POSTER PRESENTATIONS

[PP-01]

Right Coronary Artery CTO with Ambiguous Cap: Successful Recanalization via an Epicardial Collateral Approach

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Fifty-nine years old man with previous coronary artery bypass graft surgery (CABG) about 10 years ago. He was admitted to the hospital with worsening angina. Angiography revealed open saphen graft to c and saphen to diagonal, bur right coronary artery (RCA) graft was occluded. Natice RCA was occluded proximally. Good epicardial colleteral flow from circumflex artery (Cx) to RCA. Septal filling was not promising. Since patient had chest pain and electrocardiography changes, operator decided to predilate left anterior descending coronary artery prox to achieve good flow to the septals and referring him to a center for complex procedures. Patient was taken to the cath lab 1 week later. First, septal surfing and drilling was attempted, but resulted in impaired flow due to the hematoma and spasm. Further attempts for septals was unsuccesful. Cx epicardial was chosen as a secod option even though the risk of ischemia was high. With sion black and Elong 2.6 microcatheter, it was easy to reach distal cap. Then, antegrade preparation was done, followed by reverse CART with the help of guide extension After predilatation, three stents were implanted with good distal flow. After fixing RCA, OM CTO was crossed easily with PT2 fire. then prox Cx and LMCA was stented with goog flow. Procedure was copleted without any complication.

Keywords: CABG, CTO, ambiguous cap, epicardial colleterals

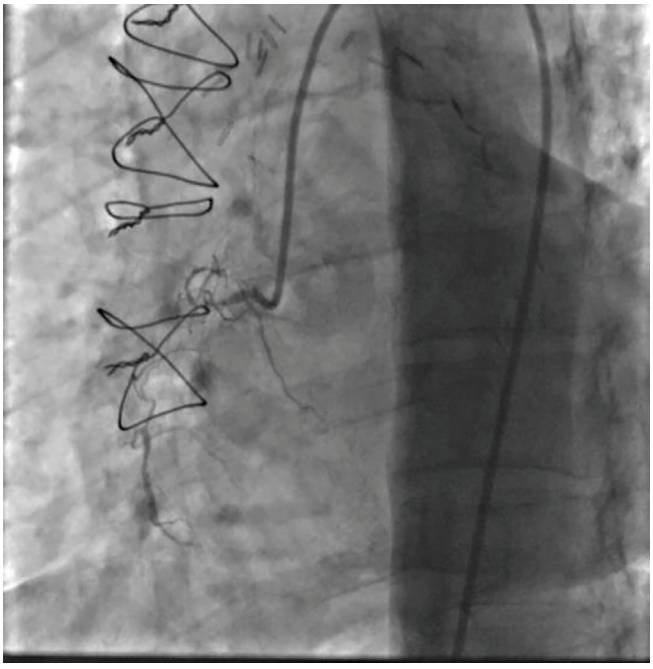

Figure 1. RCA CTO with ambiguous cap

Figure 2. Succesfull recanalization

[PP-02]

Mitral Balloon Valvuloplasty Case with Inoue Balloon Advancement Over Confida Wire

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Aim: Mitral balloon valvuloplasty is performed by performing a septostomy from the right atrium and passing to the left atrium with a curved wire, then maneuvering the balloon to the left ventricle. However, sometimes due to severe mitral stenosis, lack of wire support, and the balloon not rotating due to the proximity of the septostomy to the ventricle, difficulties may be experienced in passing the balloon over the mitral valve. In order to overcome the difficulty in passing the balloon to the ventricle due to the septostomy close to the mitral, we applied the mitral balloon to be first delivered to the ventricle with the confida wire support and then pulled back towards the atrium and placed on the mitral valve.

Case Report: A 45-year-old female patient came to our clinic with a complaint of increasing shortness of breath with exertion (NHYA STAGE 2). In her echocardiography, it was evaluated as advanced mitral stenosis (MKG 40/15) on a rheumatic basis and the patient was planned to undergo mitral balloon valvuloplasty with fluoroscopy and TTE. The patient underwent a septostomy via the femoral route. Since the passage was evaluated as close to the aorta and mitral, a second septostomy was performed from a more inferior angle. The curved wire was passed to the left atrium and the Inoue balloon was advanced over it. However, it was understood that there was a septostomy anteriorly and close to the mitral. Vertical maneuvers were not possible and the posterior loop could not be performed. It was seen that the 0.35 hydrophilic wire from the balloon could pass through the posterior wall of the left atrium and into the left ventricle. A pigtail was sent over the wire. After it was understood that it was in the LV apical, compatible with the other pigtail advanced from the aorta to the ventricle, a confida wire was sent and the pigtail was removed. The Inoue balloon was advanced to the left ventricle over the Confida wire. It was slightly inflated and retracted, and the mitral valve was fully opened. The procedure was terminated after the decrease in mitral gradient was observed in echocardiography (MVG 11/5) and no complications developed.

Keywords: Confida, Inoue, mitral balloon

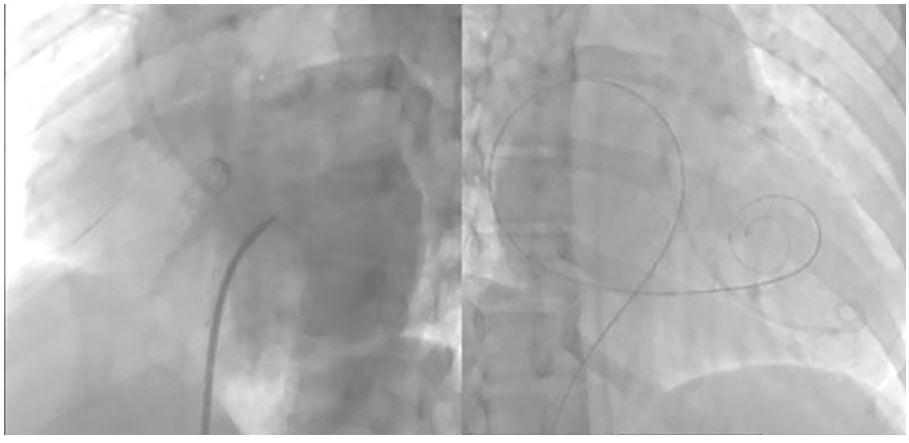

Figure 1.

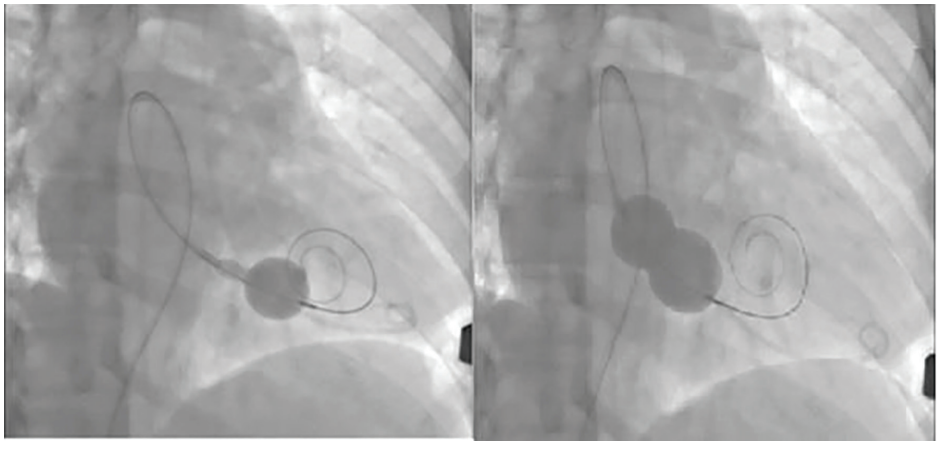

Figure 2.

[PP-03]

Intervention with Drug-coated Balloon in a Patient with Coronary Artery Spasm

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Coronary spasm is defined as diffuse or local severe vasoconstriction of coronary arteries, resulting in impaired myocardial perfusion. It was first defined by Prinzmetal in 1959 as anginal pain associated with transient ST segment elevations or depressions on the electrocardiogram. Drug-coated balloons (DCB) have also brought innovations to the field of cardiology and their use is increasing day by day. Our case is 52 years old, with a family history as a risk factor. The patient was consulted to us in the emergency department at noon with anterior myocardial infarction. Due to elevation in the anterior leads and typical chest pain on the electrocardiography, the patient was taken to the angiography laboratory. The patient had a diffuse lesion in the left anterior descending coronary artery (LAD), a local lesion in the circumflex artery (Cx) and a lesion in the right coronary artery (RCA), suggesting coronary artery spasm. Since we interpreted RCA as spasm, consecutive intracoronary nitrate was applied for LAD lesion. Since the lesions continued, the patient was young and was against stent placement, it was decided to perform DCB on the patient. Lesion preparation was performed with 3.5 20 nc. After waiting for 3 minutes and 8 atm with 3.5x30 sirolimus-coated DCB, no dissection developed and 4x15 DCB was performed for Cx lesion. The patient was given an elective appointment for two weeks for RCA lesion and left system control. In the angiography two weeks later, RCA was observed as normal, LAD and Cx were also observed as normal. As a result, this patient came with ST elevation and a lesion that did not respond to nitrate was observed. If we had placed a stent, foreign material would have been implanted into the vessel unnecessarily. In such cases, DCB application may be more advantageous for the patient. In fact, we can conclude that a study should be conducted on DCB in resistant vasospasms.

Keywords: Coronary spasm, drug-coated balloon

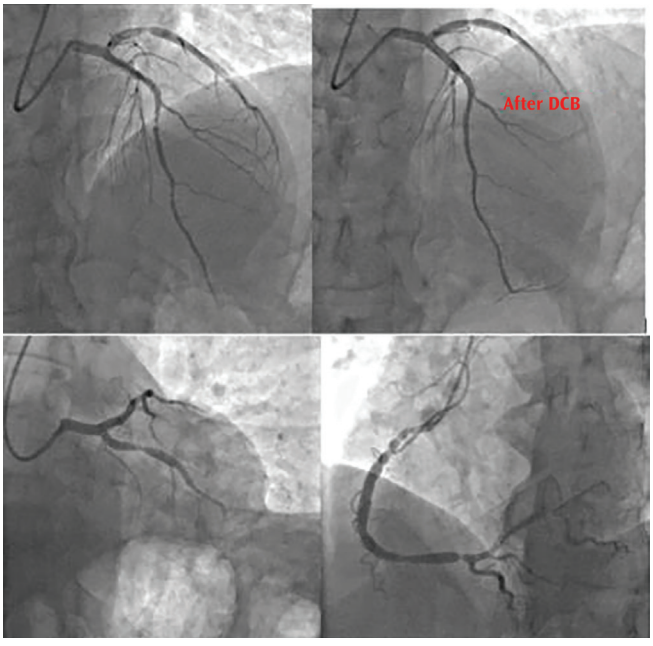

Figure 1. Results in LAD Cx and RCA and LAD after DCB

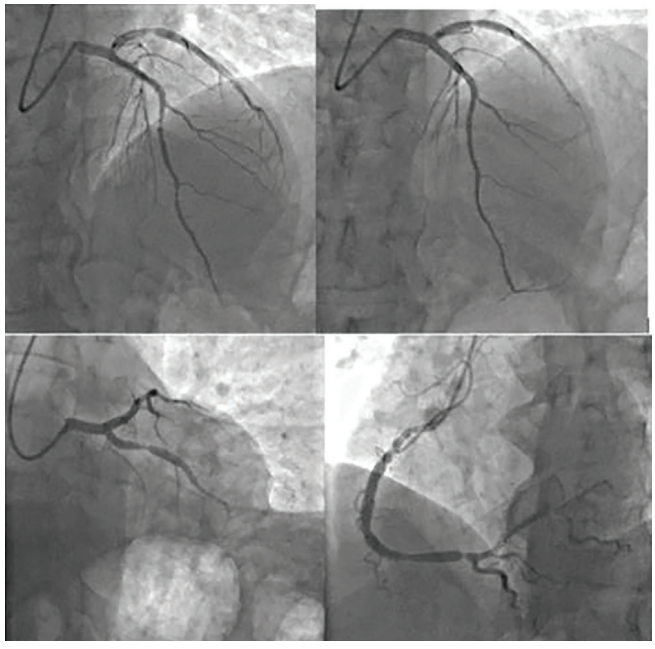

Figure 2. Second angiography

[PP-04]

Multiple HDR and Retrograde Puncture in Case of Ischemic Diabetic Foot Patient

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Sixty-five years old male patient admitted to our diabetic foot care clinic due to deep ulceration wound on the right foot. the patient was diabetic for 8 years, hypertensive and active smoker, he had coronary angiography before 3 years. The wound classified as grade 3 catagory 6 upon Rutherford classification and stage 4 fontaine classification. The DSA views revealed total occlusion of the all infrapopliteal line arteries with weak filling at the distal part of the ATA trace, we planned to perform staged revascularization staring from the anterior tibial artery. Antegrade approch by 0.035 guide wire and 0.035 microcatheter then intraplaque advancment by 0.018 halberd wire. After 0.5 cc opaque intraplaque injection, de-escalate to 0.018 v-18 Boston wire but unfortunately we were inside the subintimal space. Another HDR attempt then try to puncture by 0.018 Halberd wire but we failed to catch the intraluminal space. Non visible retrograde connection so we decided to puncture the distal segment of the anterior tibial artery by 0.64 mm canula then upforward progress by 0.018 v-18 wire till the proximal cap of the artery. At the popliteal artery level we performed randezvouz technique to advane the guide wire inside the microcatheter then externalize the wire at the groin level. Switch to the antegrade gear then multiple balloon inflation and full revascularization of the artery without any complications. In case of BTK CTO procedures, one technique may not be enough successful to end the procedure, switch to another approach and another technique can be savior, work in collaboration between the CTO techniques is pivotal in order to achieve success beacuse the failure of on may facilitate the success of the other.

Keywords: Multiple HDR, retrograde puncture, ischemic diabetic foot

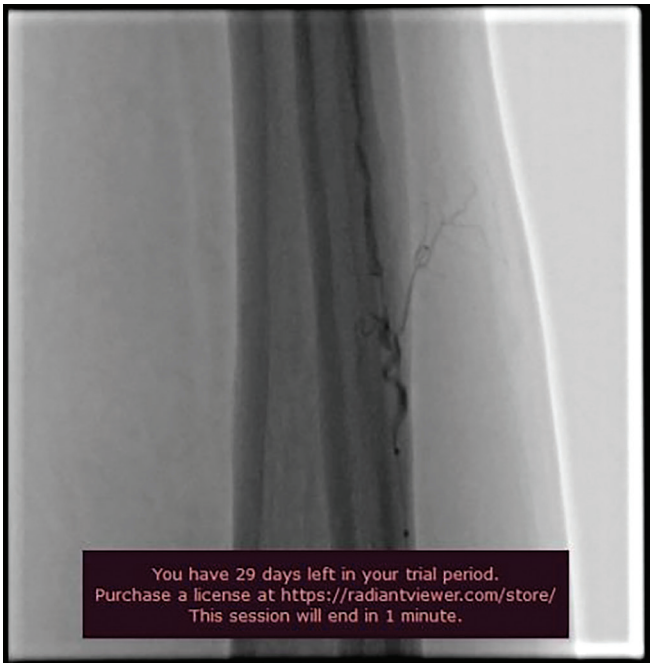

Figure 1. HDR

Figure 2. Retrograde puncture

[PP-05]

CART Technique fot BTK CTO Diabetic Foot Patient

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A 55-year-old male patient, known to have diabetes and a history of smoking, was admitted to the diabetic foot care unit due to an ulcerative wound on the right foot. The patient's clinical condition was stable. He had undergone coronary artery bypass graft (CABG) surgery four years ago, and his recent coronary evaluation showed no significant abnormalities. Following a general evaluation, peripheral angiography was planned, as Doppler ultrasonography demonstrated monophasic flow along the anterior tibial artery (ATA). The wound was located on the dorsal surface of the foot, involving both the first and second toes with deep tissue invasion. It was classified as Rutherford Grade 3 Category 5, Fontaine Stage 5, and Wagner Grade 4. An antegrade puncture was performed at the high level of the common femoral artery (CFA) using a 6F sheath. Digital subtraction angiography (DSA) revealed a TASC C lesion. A retrograde approach was attempted to treat the ATA lesion. A subintimal passage was achieved at the proximal part of the lesion using a 0.035" wire. With the support of a 0.035" microcatheter, we managed to proceed distally. However, we were unable to advance the microcatheter completely. We then advanced a 0.018" Boston V-18 wire to the proximal ATA, but redirection of the antegrade system into the true lumen distally was unsuccessful. Subsequently, a 2.0 x 80 mm Skinny balloon was advanced through the retrograde system to the proximal segment. After inflation at 12 atm, we were able to advance the antegrade wire through the distal segment during balloon deflation. The system was then switched back to the antegrade approach, and multiple balloon inflations were performed, successfully restoring blood flow and achieving full vascular patency of the ATA. In diabetic foot cases with below-the-knee chronic total occlusion, revascularization of the culprit artery is crucial for preventing amputation and slowing the progression of infection and sepsis. In long and calcified lesions, retrograde techniques and operator experience are essential. The CART (Controlled Antegrade and Retrograde Subintimal Tracking) technique remains one of the oldest yet still effective methods for managing chronic total occlusions.

Keywords: CART technique, BTK CTO, diabetic foot

Figure 1. Antegrade wire cross to the distal part

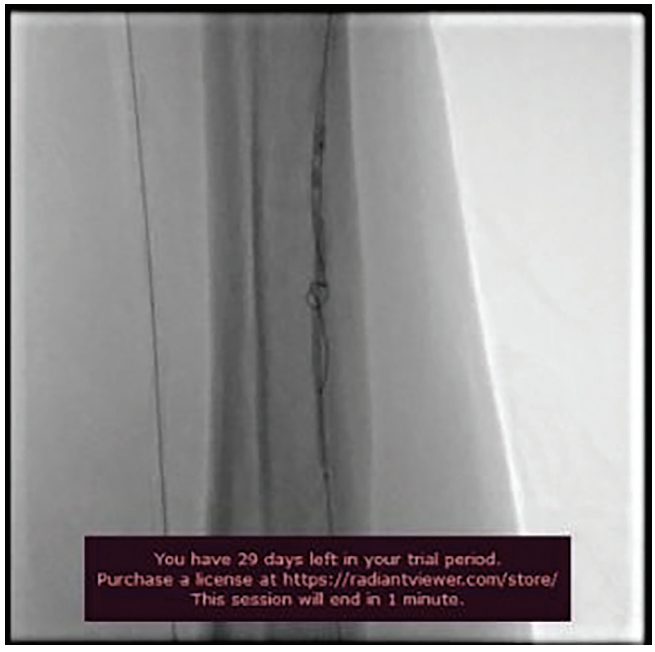

Figure 2. CART technique

[PP-06]

Personalized Management of Post-CABG Angina due to SVG Disease

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Aim: Post-coronary artery bypass graft surgery (CABG) and percutaneous coronary intervention (PCI), a 43-year-old male with CAD and recent STEMI presented with recurrent angina. Right coronary artery (RCA) CTO PCI and saphenous vein grafts (SVG) occlusion management with an ASD Occlutech device highlighted complex revascularization.

Methods: A 43-year-old male with effort angina and reduced exercise capacity post-STEMI history CABG LIMA to left anterior descending coronary artery (LAD) SVG to RCA SVG to OM PCI for LMCA to LCX in 2016 and SVG to PDA PCI in 2022, one week prior PCI for acute inferior MI involving SVG to RCA ECHO LVEF 50 apical hypokinesis moderate to severe MR, angio patent LIMA to LAD diseased SVG to RCA PCI relieved symptoms. Procedure Details: The patient underwent RCA CTO PCI following persistent symptoms. Triple injection showed a completely occluded proximal RCA with degenerative SVG to RCA and underexpanded stents in SVG to PDA. Multiple wires were used including Caravel MC Gaia 2nd Gladius EX14 Gaia 3rd The CTO was successfully crossed with conquest Pro 9 reaching PDA followed by Gladius EX14 crossing into PDA. Balloon dilations and stenting were performed along with high-pressure post-dilatation KBA optimized the results. Final stent deployment was successful achieving full expansion with a Thrombolysis In Myocardial Infarction 3 flow. Given SVG degeneration an ASD Occlutech plug was deployed to occlude the graft. Angio at six months confirmed SVG occlusion while RCA stents remained patent.

Results: CTO PCI in post-CABG patients presents unique challenges. Native vessel PCI is often preferred over SVG PCI due to better patency rates and lower restenosis risk. However CTO PCI requires advanced wire escalation strategies procedural expertise and optimized techniques such as KBA and high-pressure balloon post-dilatation. In this case SVG occlusion was necessary to prevent competitive flow and improve perfusion to the native RCA. The use of an ASD Occlutech device facilitated controlled occlusion minimizing embolization risk follow-up confirmed durable results with a fully occluded graft and patent stents. Long-term management in post-CABG patients requires a structured approach including aggressive risk factor control and guideline-directed medical therapy. Dual antiplatelet therapy lipid-lowering agents and lifestyle modifications are essential for optimizing outcomes. Regular surveillance with imaging and clinical follow-up remains crucial to ensure graft and stent patency.

Conclusion: This case underscores the importance of individualized strategies in post-CABG patients with recurrent angina. RCA CTO PCI was successfully performed despite procedural challenges. SVG occlusion with an ASD Occlutech device optimized native RCA flow. Six-month follow-up confirmed durability emphasizing the importance of procedural expertise multimodal imaging and long-term surveillance to improve patient outcomes.

Keywords: Chronic total occlusion, percutaneous coronary intervention, saphenous vein graft, revascularization, Occlutech device

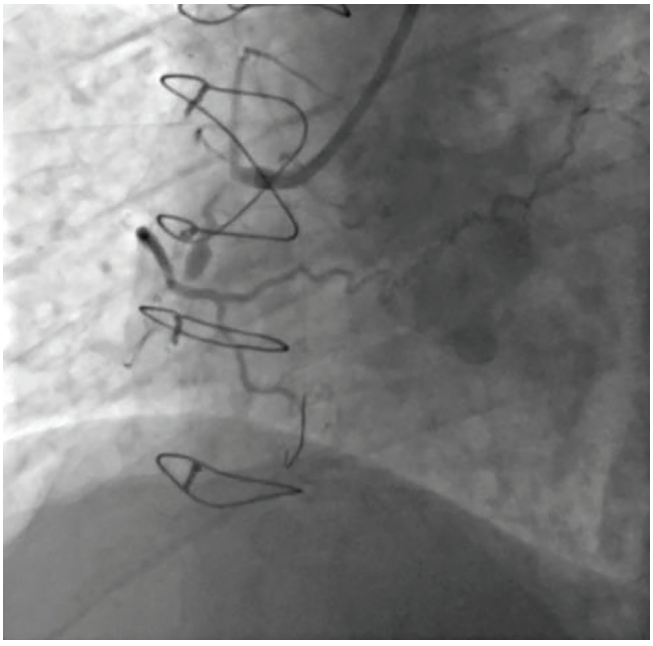

Figure 1. Right coronary artery proximal was CTO

Figure 2. Successful right coronary artery CTO revascularization and saphenous vein grafts occlusion achieved with Amplatzer Vascular Plug 2

[PP-07]

Game-changing Scenario: Nightmare Scene After Passage of Large Size Non-compliant Balloon Under a Pot-made Stent

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A 44-year-old female patient with no known disease, no history of use of drugs other than oral contraceptives, and no family history, was admitted to the emergency room with complaints of chest pain. Since elevation was observed in the inferior derivations on the electrocardiogram (ECG), primary percutaneous imaging catheterization was performed. Since the imaging revealed LMCA: Normal LA. Normal Cx: Normal right coronary artery (RCA). Proximal total occlusion was detected, RCA primary percutaneous coronary intervention was applied. No complications developed during the procedure. The patient was transferred to KYB. On the second day of her follow-up, she underwent repeat angiography due to chest pain and changes in the ECG. In the imaging performed, it was detected that the area before the RCA stent was occluded. RCA was cannulated with right guidance. Since the RCA lesion could not be crossed with floppy wire, the lesion was crossed with PT2 wire. After the lesion was inflated proximally with 3x13 NC, it was observed that the balloon did not receive sufficient flow and was inflated in the proximal region under the stent. By passing through the stent again with another PT2, proximal and distal dilatation was performed with 1x12, 1.5x12 / 2x12 / 2.5x15 / 3x13 / 3.5x15 NC balloons, respectively. Control imaging team 3 flow was obtained. However, thrombus aspiration was performed since dense thrombus was observed. In the control examination, it was observed that the thrombus had lightened but had not disappeared. Agrastat infusion was started and the patient was transferred to the intensive care unit to be followed up 2 days later. After 2 days, the patient was taken to the catheter for stent control imaging, and in the angiography, it was observed that the RCA was completely occluded proximally. The lesion was passed with the support of a 1.5x12 mm balloon with a pilot 50 wire inside the stent. The stent was predilated with 1.5x12 mm, 2.0x15 mm, 2.5x15, 2.75x15 (nc). Since sufficient flow could not be provided and a serious lesion was observed in the previously placed stent that limited the flow, the stent was postdilated from distal to proximal with a 3.5x15 mm nc balloon. The flow was re-evaluated after intravenous administration. Since a Thrombolysis In Myocardial Infarction (TIMI) 2 current and the serious lesion in the stent persisted, 3.0x19 mm des was implanted into the stent. The stent was postdilated from distal to proximal with a 3.5x15 mm NC balloon. No-reflow developed. IC nitrate and IC adenosine were administered. TIMI 2 flow was reestablished distally. When the pain recurred, it was seen that the RCA was proximally occluded in the control angiography done 2 days later. Since there was no ECG change, since the increase in cardiac markers was fixed, the lesion was accepted as CTO, and it was decided to follow up and evaluate the vitality after 1 month. It was also recommended that the patient should have a continuous thrombosed coronary image, an internal medicine opinion was obtained. No tendency to thrombosis was detected. It was thought that it could be due to the ox he used. In the control after 1 month, vitality was detected in the RCA area, the patient whose pain did not pass was taken to the laboratory for the CTO procedure, but the lesion could not be passed. A medical follow-up decision was made.

Keywords: Thrombosis, percutaneous coronary intervention, coronary complications

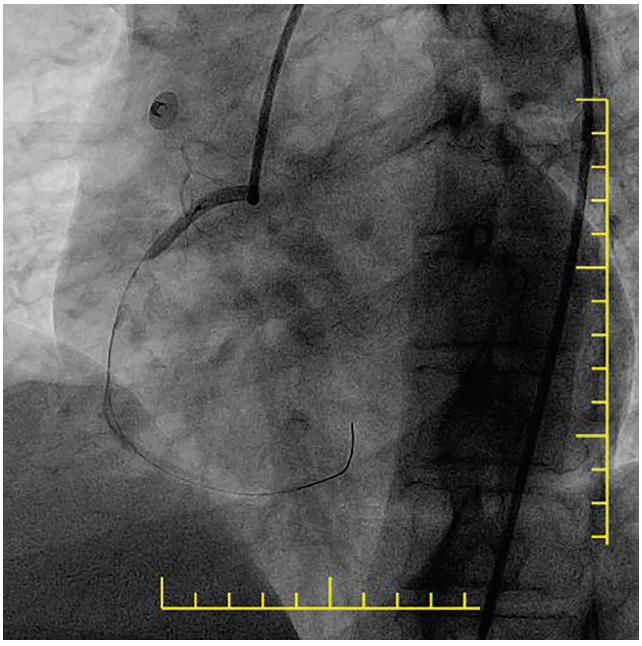

Figure 1. Introduction

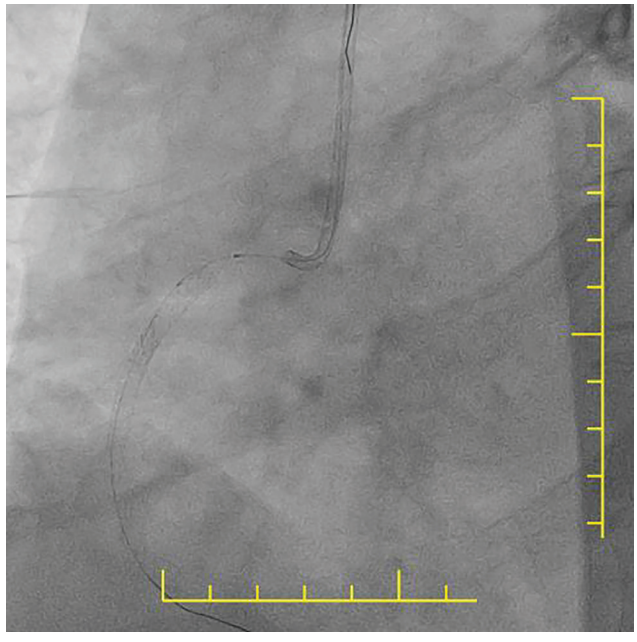

Figure 2. Under the stent

[PP-08]

The Process is not Over Until the Jail Wire is Over!

Gülden Güven

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A 45-year-old female patient with no known history of disease was admitted to the emergency room with chest pain that started 1 hour ago and was taken to the catheterization laboratory for primary percutaneous intervention due to elevation in the anterior wall observed in the electrocardiography. In the coronary angiography, the diagonal alignment of the left anterior descending coronary artery was predilated with 2x12 balloons by wired separately so that there was total occlusion at the proximal diagonal level. 2.75x32 Des was implanted. It was post dilated with 3x20 Nc. After dilation, the stent was implanted with an overlap of 3.5x18 Des due to dissection seen proximally. A pot was performed with 4x10 Nc. No residual stenosis was left. After the procedure, the wire in the side branch was tried to be pulled with a balloon (1.5x20 / 1.25x12) so that it would be under the stent and the tip of the wire was pulled out of the catheter by extending into the catheter and being pulled out. It was tried to be pulled by trapping with a 2.5x15 balloon but it was not successful. Since the part of the wire that was pulled out with the snare could not be pulled, the stripped wire was tried to be grasped with the help of additional wires. The floppy part of the additional wires was also pulled out inside the stent. Since the stent could not be passed with the intracoronary snare/guide extension, the cardiovascular surgery team was consulted and the patient was transferred to the cardiovascular surgery for surgical purposes. The patient underwent single-vessel bypass. Outpatient clinic checks are ongoing.

Keywords: Coronary complications, coronary angiography, acute coronary syndrome

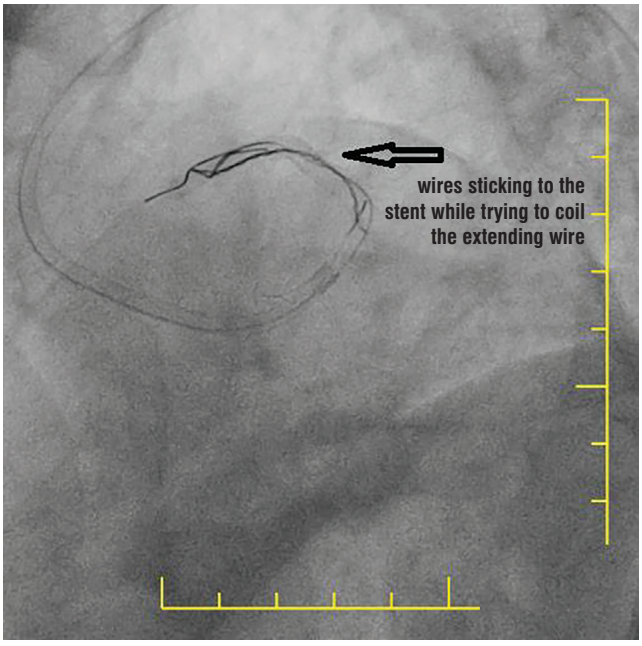

Figure 1. Coiled taller

Figure 2. Extending wire

[PP-09]

An Invisible Trap in Invasive Diagnosis: Angiography or Electrocardiogram? Who Should Have the Final Say?

Merve Akbulut Çakır, Fatih Kardaş, Emirhan Çakır, Gizem Ayyıldız

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Coronary angiography is an indispensable diagnostic method for diagnosing coronary artery disease by providing anatomical imaging of the vessels feeding the heart. However, in some cases, when only angiographic imaging is evaluated, it can confuse interventional cardiologists. Especially, if the issue is acute myocardial infarction, which is of vital importance. When the coronary angiography of the patient who was consulted to us from an external center and whose electrocardiogram (ECG) was compatible with acute lateral myocardial infarction was evaluated, no totally occluded coronary artery was seen, the patient's angina complaint had not passed and the ST elevation continued on the ECG. When percutaneous transluminal coronary angioplasty (PTCA) was performed on the lesion proximal to the left anterior descending coronary artery (LAD), it was seen that the flow of the diagonal artery originating from this region came. It was thought that the thrombus proximal to the LAD occluded the ostium of the diagonal artery. Then, the LAD was stented, PTCA was performed on the diagonal ostium and the procedure was terminated. Although coronary angiography has a very important place in the diagnosis of acute coronary syndrome today, this case has shown how important the guidance of ECG is when the lesion cannot be detected.

Keywords: Acute coronary syndrome, electrocardiography, lateral myocardial infarction, percutaneous coronary intervention

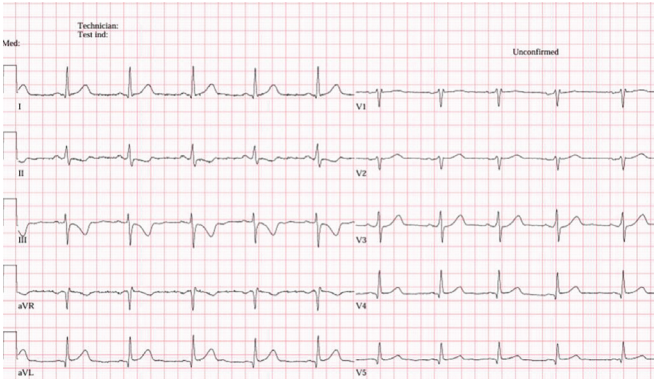

Figure 1. ST elevation in D1, AVL, V5-6, ST depression in D2, D3, AVF on ECG

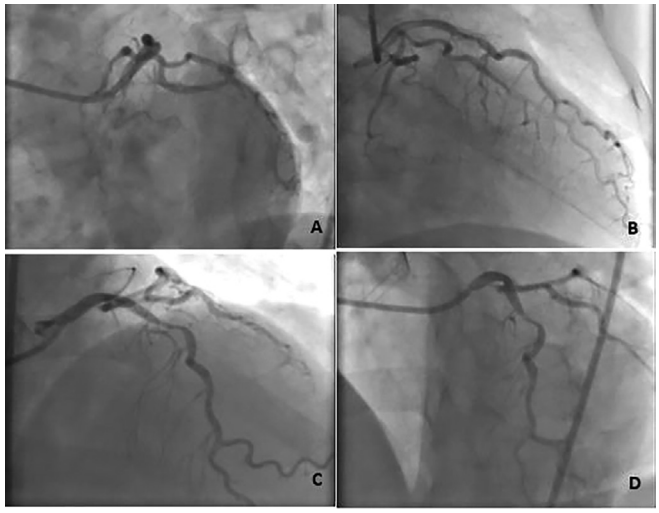

Figure 2. (**A**) Left caudal pose. **B**) Right caudal pose. **C**) Right cranial exposure shows a proximal Lad lesion, no total occluded lesion. **D**) Left cranial exposure, no total occluded vessel is seen

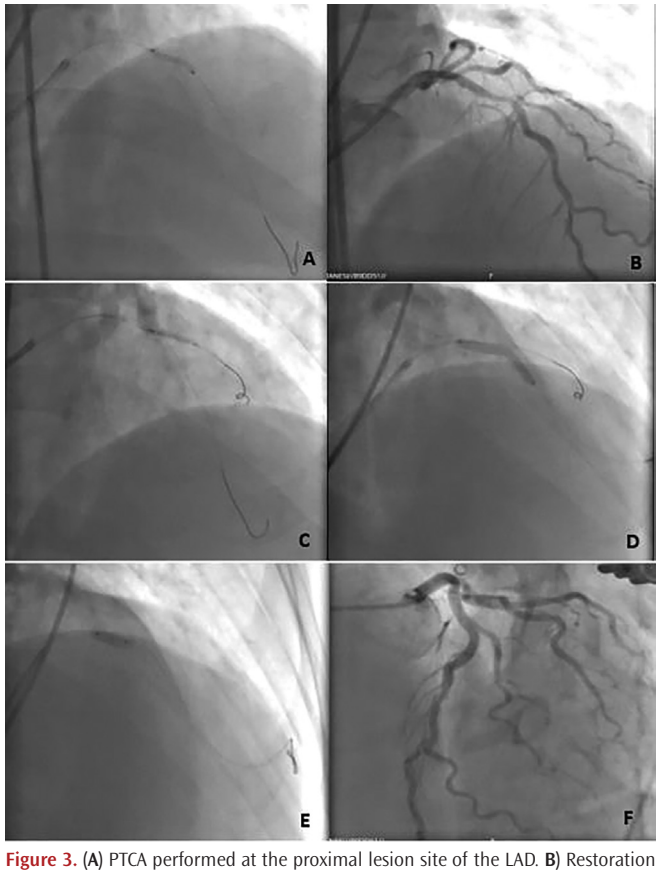

Figure 3. (**A**) PTCA performed at the proximal lesion site of the LAD. **B**) Restoration of flow to the Dg artery after PTCA. **C**) PTCA of the Dg artery. **D**) Stent implantation at the LAD proximal lesion site. **E**) POT with NC balloon in LAD stent. **F**) Left cranial view showing LAD and Dg artery flow as TIMI-3

[PP-10]

Treatment of Acute Stroke Developing During Coronary Angiography with Abciximab

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Cardioembolism accounts for approximately 25% of ischemic strokes globally and is more frequently associated with higher morbidity and mortality rates. Potential sources of cardioembolism involving the intracranial circulation include paradoxical embolism, dysrhythmias, structural heart disease, and valvular heart disease. Ischemic infarction can also occur during procedural procedures. It is a rare condition (0.2-0.4%) but has a high mortality. Cerebral ischemic events can also occur during and after percutaneous coronary intervention. In our case, we aimed to present the successful treatment of ischemic stroke during coronary angiography with abciximab.

Keywords: Abciximab, stroke, coronary intervention

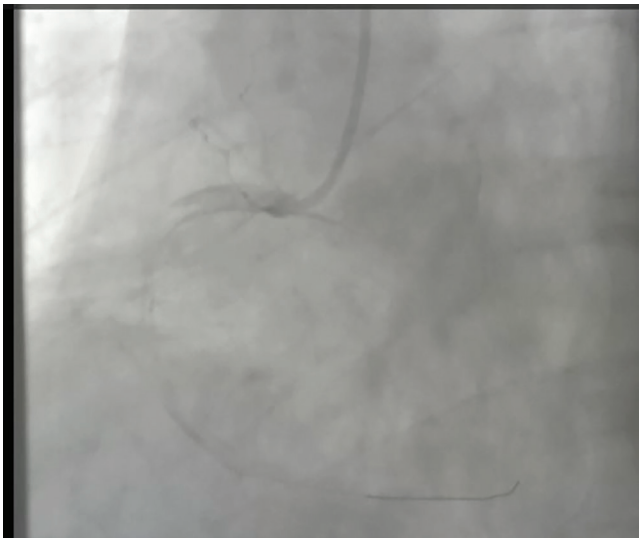

Figure 1. Post-balloon thrombus in right coronary artery

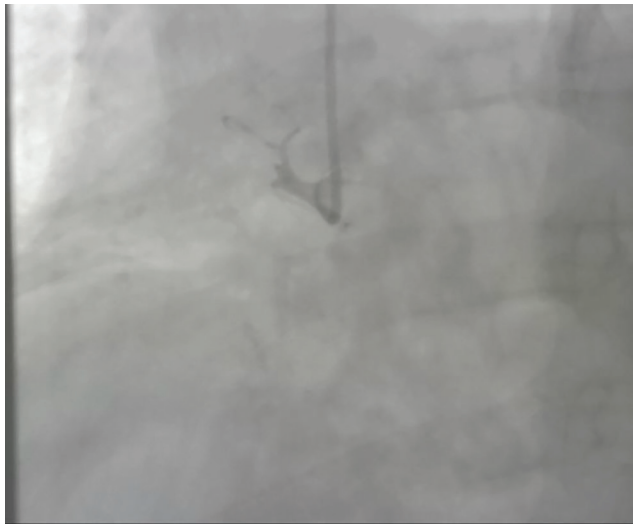

Figure 2. Thrombus in the right coronary artery