JL: how to do it?

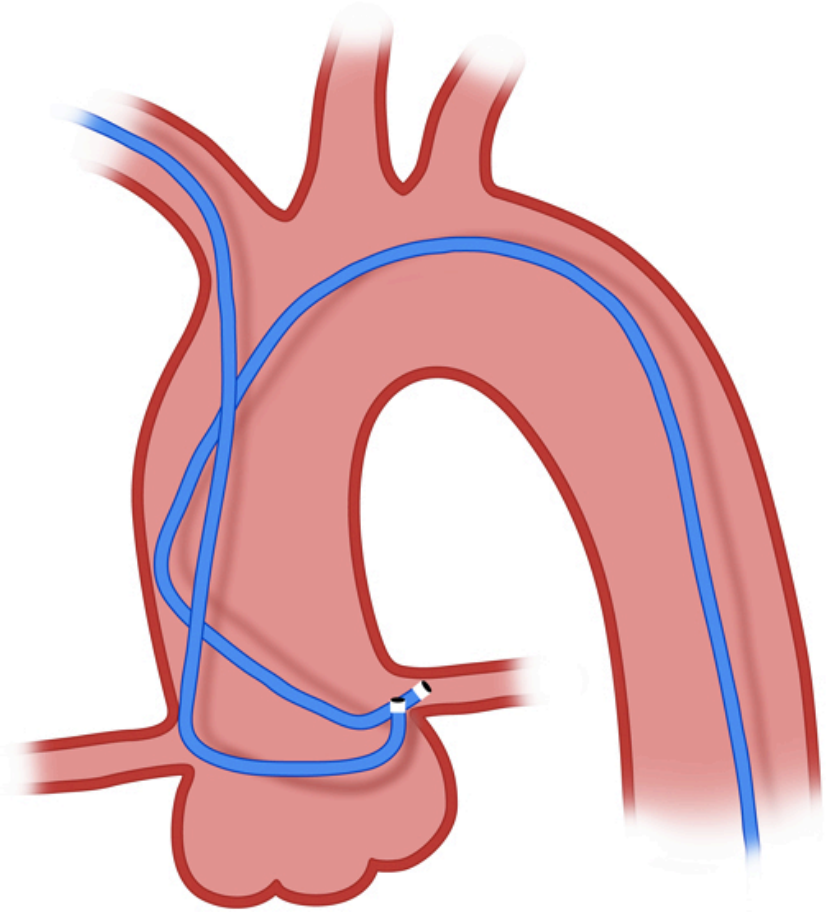
Catheter often arrives in right or non-coronary sinus

Pull and clockwise rotate to get into left sinus

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

Get co-axial!

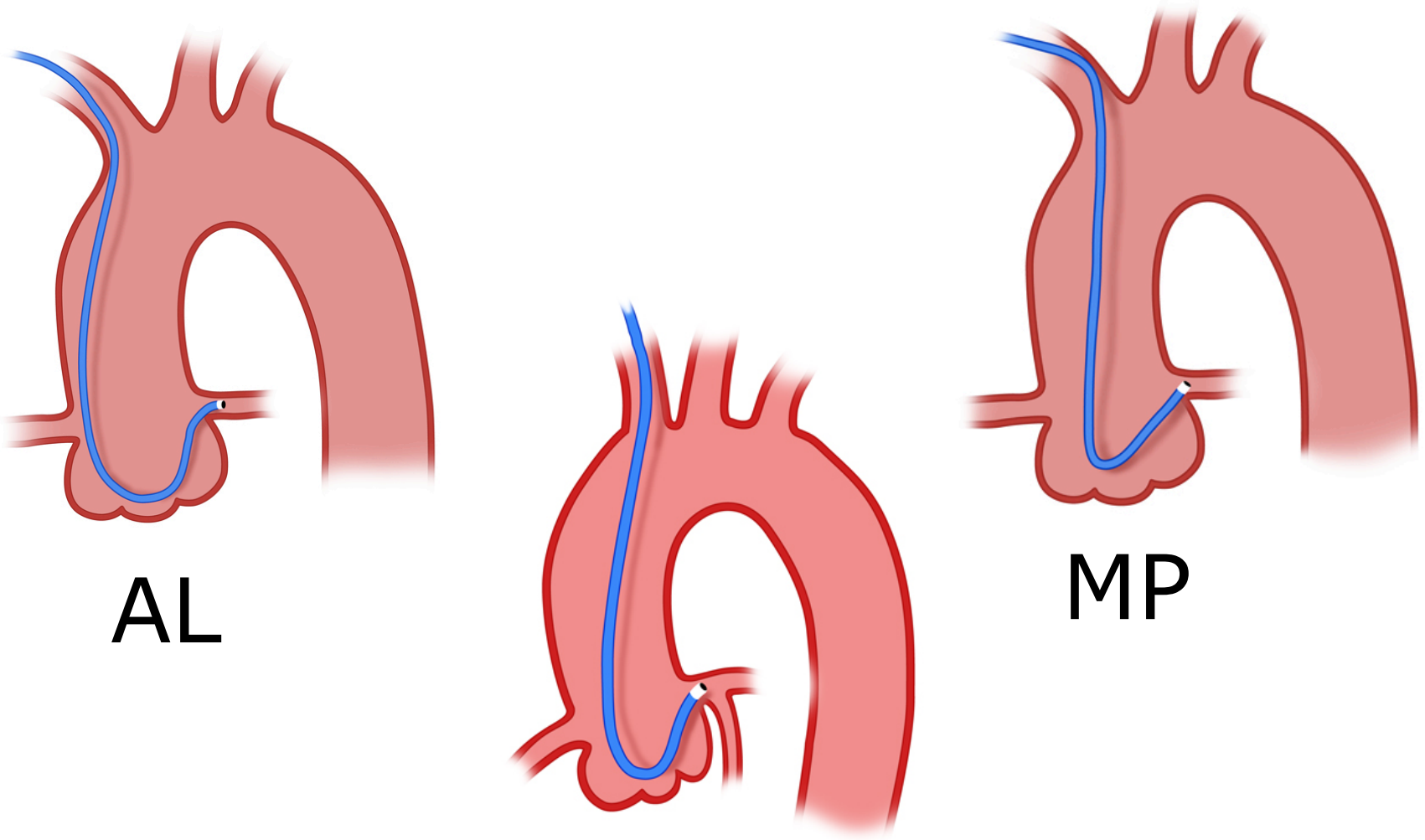
JL right radial vs femoral, different size of catheter and different co-axiallity



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



extra back-up GC

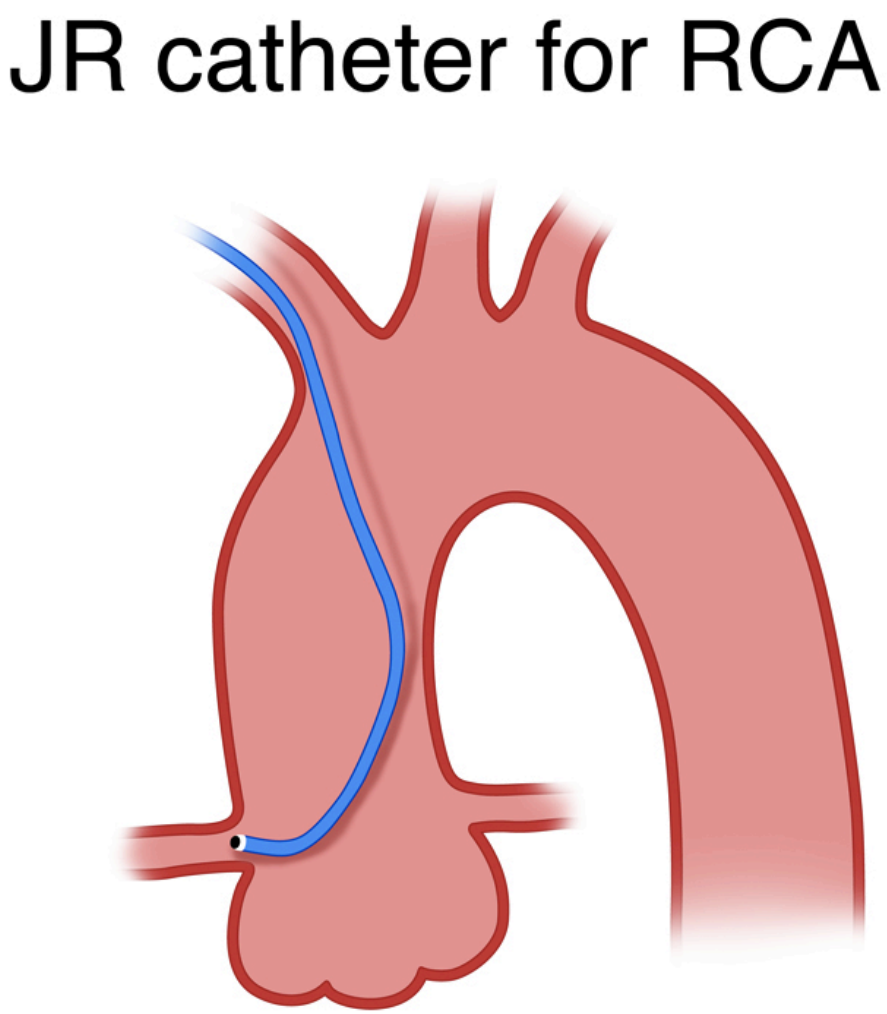
Catheter exchange

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

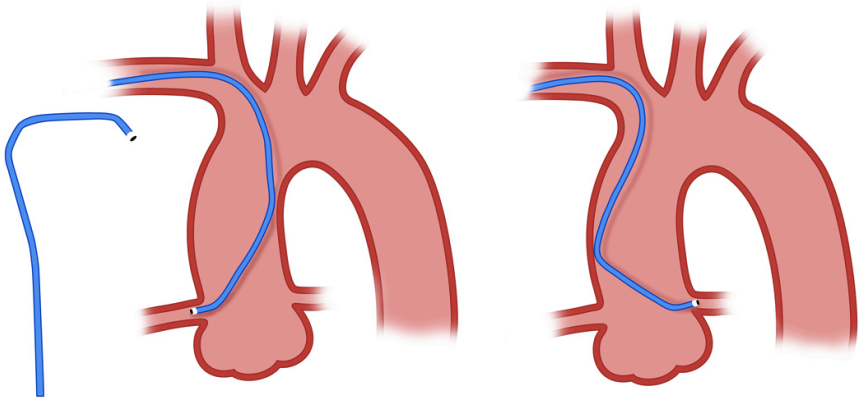
2 methods:

- Long (260cm) wire
- Standard wire

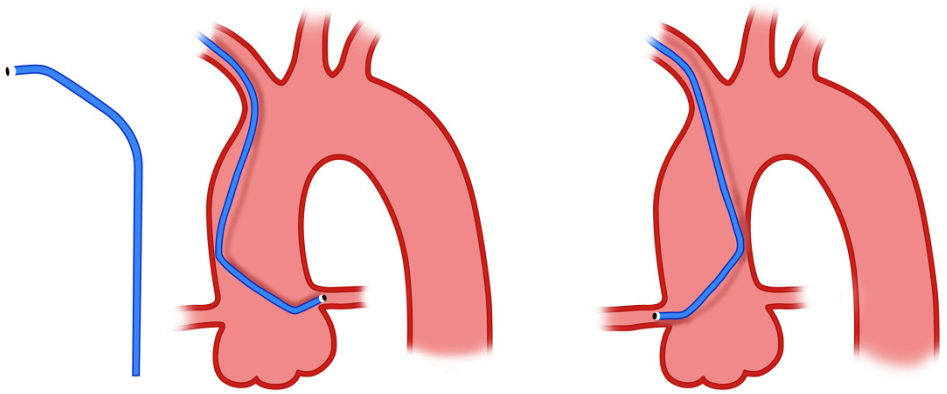
JR catheter



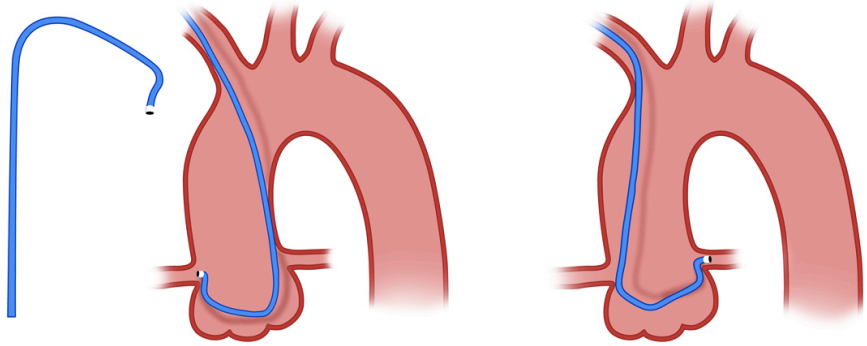
Dedicated catheters for both ostia



Tiger

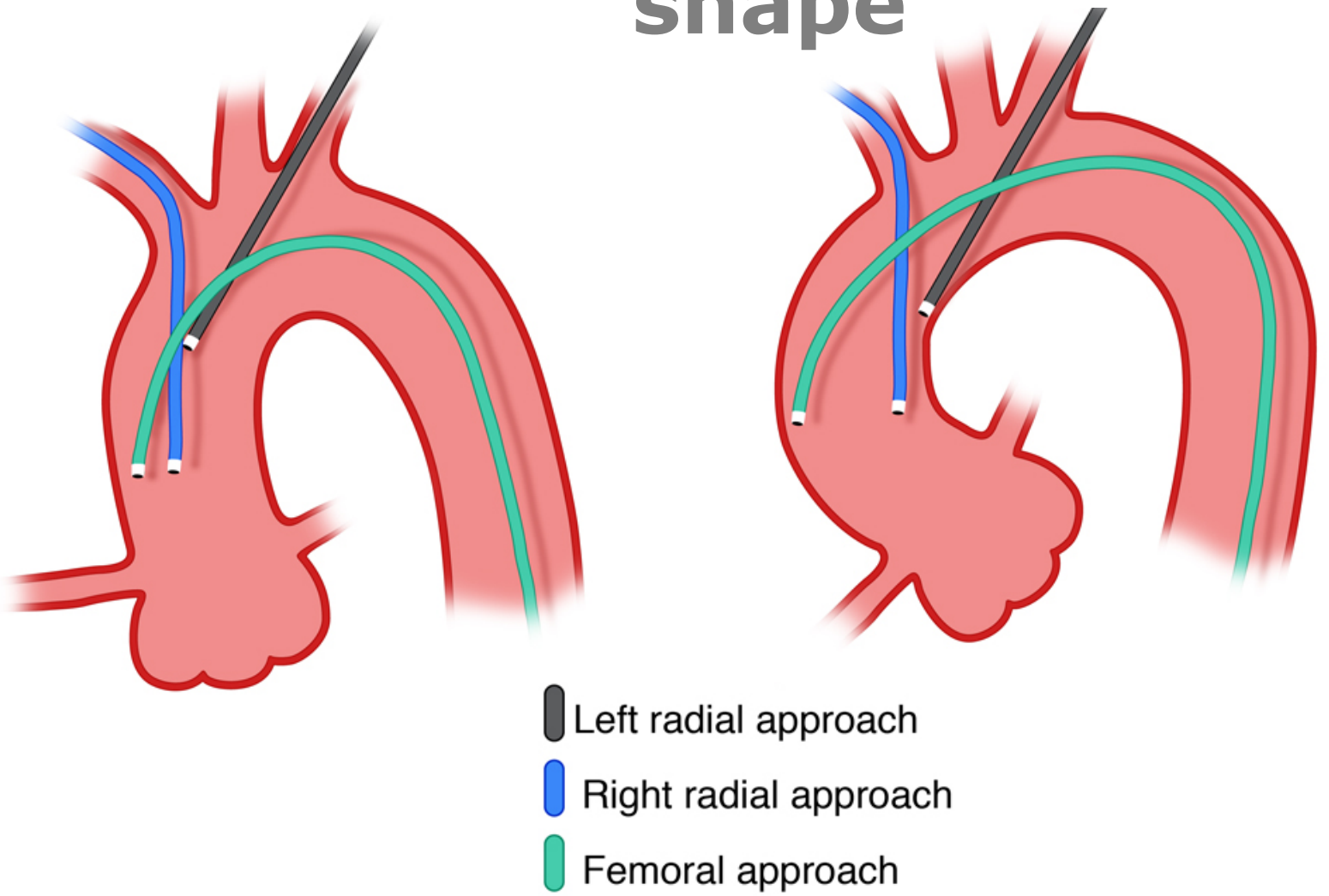


Barbeau



BLK

Catheter course according to vascular approach and aorta shape



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

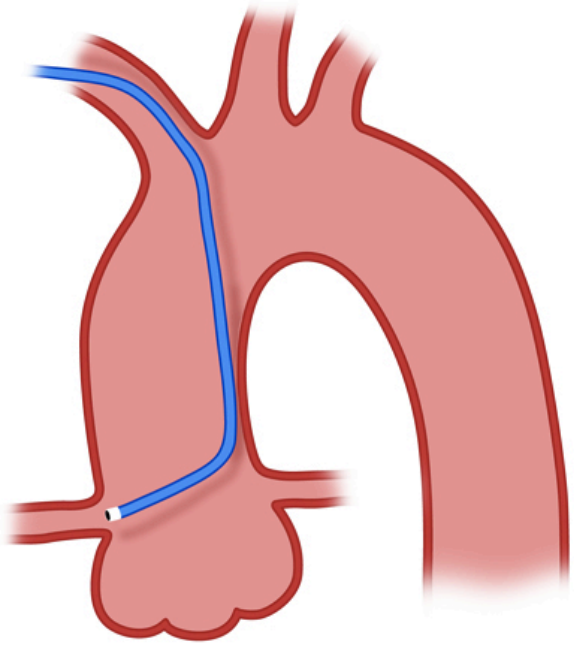
Sub-clavian tortuosity

Enlarged aorta

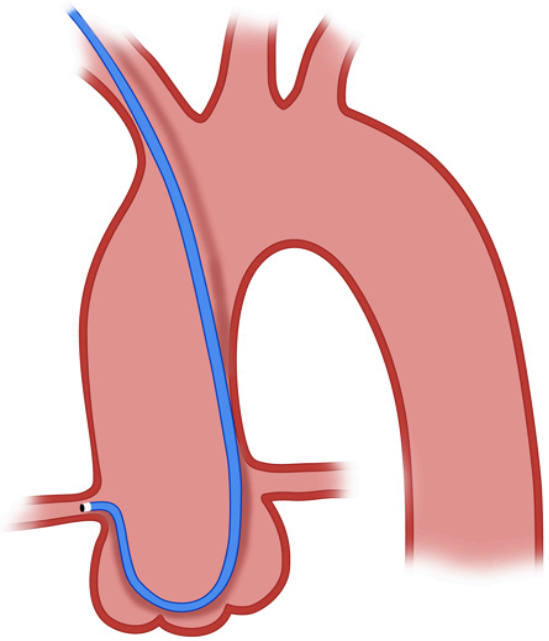
Extreme take-off

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

Catheter for diagnostic - summary

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