Intravascular Ultrasound-Guided Recanalization of a Coronary Chronic Total Occlusion Located in a Stent Implanted Subintimally: A Case Report

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Abstract
Successful percutaneous recanalization of coronary chronic total occlusion (CTO) results in improved survival, as well as enhanced left ventricular function, reduction of angina, and improved exercise tolerance. The procedural success rate has increased over time, but CTO recanalization does still fail in about 20% of cases. Different strategies and specific devices for CTOs have been developed with various degrees of success. We report the case of CTO after a first unsuccessful treatment attempt during which subintimal wire positioning without reentry into the distal lumen, and stent implantation were done. At the second revascularization, intravascular ultrasound guidance allowed reentry of the distal true lumen through the stent, restoring normal flow.

Key Words
- Interventional cardiology
- Intravascular ultrasound
- Revascularization
- Coronary artery disease
- Coronary vessels

INTRODUCTION
Percutaneous coronary intervention (PCI) of coronary chronic total occlusion (CTO) remains an important challenge in interventional cardiology. Even today, CTO is one of the major reasons why patients are referred for bypass surgery. Guide wire crossing is the most important component of a successful PCI for CTO. Reaching the distal true lumen is mandatory to reestablish antegrade flow in the distal coronary lumen. However, subintimal passage of the guide wire during recanalization is common and may result in inability to reach the distal true lumen. Coronary angiography is limited in its ability to guide the wire crossing in PCI for CTO. On the other hand, intravascular ultrasound (IVUS) can provide information about the exact location of the guide wires within a coronary artery, and discriminate the false lumen from the true lumen before guide wire crossing.

We report the case of a CTO after a first unsuccessful treatment attempt during which subintimal wire positioning without reentry into the distal lumen, and stent implantation were done. At the second revascularization, IVUS guidance allowed reentry of the distal true lumen through the stent, restoring normal flow.

CASE REPORT
A 61-year-old female complained of chest pain on exertion. A cardiac check-up revealed dyslipidemia as the only cardiovascular risk factor, and a treadmill stress test was positive. The patient was referred to another hospital for coronary angiography which showed single vessel disease with chronic occlusion of the middle left anterior descending artery, and normal left ventricular function without regional wall motion abnormalities.

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Manuscript received January 24, 2006; revised February 22, 2006; accepted March 31, 2006
The angiographic lesion characteristics were as follows: tapered stump, mild calcification, no bridging collaterals, lesion length of 20 mm, and good perfusion of the distal true lumen via collaterals. A recanalization attempt was unsuccessful. The wire entered the subintimal space just after the proximal CTO cap, but caused a long subintimal dissection as far as the distal left anterior descending artery which was probably not recognized. After balloon dilation (2.0 × 10 mm, 8 atm), stent implantation (Duraflex 3.0 × 25 mm, 16 atm; Goodman) was performed. The proximal 6 mm of the stent lay in the true lumen, and the remainder in the false lumen. The final angiographic results showed no reflow.

The patient was then referred to our hospital for further evaluation and treatment. Baseline electrocardiography showed a normal cardiac sinus rhythm, normal axis, normal intervals and no signs of ischemia. A repeat treadmill test (Bruce protocol, double product = 25,500) was again electrically positive. A second CTO recanalization was scheduled 6 months after the first attempt.

The baseline angiography showed occlusion of the mid left anterior descending artery beginning at the proximal end of the stent (Fig. 1). The femoral approach with an 8 French Judkins left 3.5 was chosen. Using the conventional wire technique with wires of incremental stiffness (Zeon 3 gram, Zeon; Miracle 6 gram, Asahi Intecc; Conquest pro 12 gram, Asahi Intecc) then the parallel wire technique, crossing the stent occlusion was achieved, but it was not possible to reenter the distal true lumen (Fig. 1 - C).

The IVUS-guided technique was then tried. In stent pre-dilation (Ryujin plus 1.5 × 15 mm, Terumo; Aqua 2.5 × 15 mm, Cordis) was done to allow the positioning of the IVUS catheter (Atlantis SR pro 2, Boston Scientific). With IVUS, it was possible to identify the point at which the stent left the proximal true lumen and entered the false lumen, as well as to identify the true lumen aside the stent (Fig. 2). Using the Conquest pro 12 gram wire without support catheter, reentry through the stent in the distal true lumen was achieved (Fig. 3). Thereafter, dilation of the passage through the stent (Ryujin plus 1.5 × 15 mm, Terumo; Aqua 2.5 × 15 mm, Cordis; 15 atm) as well as dilation of the middle and distal left anterior descending artery was done, restoring distal flow (Fig. 4). Two Cypher stents (Cypher 3.0 × 33 mm, 22 atm; Cypher 2.5 × 23 mm, 20 atm, Cordis) were implanted with good final result (Fig. 5). Clinical follow-up was uneventful. The treadmill test (Bruce protocol, double product = 24,426) was done 6 weeks after the procedure and was subjectively and electrically negative.

Fig. 1 Baseline angiography before the recanalization retry
A: Simultaneous contrast injection from the left and right coronary artery is shown in an epicranial view. The course of the opacified distal true lumen terminates under the implanted stent (arrow).
B: Contrast injection only from the right coronary artery is shown. The course of the opacified distal true lumen terminates under the implanted stent (arrow). This misalignment of the stent with the distal true lumen indicates subintimal location of the stent.
C: Crossing of the stent was achieved with the parallel technique, but it was not possible to reenter the distal true lumen.
Fig. 2 Intravascular ultrasound recording after in-stent pre-dilation
The angiographic view (upper left, epicranial) shows the location of the corresponding IVUS frames.
A, A The proximal 6 mm of the implanted stent lies in the true lumen.
B, B The stent lies subintimally.
C, C Distal to the stent, we can see a side branch which is not connected with the false lumen where the IVUS catheter lies.
IVUS = intravascular ultrasound; TL = true lumen; FL = false lumen; red = external elastic membrane; yellow = true lumen; green = false lumen; blue = IVUS catheter.

Fig. 3 Distal true lumen was reentered through the stent under IVUS guidance
The angiographic view (left, right anterior oblique 30/0) shows the first wire with the tip in a septal branch, with the IVUS catheter.
A, A The second wire lies in the distal true lumen. The IVUS frame shows the second wire (arrow) located in the true lumen.
Red = external elastic membrane; yellow = true lumen; green = false lumen; white = stent strut; black = second wire; blue = IVUS catheter. Other abbreviation as in Fig. 2.
DISCUSSION

A successfully revascularized CTO confers a 10-year survival advantage compared to failed revascularization. In the present case, a previous procedure had been unsuccessful and therefore coronary artery bypass grafting surgery or repeat PCI was an option. After discussion with the patient, the referring cardiologist opted for repeat PCI in a center specialized in the treatment of complex cases. After reviewing the coronary angiography and evaluating clinically the patient, we also selected PCI for this lesion as we thought the percutaneous procedure was still less invasive than surgery.

Despite the availability of a variety of guide wires and newer devices especially designed to cross CTO, the recanalization of CTO remains technically difficult with an overall success rate of about 80%. Subintimal passage of the guide wire during recanalization is common and, if unrecognized, may lead to severe complications. Treating chronic total occlusion using subintimal tracking and reentry with subsequent stent implantation is feasible with a good end result. The important characteristic of the subintimal tracking and reentry technique is that the subintimally implanted stent is a conduit leading from the proximal true lumen to the distal true lumen. In this case, a stent was implanted subintimally without reentry in the distal true lumen during first failed revascularization attempt.

The IVUS-guided technique have been shown to be safe and effective for helping reentering the distal true lumen after an initial wire enters a false

Fig. 4  Angiographic view (upper left, epicranial) and corresponding IVUS scan of the post balloon dilation of the passage through the stent in the distal true lumen
The angiogram shows the opacified true lumen separate from the stent and the four IVUS frames from proximal to distal illustrate the passage into the true lumen.
A, A and B, B The IVUS catheter crosses through the stent struts.
C, C and D, D The IVUS catheter lies in the true lumen, as demonstrated by the visualization of the surrounding vessel walls.
Yellow = true lumen; green = false lumen; white = stent strut; blue = IVUS catheter. Other abbreviation as in Fig. 2.
lumen. Although rare, the main potential complication is the risk of perforation due either to the manipulation of stiff wires or balloon pre-dilation in the false lumen. Such advanced technique should be therefore undertaken only by experienced interventionists skilled in pericardiocentesis and the management of cardiac tamponade.\(^4\,5\) In the present case, the false lumen was inside a stent, which means balloon pre-dilation and IVUS insertion was also performed inside the previously implanted stent. Therefore, the perforation risk in this setting was low.

The second procedure illustrates the utility of IVUS-guided technique for reentering the distal true lumen through a stent implanted subintimally. After unsuccessful reentry in the distal true lumen with the conventional wire technique and parallel wire technique, it was possible to locate the true lumen situated inside the stent with an IVUS catheter inserted in the stent, so guiding the manipulation of a second wire through the stent struts into the true lumen. The present case illustrates the use of the IVUS-guided technique for reentering the true lumen through an occluded stent located subintimally.

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**Fig. 5** Final angiographic results (epicranial (upper left) and spider (upper right) view]

A, A': The IVUS scan from inside the newly implanted stent show the compression of the previous stent implanted subintimally.

Yellow = true lumen; green = false lumen; white = stent strut; blue = IVUS catheter. Other Abbreviation as in Fig. 2.
References


