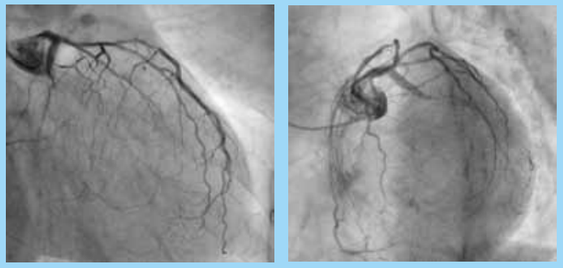
Fig.4

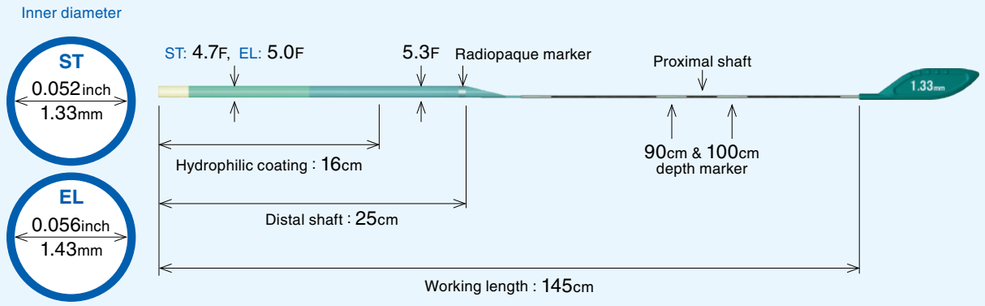


Physician's comments

Compared to competitive products like GuideLiner (Teleflex) and Guidezilla (Boston Scientific), GUIDEPLUS can be delivered easier and safer to deeper locations due to its hydrophilic coating and flexible shaft. For this case, GUIDEPLUS was advanced easily to the bifurcation at #3. Due to the back-up attained from GUIDEPLUS, delivery of balloons and stents were feasible, and it led to the successful outcome of the procedure.

Care should be taken for the deliverability of IVUS catheters (due to its comparatively small inner lumen), and low visibility under angiography, but I still consider GUIDEPLUS to be a very effective device.

Catheter design



Ordering information

Product Name	Model No.	Maximum External Diameter	Distal Shaft Length	Compatible Guiding Catheter	Inner Diameter
GUIDEPLUS™ II	GUIDEPLUS 2 ST INT	1.76mm / 5.3F	250mm	6F / ≧0.070inch	1.33mm / 0.052inch
	GUIDEPLUS 2 EL INT				1.43mm / 0.056inch

NIPRO
VASCULAR DIV.
http://med.nipro.co.jp/en_products

NIPRO CORPORATION
3-9-3, Honjo-Nishi, Kita-Ku, Osaka 531-8510, Japan

- Please consult your sales representative regarding stock availability.
- Please refer to the Instructions For Use for further details regarding product use and specifications.
- GUIDEPLUS is a trademark of NIPRO Corporation.

[Manufacturing facility]
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Case Report_GPLUS2_2007_CR1E

CASE REPORT

Efficacy of GUIDEPLUS™ for a distal RCA CTO

Dr. Koichi Kishi
Director, Cardiology Department
Tokushima Red Cross Hospital

Introduction

Recently RX type coronary penetration catheters (guide extension catheters) are often utilized in procedures due to their ease of use. However, their specifications and characteristics vary greatly from one product to another due to the differences in their design concept.

Since GUIDEPLUS (NIPRO Corporation) is not equipped with a metal marker at the tip, its shaft is extremely flexible, and it provides for superior trackability for tortuous lesions in coronary arteries. Moreover, its excellent hydrophilic coating realizes excellent crossability. Also, due to the extremely flexible tip it is feasible to perform deep seating of the catheter relatively safely.

We hereby report on a case experienced in which the use of GUIDEPLUS was effective for a CTO in the distal RCA.

Case Introduction

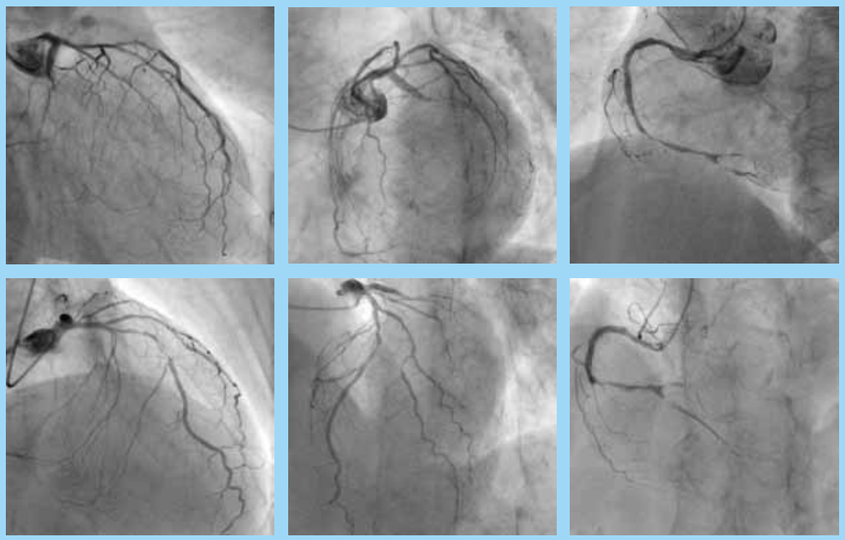
69 year old female

Diagnosis: effort angina

Risk factors: dyslipidemia, diabetes, hypertension

Coronary angiogram: Triple vessel disease, which includes a CTO at RCA and CX. The target lesions were severely stenosed lesions at RCA Prox. 75%, RCA Dis. 90%, RCA PAV 100%, and RCA PDA 99%. (Fig.1)

Fig.1



Procedure

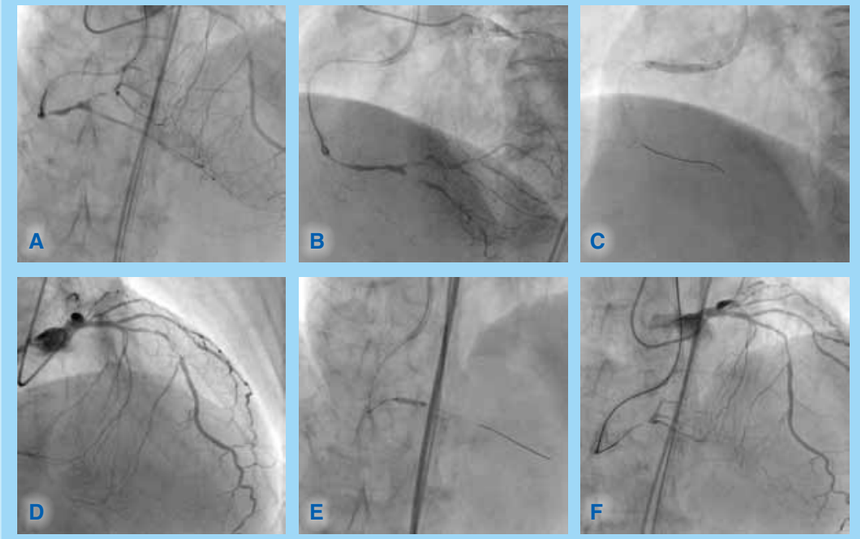
A 7F sheath was inserted from the right femoral artery, with a 7F SAL 1.0 SH guiding catheter advanced. However, unable to engage the guiding catheter, it was switched out to a 7F IMA. Consequently, a 6F sheath was inserted from the left femoral artery, and a contralateral angiogram was performed.

Initially, a Runthrough NS Extra Floppy guidewire (Terumo) was inserted under the support of a Caravel (Asahi Intecc) coronary micro catheter, but due to inadequate backup, Caravel was unable to cross RCA Dis. In order to attain backup, a GUIDEPLUS was selected (Fig.2A, B). However, performing angiography became problematic due to the wedged pressure from the stenosis at RCA Prox. Therefore, a 3.5mm DES was implanted to RCA Prox. to maintain sufficient inner lumen, and a GUIDEPLUS was inserted (Fig.2C).

RCA Dis. was dilated with a 2.5mm balloon (Fig.2D). GUIDEPLUS was advanced to RCA PDA after switching the wire from an X-treme XT-R to an Asahi Gaia First. RCA PDA was dilated with a 1.0mm balloon. After confirming antegrade blood flow, pre-dilatation was performed using a 2.0mm balloon, and a 2.25x12mm DES was implanted (Fig.2E).

Since XT-R faced difficulty crossing the CTO at RCA PAV, Gaia First was carefully manipulated, and it succeeded to cross to the distal true lumen (Fig.2F).

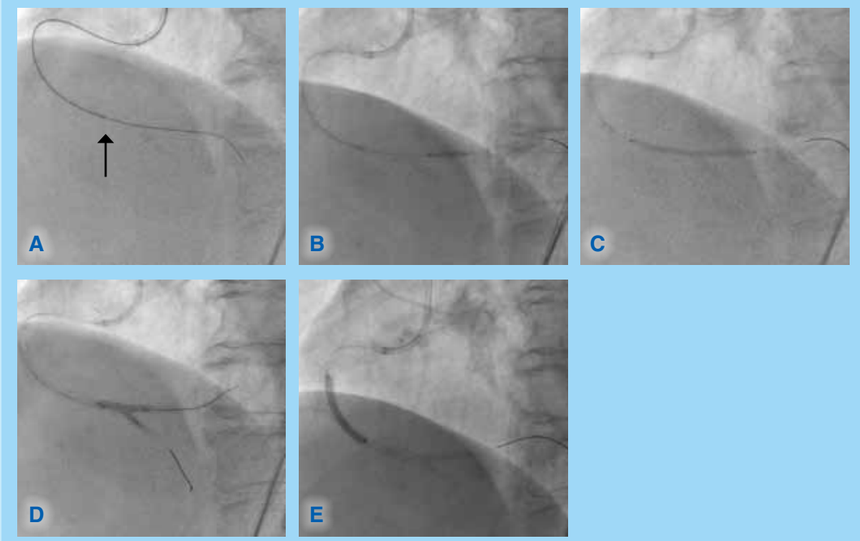
Fig.2



Since a 1.0x6.0mm balloon could not cross, GUIDEPLUS was advanced further (Fig.3A). Balloon crossing was successful under the backup of GUIDEPLUS. A 2.0mm balloon was dilated (Fig.3B). Under IVUS guidance, distal vessel diameter was determined, and a 2.25x38mm SYNERGY (Boston Scientific) was implanted across RCA PDA (Fig.3C). Simultaneous dilatation with a 3.0mm and 2.5mm balloon was performed (Fig.3D). RCA Dis. was stented with a 3.0x28mm SYNERGY stent. It was positioned to link with the distal stent (Fig.3E).

To complete the procedure, post dilatation was performed with a 3.5mm non-compliant balloon, and adequate expansion of proximal, mid, and distal portion was confirmed (Fig.4).

Fig.3



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