Challenging case of an RCA CTO

CASE PRESENTATION

73 y old gentelman

- HTN
- Ex Heavy Smoker

CASE PRESENTATION

Presented for **NSTEMI**

- **TTE:** anterior wall hypokinesia, LVEF 55%
- **Cardiac catheterization :**
  - severe proximal and mid LAD stenosis
  - severe stenosis of the first marginal branch;
  - Chronic occlusion of proximal RCA (J CTO score = 3)

→ Consecutive PCI of LAD and Marginal with 2 DES

CASE PRESENTATION

Follow up visit 3 months later: patient described **persistant stable angina CCS 3**

- **Myocardial scintigraphy :** viable myocardium in inferior wall as well as reversible perfusion defect involving almost entire RCA distribution

→ **RCA CTO** recanalisation

PROCEDURE DETAILS

Dual Radial 7F

Antegrade approach

- Wire crossed successfully the proximal cap than passed into ***false lumen***
- *Escalation wire technique* : FAILED → False lumen in distal RCA
- *Parallel wire technique* : FAILED → False lumen in distal RCA

Retrograde approach

- Epicardial distal collateral via LAD used
- Wire failed to cross the distal cap with ***extension of the dissection and intramural hematoma***
- No more visualization of the distal RCA

PROCEDURE DETAILS

ANTEGRADE DISSECTION AND RE ENTRY

- *Stingray LP system* with no visualization of the distal landing zone
- Retrograde wire left in place as marker
- Puncture with confianza pro 12
- True lumen regained
- PCI done successfully with good end result

Procedure complications

Epicardial collateral perforation on final control

- Non responding to fat embolization
- Successful closure with 2 coils

TTE : Circonferential pericardial effusion with no compression on cardiac cavities

- 48 hours monitoring
- Stable pericardial effusion allowing home discharge
- ***TTE 1 week later*** showed decrease in the size of the pericardial effusion
- ***TTE one month later*** --> no more pericardial effusion