

How to manage device uncrossable lesion: A case from CCT 2015

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61-year-old, male

CCT

Diagnosis: NSTEMI

Present history: 23 years of diabetes mellitus (Insulin therapy). Stable angina for 20 years. Emergent department visit because of severe prolonged chest pain.

Coronary risk factor: Diabetes

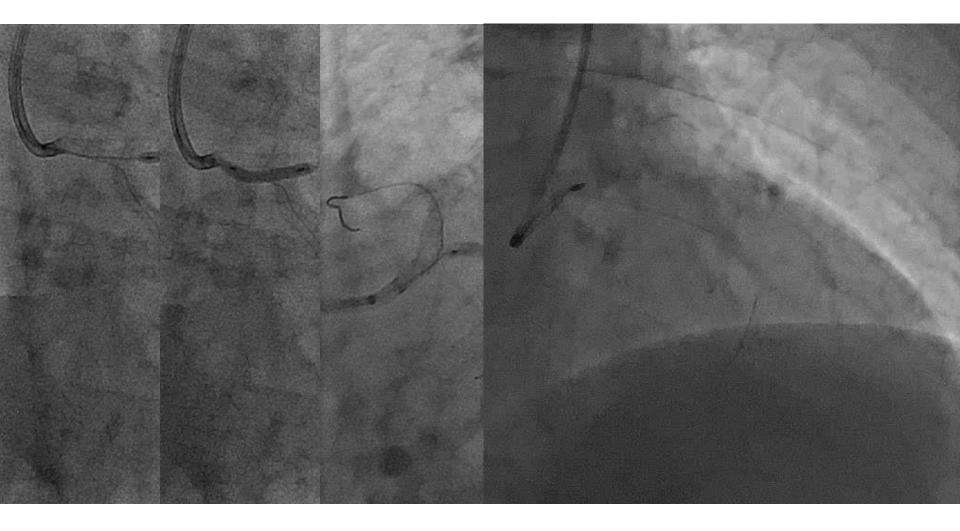


Baseline CAG



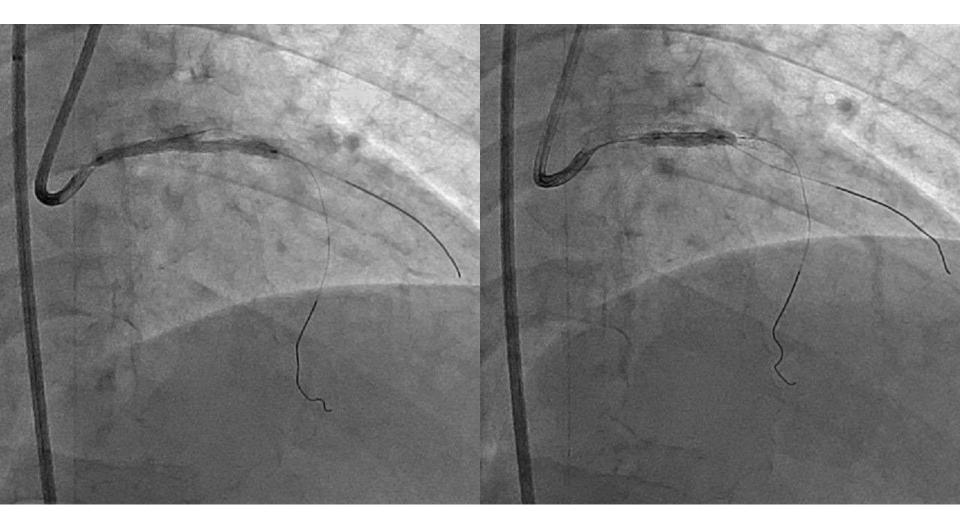


First stage PCI



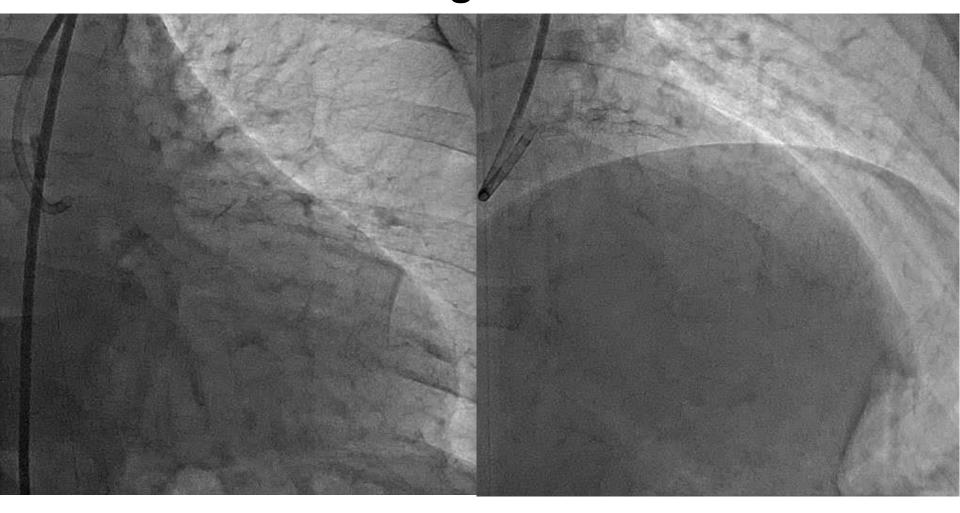


First stage PCI



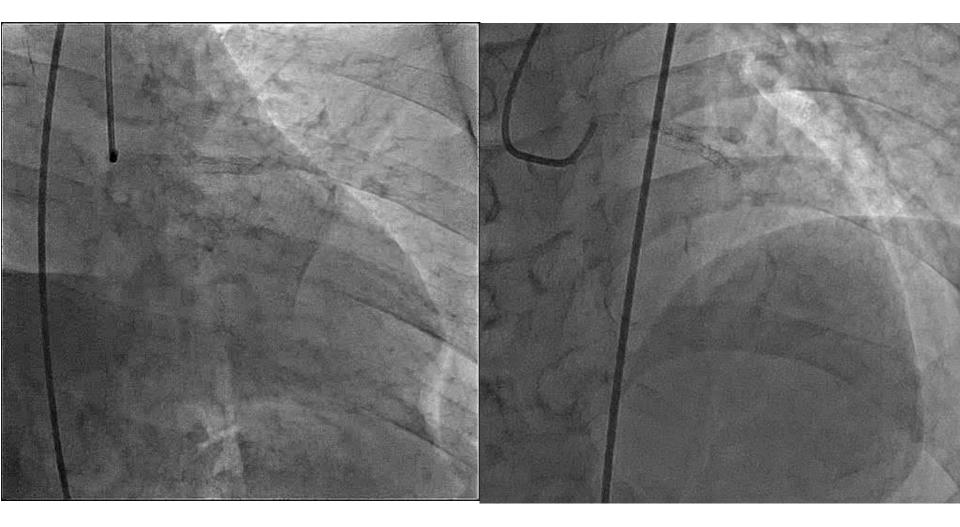
Complex Cardiovascular Therapeutics Angiograms immediately after first stage PCI

CCT



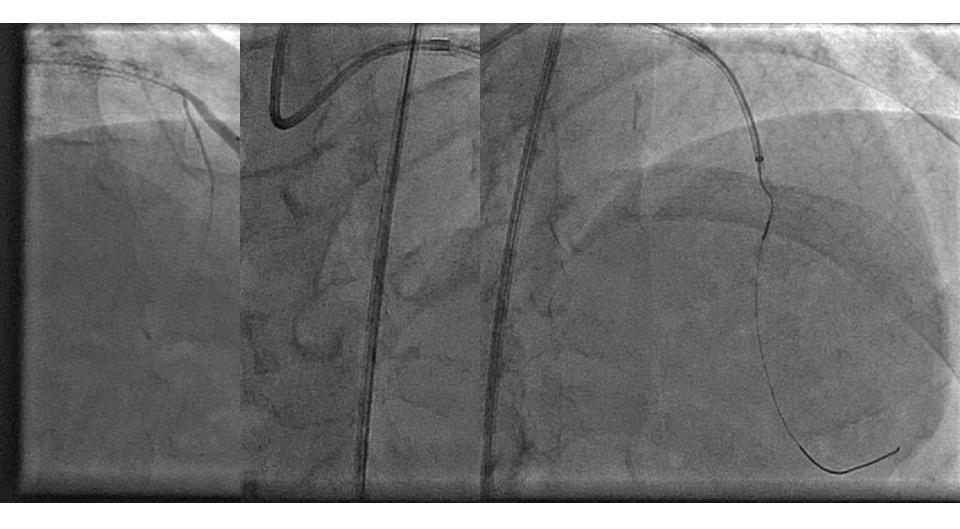


Second stage PCI





Second stage PCI





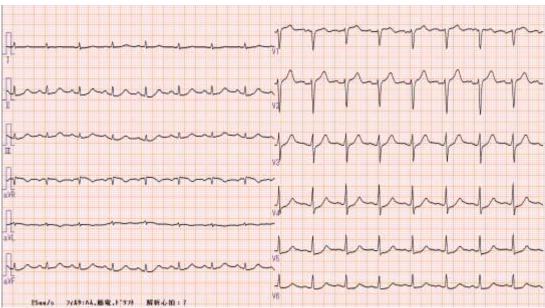
Angiograms after second stage PCI



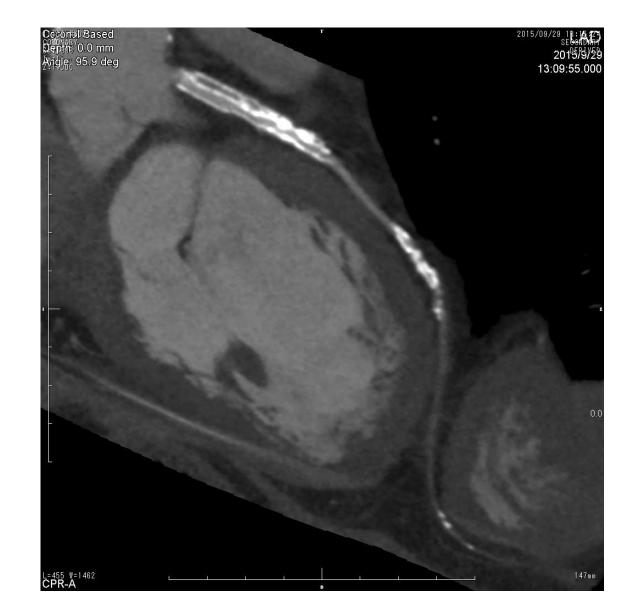


Chest X-ray and ECG



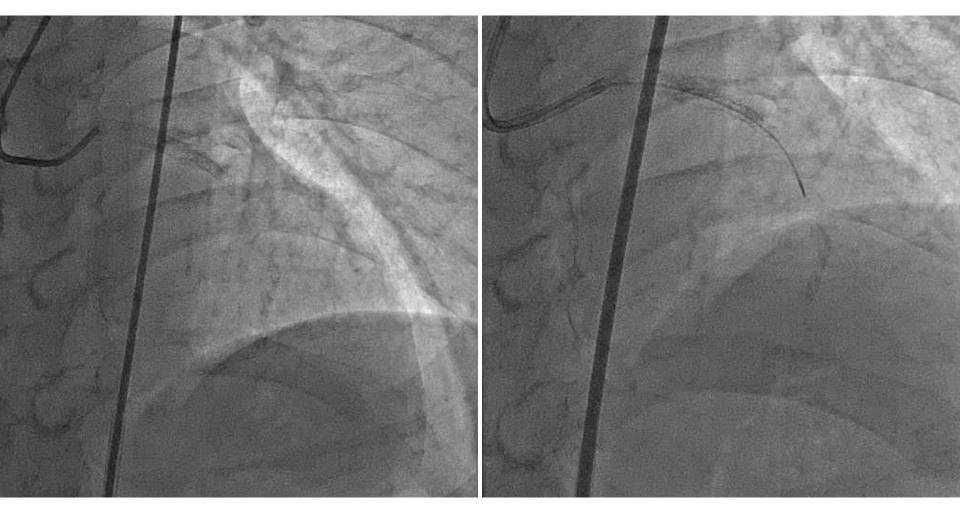






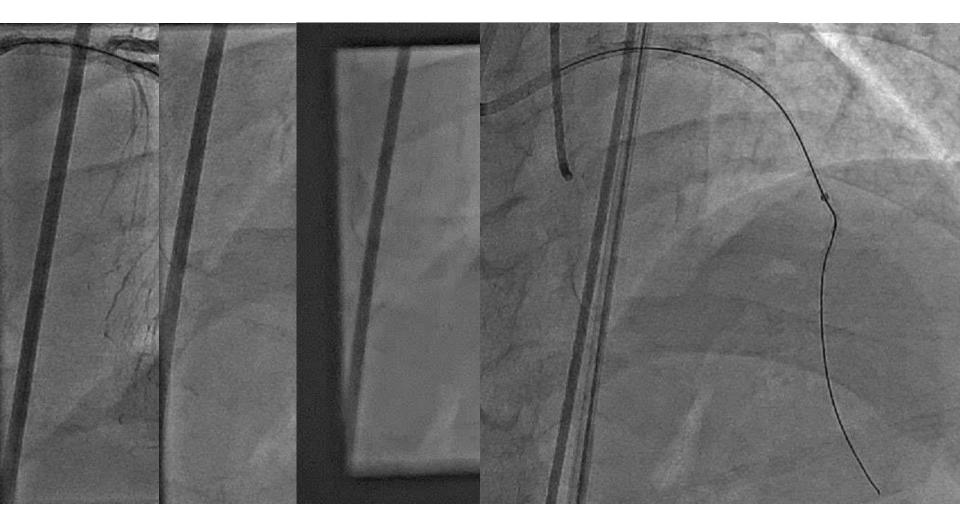


Baseline CAG at third attempt





Third stage PCI

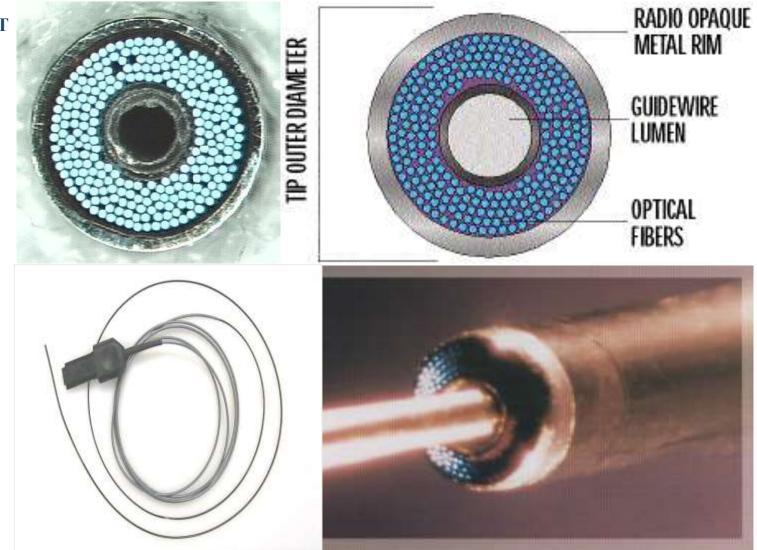




Third staged PCI

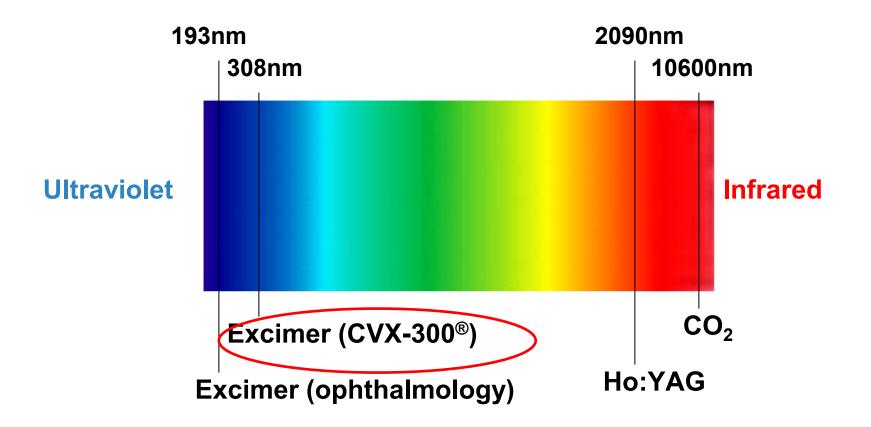








Ultraviolet vs. Infrared



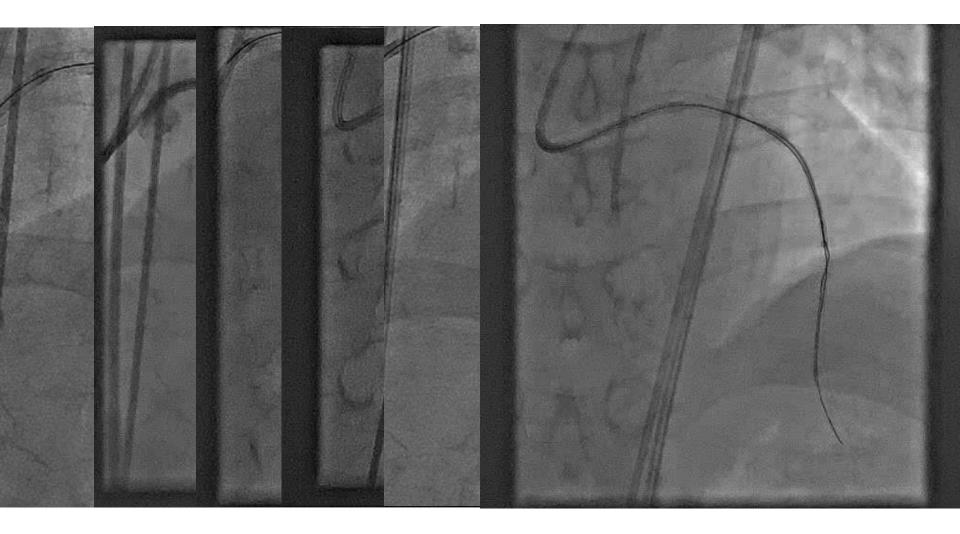


Mechanism of action

Photochemical	B Photothermal	Photomechanical
Dissolving molecular bonds	Produces photo- thermal energy	Creating kinetic energy

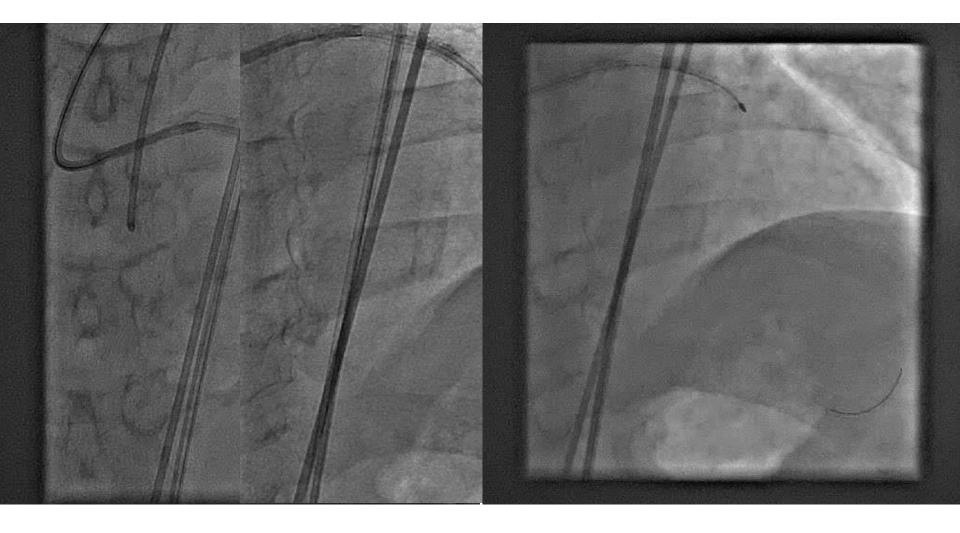


Third stage PCI

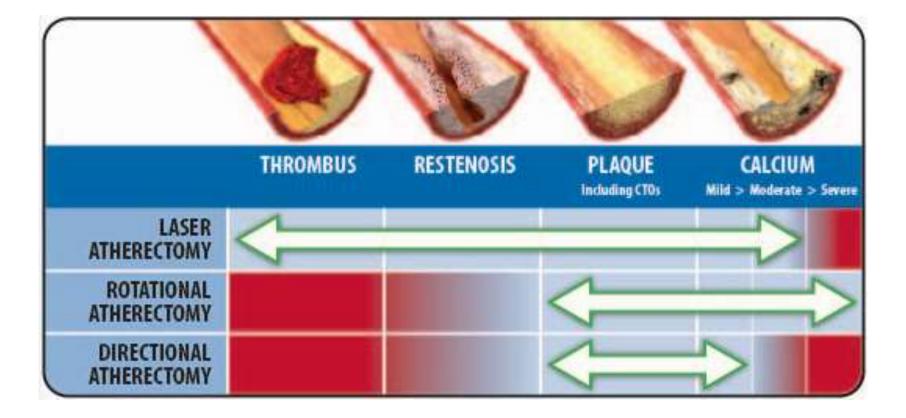




Third stage PCI

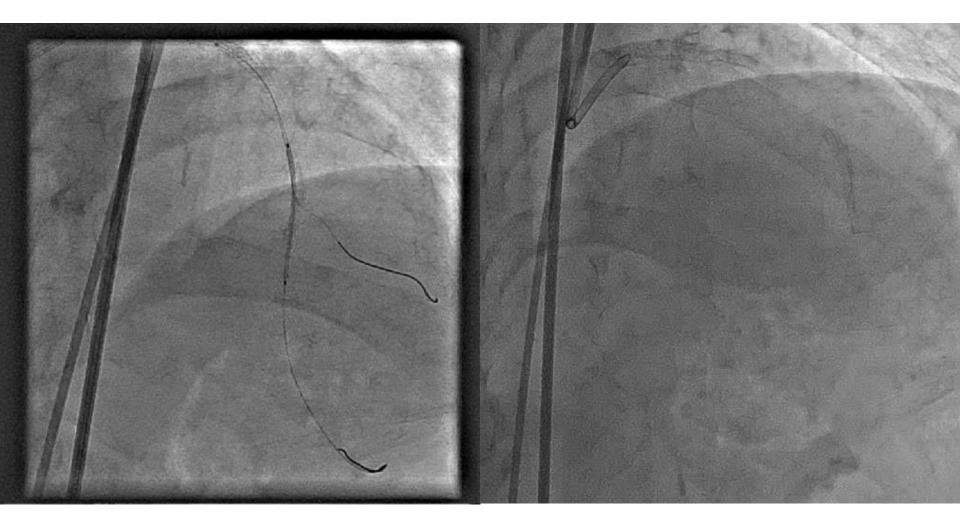








Final angiogram





How to manage device uncrossable lesions

- Anchor balloon technique
- Mother-child technique (Monorail system; GuideLiner, Guidezilla, Guiding extension; KIWAMI etc, including KIWAMI lock)
- Low profile balloon (including .010" slender system)
- Tornus catheter
- Cracking technique (with a non coated and non tapered stiff wire like Miracle 12)
- Buddy wire (Utilize principle of action and reaction)
- Debulking (Rotablator, Excimer laser)



Message

Combination of several techniques (mother-child, small profile balloon, cracking, buddy wire and combined debulking with excimer laser and rotablator) can manage severe calcified CTO lesion.