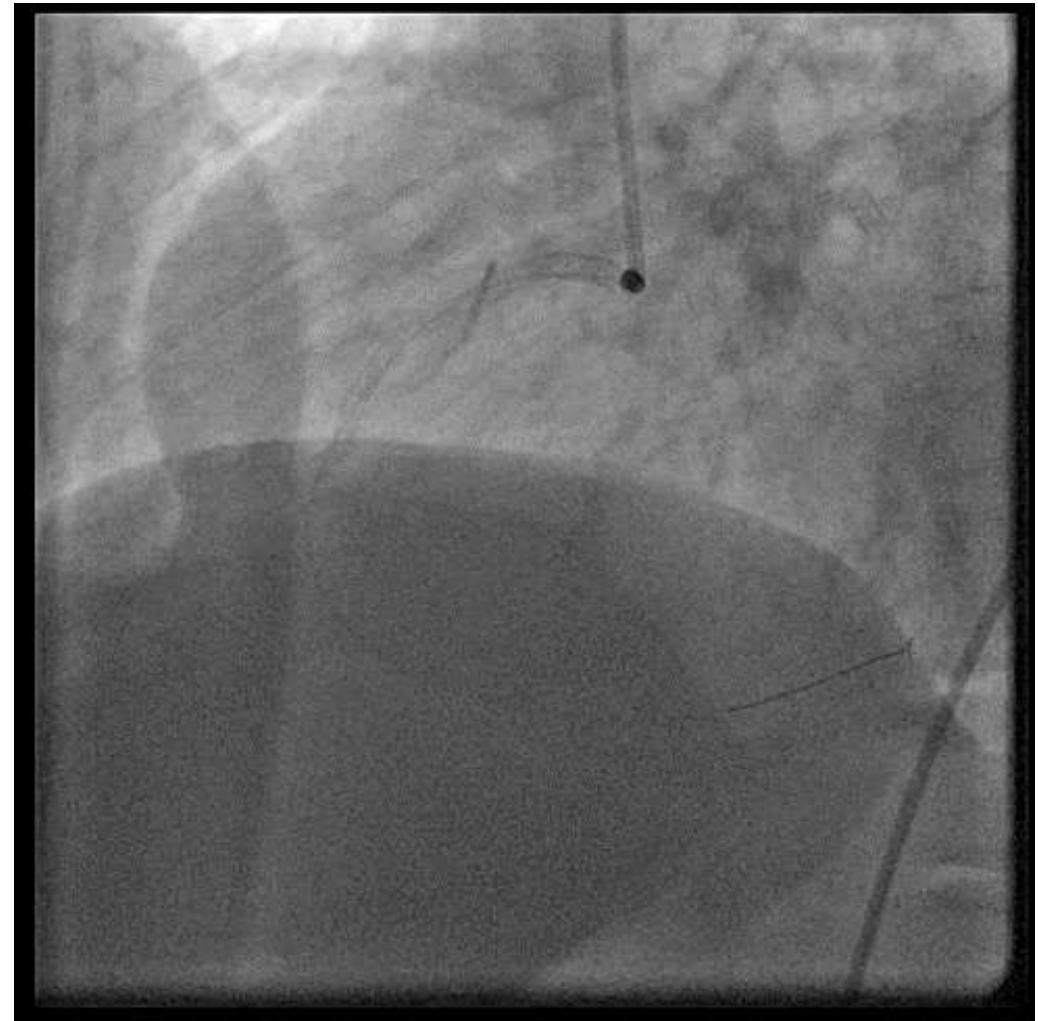
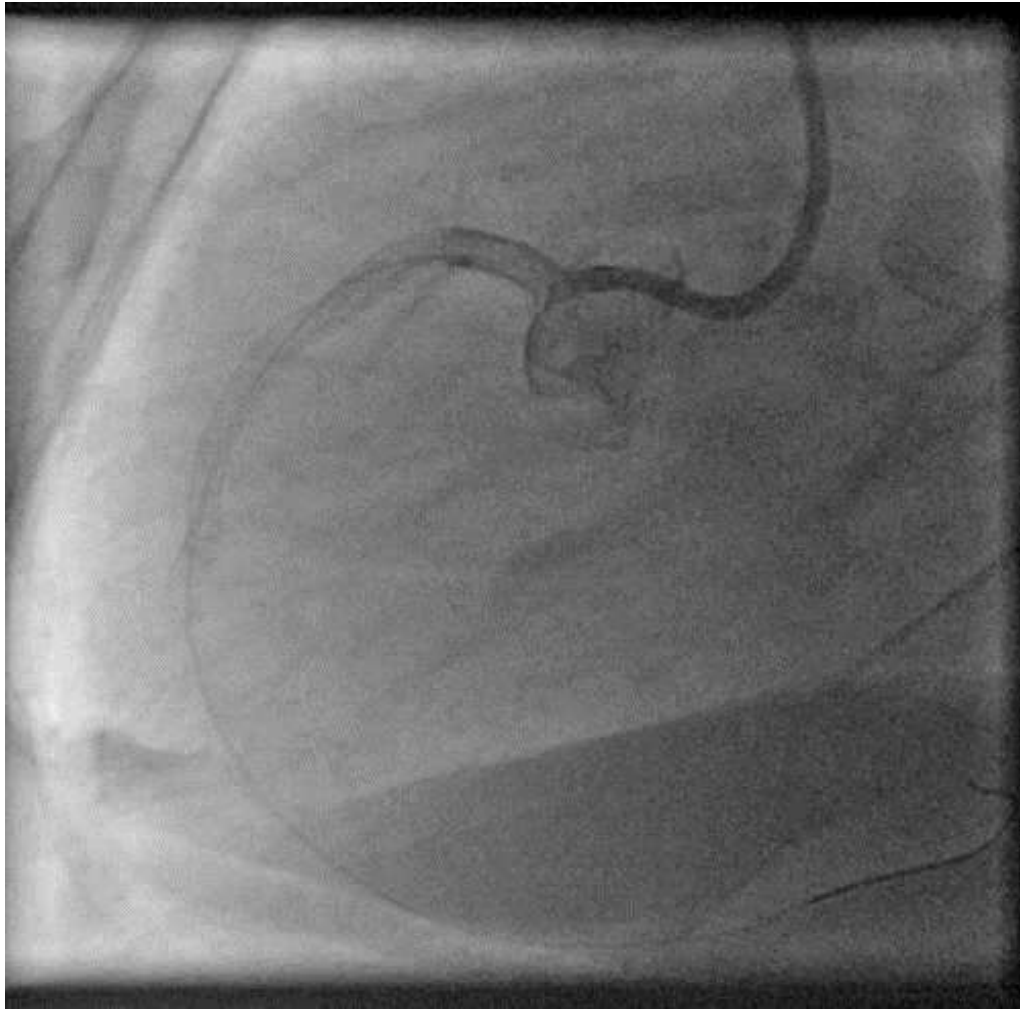




RECROSS (DLMC), Sion wire crossing the CTO cap advanced distally



➤ **Final result**



**3 overlapping DESs all the way up to the ostium, Post dilatation 4x20 mm NC balloon**





## *Take home messages*

- Throughout procedure gather information, perceive, act accordingly
- Know when to remove antegrade syringe to keep the case antegrade
- DLMC are helpful in gaining access from strategic SB or in some ADR cases
- Do not give up AL catheter even in ostial occlusions and never sacrifice support



*Thank you*

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