

TCTAP C-039**Directional Coronary Atherectomy in a Patient Who Was Intolerant for Dual Anti-platelet Therapy Due to Coexistent Malignancy yet Niche but Necessary Option**

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[CLINICAL INFORMATION]

Patient initials or identifier number. Y.S

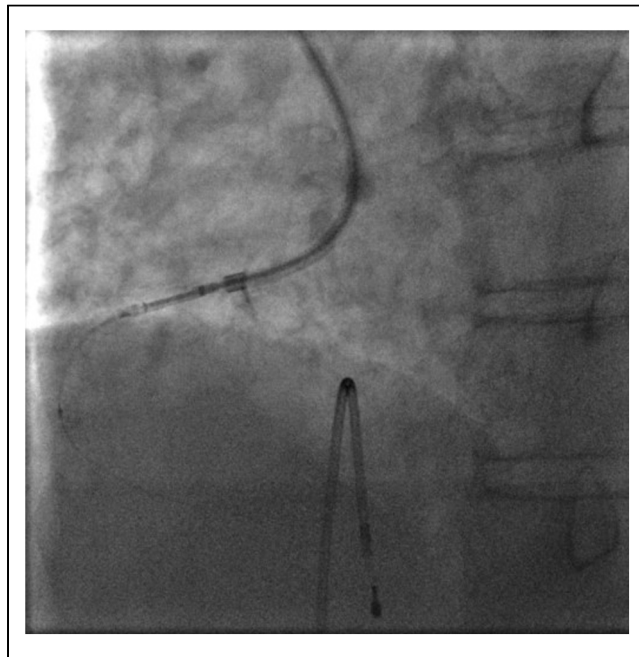
Relevant clinical history and physical exam. A 70-year-old male was a hemodialytic patient with angina pectoris, whose angiogram showed severe stenosis in the proximal RCA. On the other hand, he was required to undergo a surgery to treat cholangiocarcinoma as soon as possible. Therefore, it was intolerable for him to take dual antiplatelet therapy (DAPT). Then, we planned to perform coronary revascularization using a directional coronary atherectomy (DCA) instead of stenting strategy.

Relevant test results prior to catheterization

Relevant catheterization findings. Severe stenosis in the proximal RCA.

**[INTERVENTIONAL MANAGEMENT]**

Procedural step. An 8-Fr guiding catheter (Hyperion JR 4.0 SH, ASAHI INTECC) inserted into the RCA via a right femoral artery. A floppy guide wire (Run through NS Ultra Floppy, Terumo) successfully passed through the lesion. Then, it was exchanged to a support guide wire (ASAHI Grand Slam, ASAHI INTECC.) using a microcatheter. In addition, the IVUS and the OFDI showed a calcified nodule in the target lesion. We attempted to cross the DCA catheter (ATHEROCUT, Nipro) to the lesion but it could not pass. Then, the lesion was dilated by a 2.5 mm scoring balloon (Lacrose NSE ALPH, Goodman). After that, the DCA catheter successfully passed through the lesion and we performed 8-times atherectomy. Additionally, the lesion dilated by a 4.0 mm scoring balloon (Lacrose NSE ALPH), and the final residual stenosis was 25% stenosis.



Case Summary. A stentless PCI strategy using a DCA seemed to be a niche but a necessary option to the intolerant case for DAPT.

TCTAP C-040**Multivessel PCI on a 31-year-old ACS Patient Complicated by Difficulty Wiring an Extensive RCA Dissection and Recurrent No Reflow Phenomena**

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[CLINICAL INFORMATION]

Patient initials or identifier number. MBAH

Relevant clinical history and physical exam. A 31-year-old man with acute anginal pain associated with nausea and dyspnea presented to our Emergency department 11 hours following the angina. His risk factors were hypertension, cigarette smoking and positive family history of IHD, as his father suffered MI at 50. His vital signs were stable during admission. Physical examination was unremarkable.

Relevant test results prior to catheterization. His ECG showed mild ST elevation at lead III, mild ST depression in V6, I and aVL, and biphasic T in V2-V5. His echocardiogram showed normal left ventricular function with no regional wall abnormality and mild left ventricular hypertrophy. His peak Troponin I was 8228.0 pg/ml.

Relevant catheterization findings. Coronary angiogram performed via right radial route. However, due to short ascending aorta there was difficulty to engage the coronary ostia. The LAD had CTO lesion with bridging collateral and retrograde filling from left Circumflex. The RCA had severe proximal lesion followed by mid-segment occlusion. Further on cranial projection proximal RCA dissection seen, which may have been spontaneous or catheter induced. Contrast staining at the dissected segment seen.

[INTERVENTIONAL MANAGEMENT]

Procedural step. We used radial approach using a JR 3.5 6Fr catheter. It appeared now that the dissection has spread to the ostium of RCA. Gentle wiring attempted to select the true lumen. We could not wire the true lumen with BMW wire and Run through Floppy Hypercoat