Case Summary. We experienced a severe tortuous and calcified RCA PCI case. Guideliner a rapid exchange type child catheter was very useful and simplified the procedure but we should take care to the possibility of the injury.

TCTAP C-126
Stent Implantation with Successful Cokatte Passage by Balloon Sealed Calcified Lesion
Haeng Nam Park
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[CLINICAL INFORMATION]
Patient initials or identifier number. 0070026450
Relevant clinical history and physical exam. Case; 60’ Male
Clinical Diagnosis; NSTEMI
Present Illness:
He presented with severe chest oppression and referred to other hospital
ECG revealed ST depression and Trop level slightly elevated, then transferred to my hospital.
Past History:
PCI to RCA due to AMI in 2009
HD from 2005
Relevant catheterization findings. RCA: Shep redd’s crook type, severe calcified #2,3 severe stenosis
LCX, #11 severe stenosis
LAD; patent
[INTERVENTIONAL MANAGEMENT]

Procedural step. Transfemoral approach, Guiding catheter; 7F Hypertension RB1
Guide wire; Sion black
Sion black crossed easily, but IVUS could not advance proximal tortuous part of RCA. Then we dilated target lesion with 2.5mm balloon. Next, we tried to put the stent, but stent also could not pass the same part. We used the Guideliner, but Guideliner could not pass the same part with usual maneuver and “slip through technique”. Then we changed guiding catheter to AL1 and support catheter to Cokatte. Cokatte also could not advance with manual maneuver, but fortunately Cokatte could advance proximal tortuous part with “slip through technique”. Finally, we putted two DES.
Case Summary. We sometime experience difficult stent delivery due to severe tortuous calcified lesion. We could deploy the stents with successful Cokatte passage by balloon sealed calcified lesion. “Slip through technique” might be useful such like situation.

TCTAP C-127
Usefulness of Corsair and Coronary CTO Guidewire in Successful Re-Wiring After the Pull-out of Guidewire from Dissected Lesion During PCI for Heavy Calcific, Angulated Lesion
Sang-Ho Park

[CLINICAL INFORMATION]
Patient initials or identifier number. CYS

Relevant clinical history and physical exam. A seventh seven year-old woman was admitted to our hospital due to effort induced chest pain. As a coronary risk factor, she had the history of diabetes, hypertension, and dyslipidemia. There was no significant finding in physical exam.

Relevant test results prior to catheterization. Initial electro-cardiogram showed normal sinus rhythm. Transthoracic echocardiogram showed that normal left ventricular systolic function.

Relevant catheterization findings. Coronary angiogram showed tight stenotic, angulated lesion at mid portion of left anterior descending artery (LAD) with heavy calcification and another intermediate to severe tandem stenosis at mid portion of LAD. Also, there was the tight stenotic lesion at mid portion of right coronary artery (RCA) (Fig.1)

[Interventional Management]
Procedural step. First, PCI for RCA lesion successfully finished (Bio-matrix 3.5x18 mm). Immediately after RCA PCI, PCI for LAD lesion was performed. EBU 6F Guiding catheter was engaged into LM. Run-through guidewire was selected. The passage of guidewire into target lesion was not easy due to calcific nodules and severe angulation but finally was successful after supported by finecross microcather. Next, ballooning with Maverick 2.0x20 mm was done and stent deployment was tried but could not be passed into target lesion. Next, more larger size balloon (quantum 2.5x15 mm) was used. The attempt to put the stent was tried but failed. Unfortunately, instead of stent passage, guidewire was pulled out in ballooned, heavy calcific lesion during the trial to pass the stent into target lesion. The multiple attempts to re-pass the guidewire were failed and coronary dissection progressed into TIMI flow 0-1 (Fig 2). Next, Fielder XT supported by the Corsair catheter was successfully passed into dissected LAD lesion in the same way using wire tracking for CTO lesion (Fig 3). And then, after sequential ballooning was done many times, stent could not be passed at angulated portion. So, after the miracle wire was changed into gland slam wire, stent passage was re-tried but also failed. Finally, using SFHeatrail catheter, the anchor-ballooning technique was performed and two stents were successfully implanted (Fig 4).