JL: how to do it?

Catheter often arrives in right or non-coronary sinus

Pull and clockwise rotate to get into left sinus

If catheter below LCA ostium anticlockwise and advance (or pull)

Get co-axial!
JL right radial vs femoral, different size of catheter and different co-axiallity
Second choice catheters, LCA

Dilated aorta: JL4-5-6, AL2-3

High take-off / aberrant: AL2 or AL3

Distorted aorta: AL3 or MP

No reach: Extra back-up guide
Second choice catheters, LCA

AL

extra back-up GC

MP
Catheter exchange

It is preferable to keep the 0.035” wire in the ascending aorta

2 methods:
   Long (260cm) wire
   Standard wire
JR catheter for RCA
Dedicated catheters for both ostia

Tiger

Barbeau

BLK
Catheter course according to vascular approach and aorta shape

- Left radial approach
- Right radial approach
- Femoral approach
Alternative catheters, RCA

High and anterior  AL1 or AR
Short aorta  JR 3.5
Inferior take-off  MP
Why standard catheters don’t fit?

Short patient
Barrel chested
Sub-clavian tortuosity
Enlarged aorta
Extreme take-off
Aberrant origin
Alternative catheters, RCA

MP

AL
Key messages

Most diagnostic angiography can be done with standard catheters

Gentle movements to avoid spam

LCA – JL3.5, different manipulation

RCA – JR4, similar manipulation
Available Judkins catheters (JL3.5 & JR4)
Adapted catheters according to anatomy variations or patient morphology
Use of dedicated catheters to perform both coronary injections
Specific catheter exchange technique to keep wire in ascending aorta