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Advances in Procedural Techniques - Antegrade

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Abstract: There have been many technological advances in antegrade CTO PCI, but perhaps most importantly has been the evolution of the "hybrid" approach where ideally there exists a seamless interplay of antegrade wiring, antegrade dissection re-entry and retrograde approaches as dictated by procedural factors. Antegrade wire escalation with antegrade dissection re-entry is the preferred approach for CTOs without significant calcification. Calcified CTOs, however, usually require either a retrograde or an antegrade dissection re-entry approach, or both. Antegrade dissection re-entry is well suited to long occlusions where there is a healthy distal vessel and limited "interventional" collaterals. Early use of a dissection re-entry strategy will increase success rates, reduce complications, and minimize radiation exposure, contrast use as well as procedural times. Antegrade dissection can be achieved with a knuckle wire technique or the CrossBoss catheter whilst re-entry will be achieved in the most reproducible and reliable fashion by the Stingray balloon. The preference for the different techniques will depend on the operator's personal experience and the complexity of the lesion. The ultimate aim remains to be seen whether use of newer dissection re-entry strategies will be associated with lower restenosis rates compared with the more uncontrolled subintimal tracking strategies such as STAR and whether stent insertion in the subintimal space is associated with higher rates of late stent malapposition and stent thrombosis. It is to be hoped that the algorithms, which have been developed to guide CTO operators, allow for a better transfer of knowledge and skills to increase uptake and acceptance of CTO PCI as a whole.

Keywords: Antegrade dissection re-entry, chronic total occlusion, knuckle wire, CrossBoss catheter, Stingray balloon.

INTRODUCTION

Recent advances in the field of chronic total occlusion (CTO) percutaneous coronary intervention (PCI) have resulted in success rates of greater than 80% being reported in unselected and complex populations in centers with CTO PCI specific experience [1]. This compares favorably with historical data where success rates between 50 to 75% [2-5] were described. Whilst there have been developments in device and technique, the fundamental change has been the evolution of a "hybrid" approach to procedural strategy, with a central tenet of using all feasible techniques (antegrade wiring, retrograde wiring, antegrade dissection re-entry or retrograde dissection re-entry) to achieve procedural success in the most efficient and expedient fashion.

Recent studies have demonstrated the benefits of CTO PCI in alleviation of stable angina [6], as well as improvement in left ventricular function [7], quality of life [1] and in long-term survival [6]. In addition, the rate of repeat revascularization for CTOs remain low, with the presence of a CTO remaining both a strong predictor of referral for coronary bypass surgery (CABG) of medical therapy. Indeed, only 10-15% of CTOs are treated with PCI [8] and there is slow uptake of the newer techniques, including retrograde or antegrade dissection re-entry. Contributors to this low attempt rate include: skepticism regarding clinical benefit,

operator inexperience, particularly with the newer techniques; a perceived greater risk of complications; and limitation of time and resources.

This review will focus on advances in antegrade procedural strategy.

A. IMAGING

I. Angiographic Assessment

A renewed Focus on Dual Injections

Detailed angiographic assessment is a critical part of the pre-procedural assessment. For example, in all antegrade CTO PCI, one must generate a proximal cap, traverse the occluded segment and distal cap before entering the distal true lumen. Although some of these segments may be defined by pre-procedure angiographic review, more information will be gleaned from dual injections (antegrade and contralateral) performed at the time of the CTO PCI [1]. Such injections, when performed properly, will appropriate magnification and contrast without obscuring, allow identification of collateral supply as well as assessment of both occlusion length and the quality of the distal vessel.

A Detailed Assessment of Collateral Filling Patterns

Definition of the location and type of collateral supply is important in order to facilitate potential retrograde access but also to define any antegrade collateral contribution to distal flow, which may potentially be compromised during antegrade PCI attempts (either through antegrade dissection or deliberate branch occlusion with anchor balloons).

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