Heavily calcified and tortuous LCX intervention

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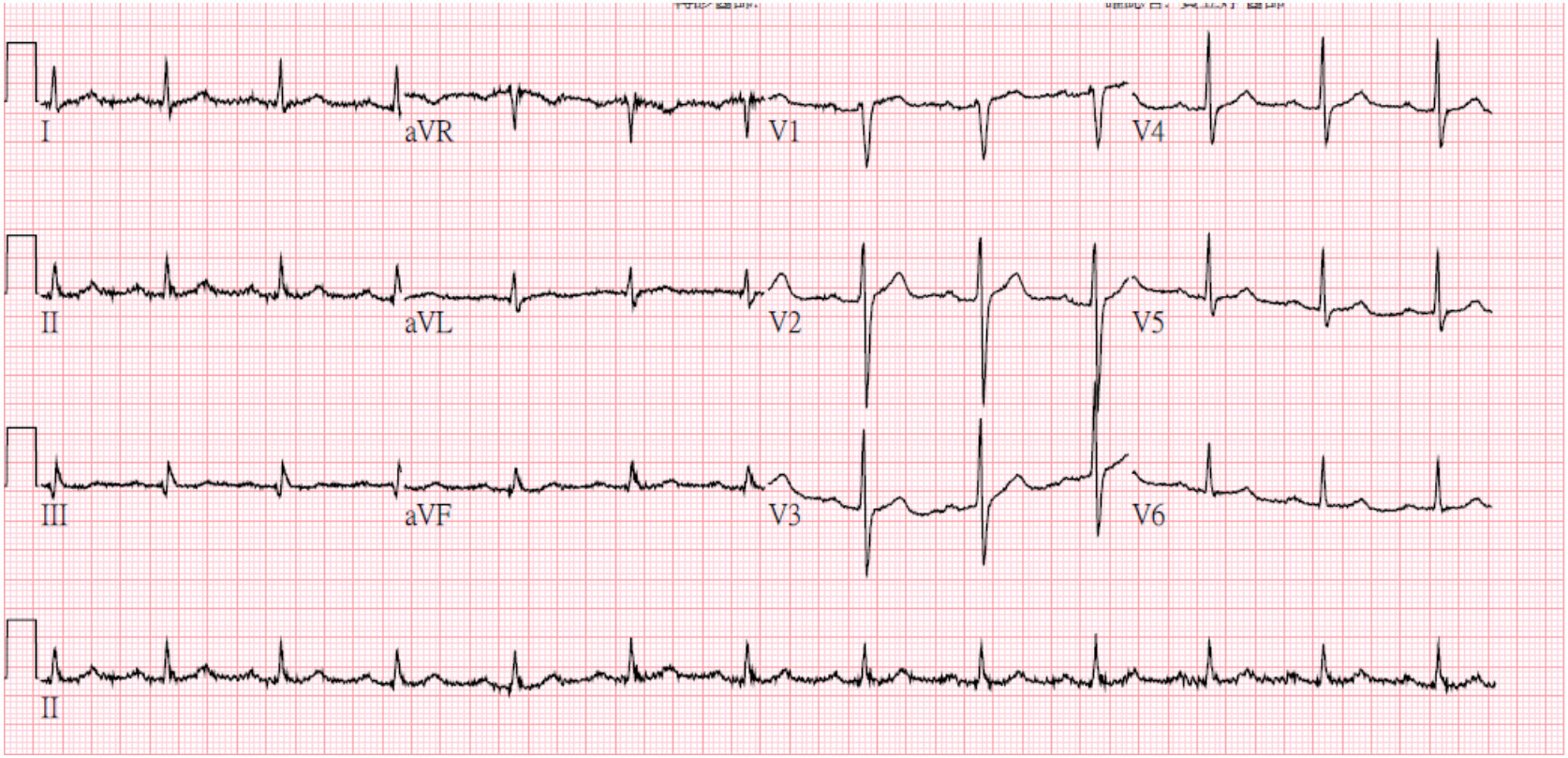
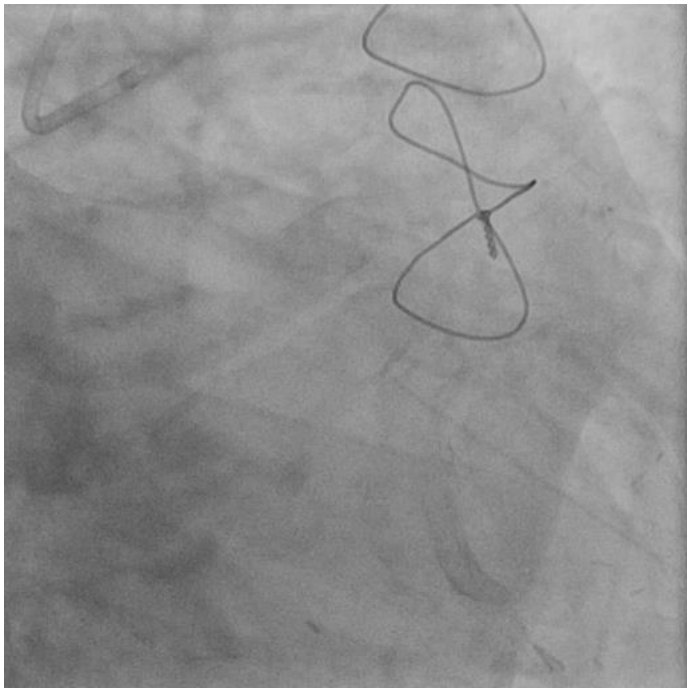
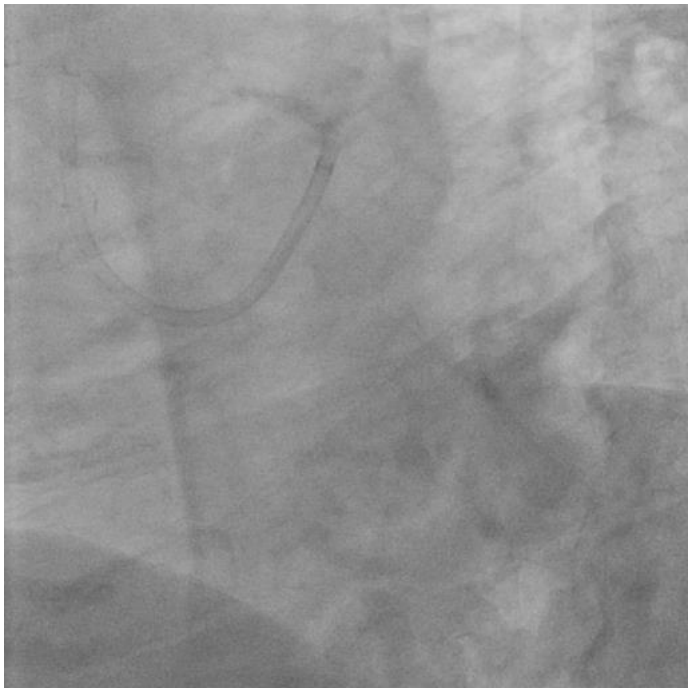
Brief History

- 57 y/o man
- Hypertension
- DM
- LM+3vd s/p CABG 2 years ago
- Recurrent effort angina for months
- Positive Th-scan at the other hospital
- CAG: patent LIMA, but SVG-Dx-(OM-PDA totally occluded).

ECG at admission



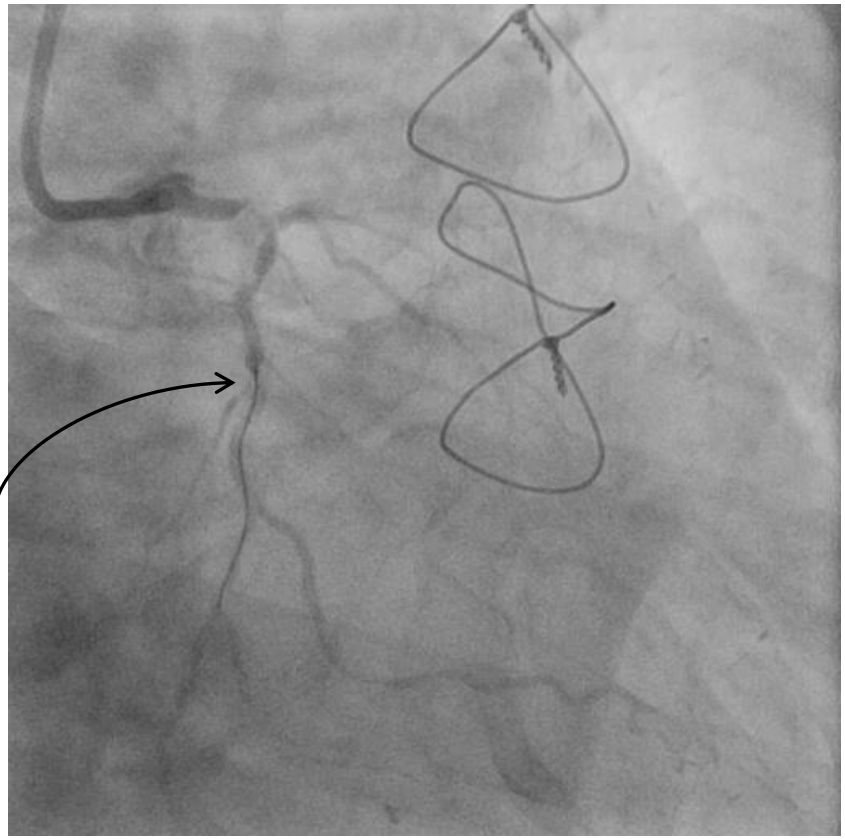




GC: 7F EBU 4.0

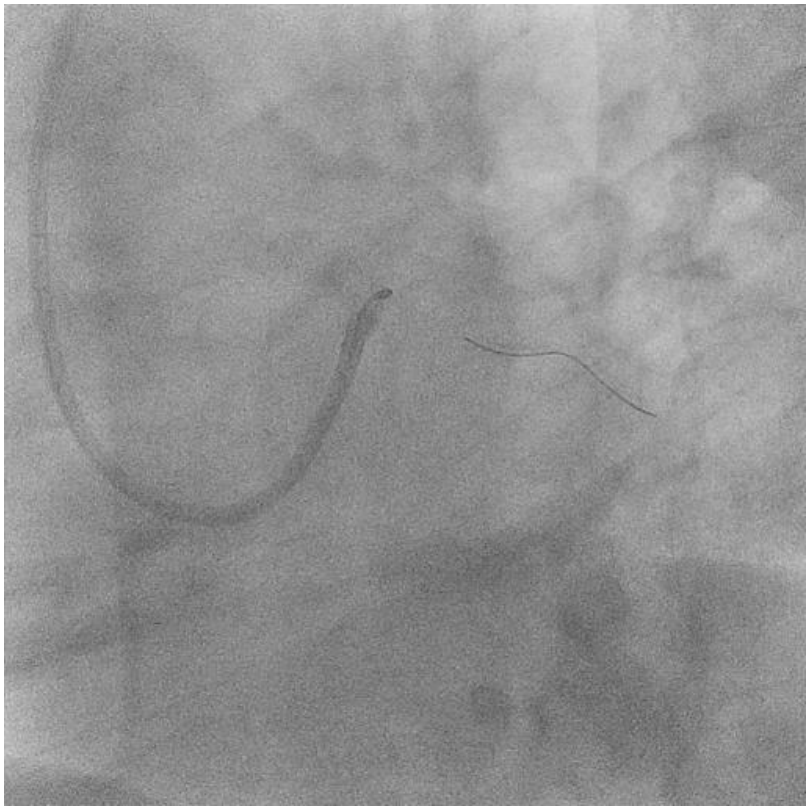
Microcatheter: Corsair

GW: Fielder FC, and then Rota-extrasupport wire

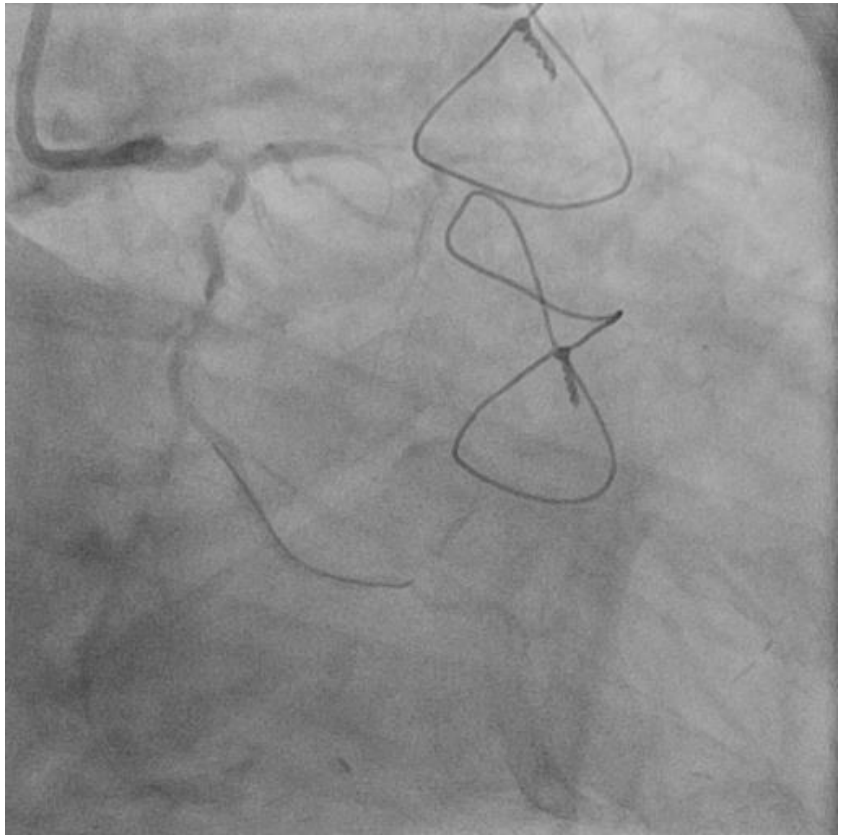


MC was stopped here.

Wire could not be more advanced and go into OM due to high resistance.



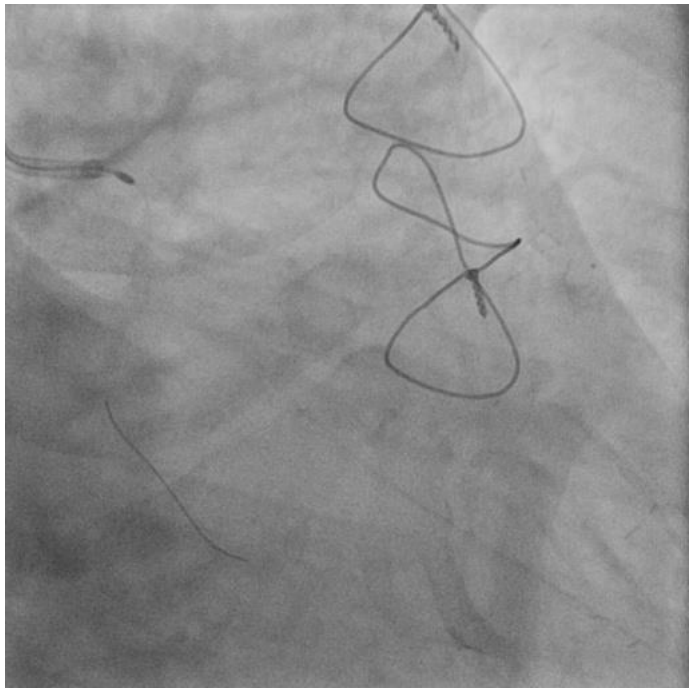
Rotablation of the proximal part with a 1.25mm burr.

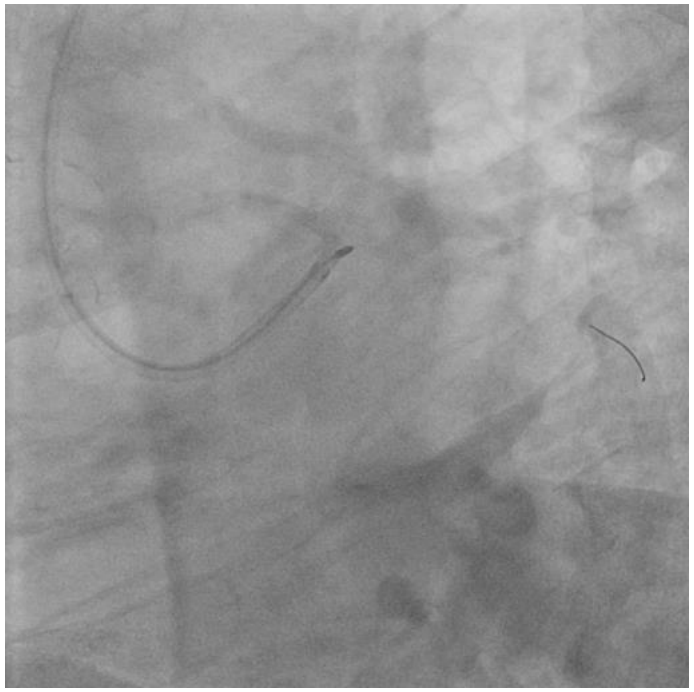


Rewiring into OM.

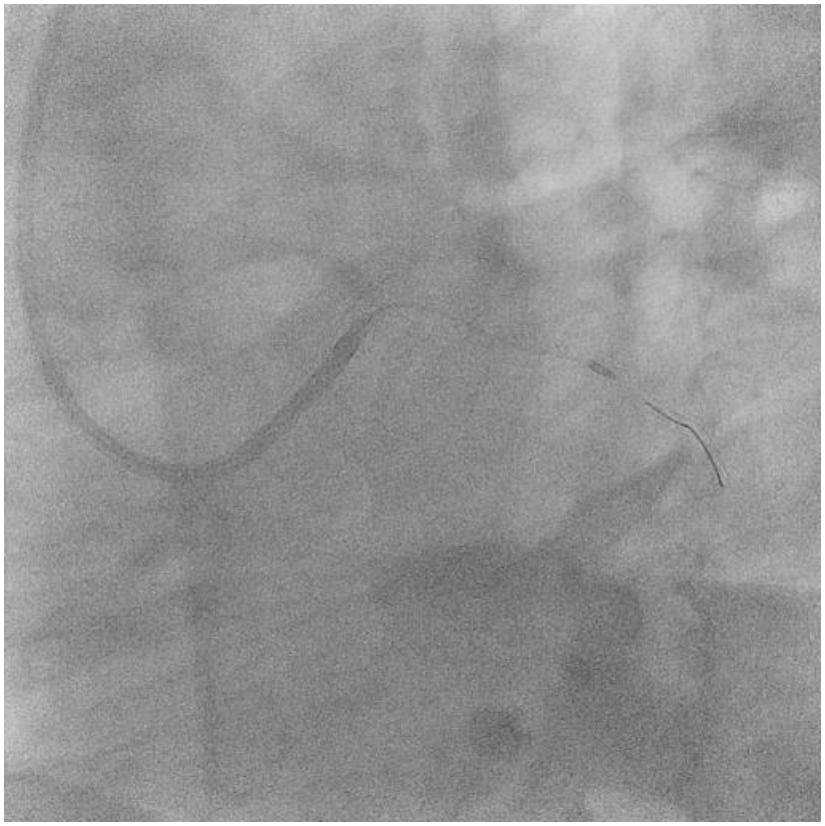
2nd attempt of rotablation.

9th attempt of rotablation up to 220000 rpm.

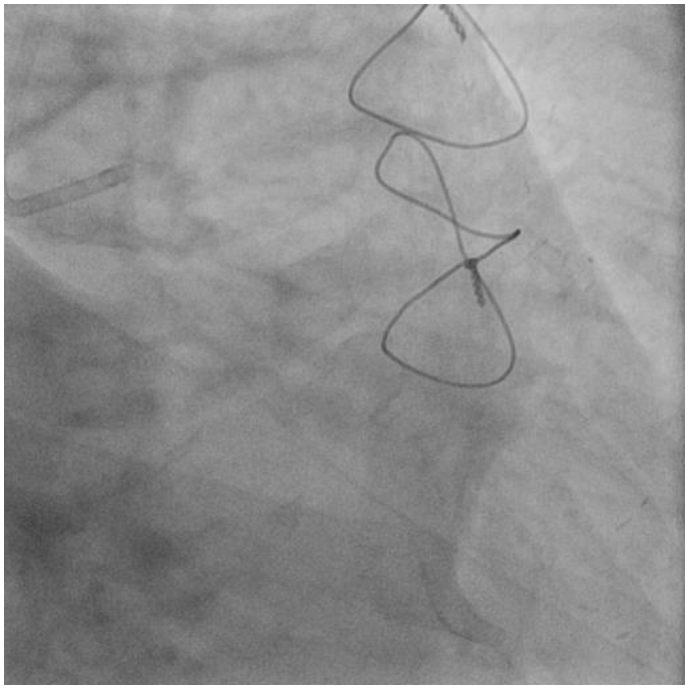


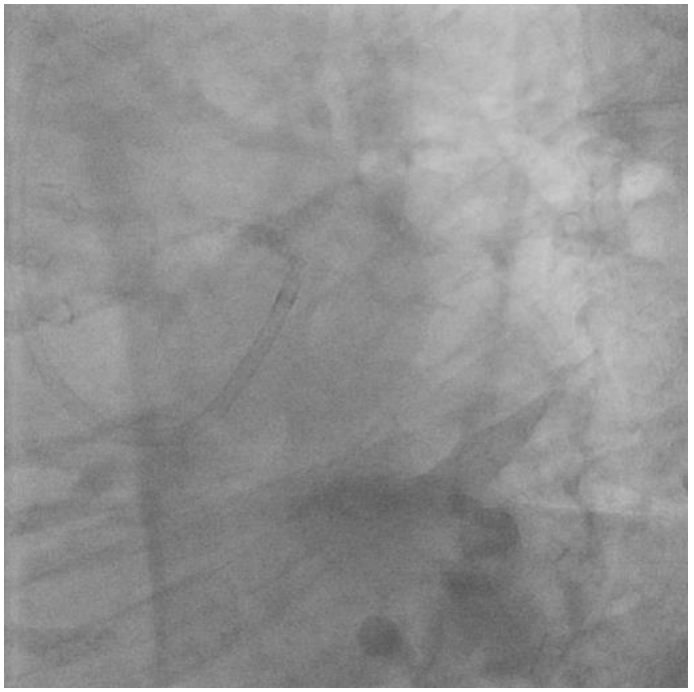


10th attempt of rotablation for d-LCX.

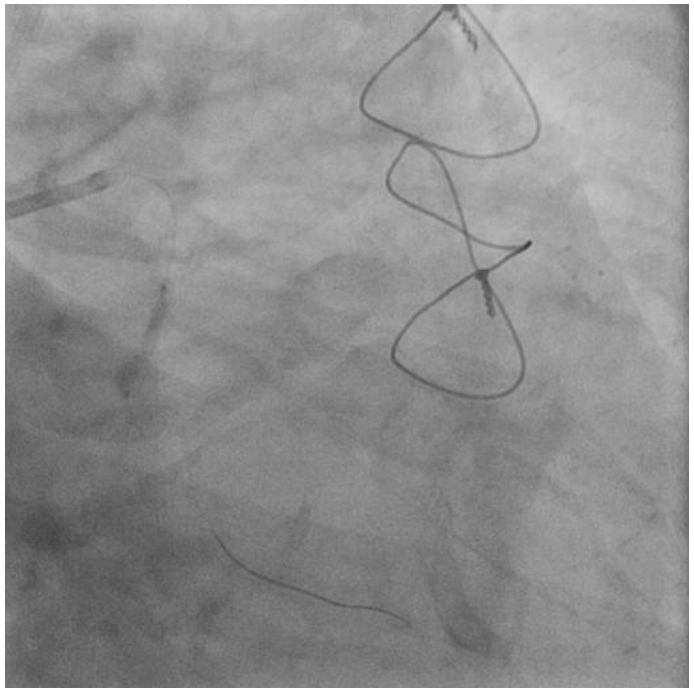


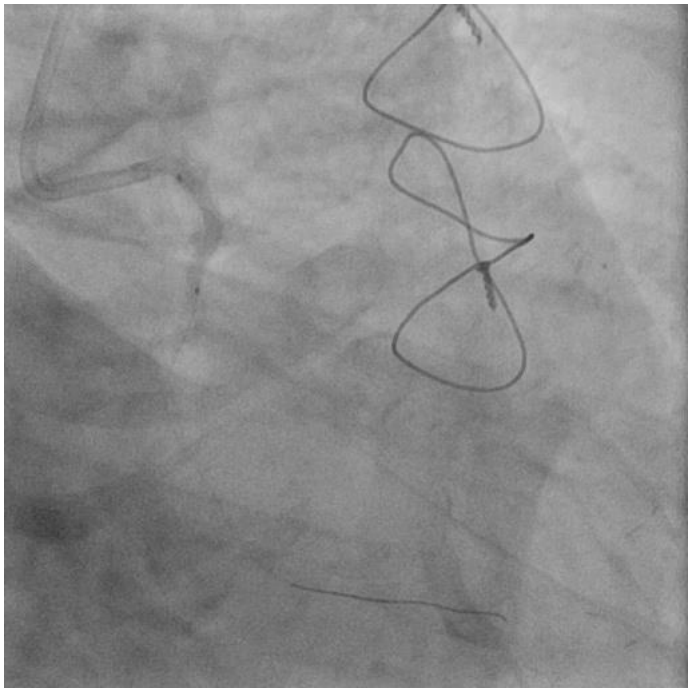
16th attempt of rotablation up to 220000 rpm to cross distal lesion.



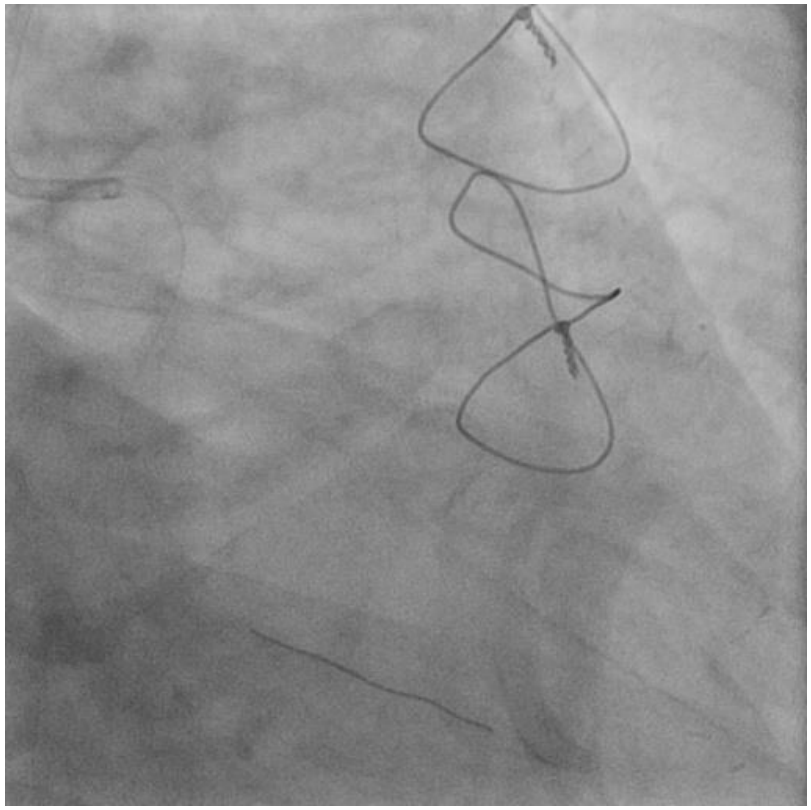


CAG s/p rotablation (Wire was dislodged when retrieving burr).

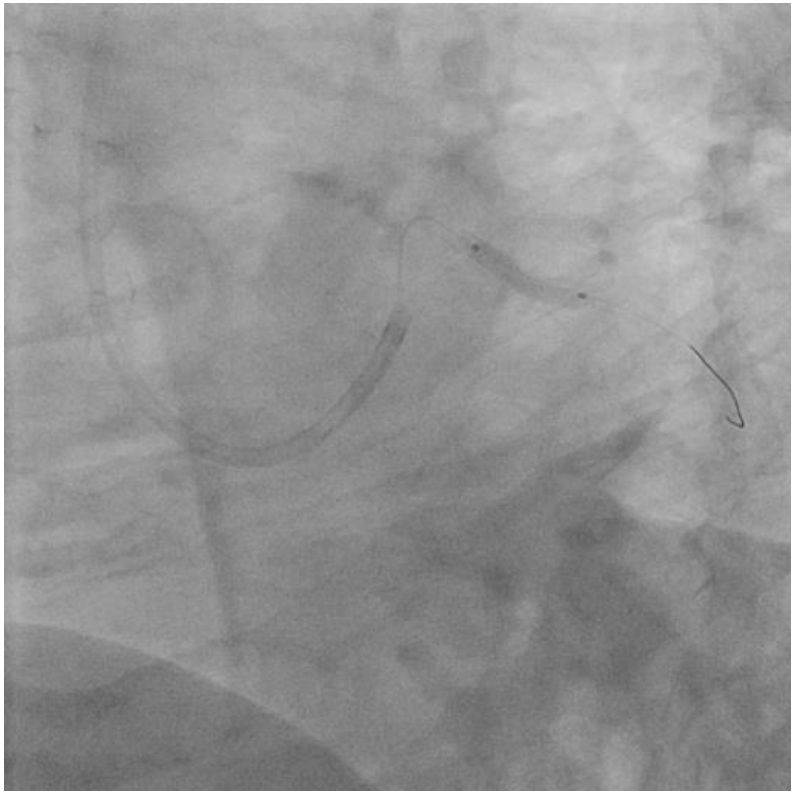




POBA with Apex 2.5X20mm and NC Quantum Apex 2.75X15mm.

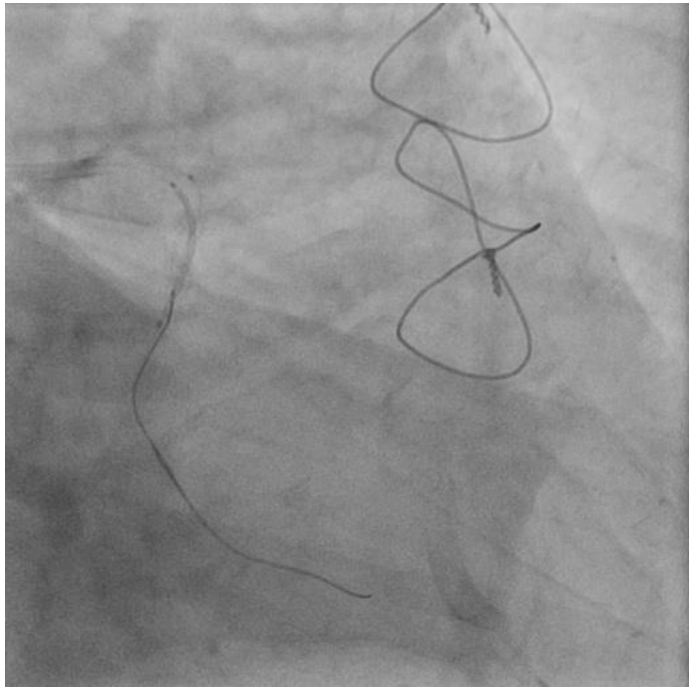


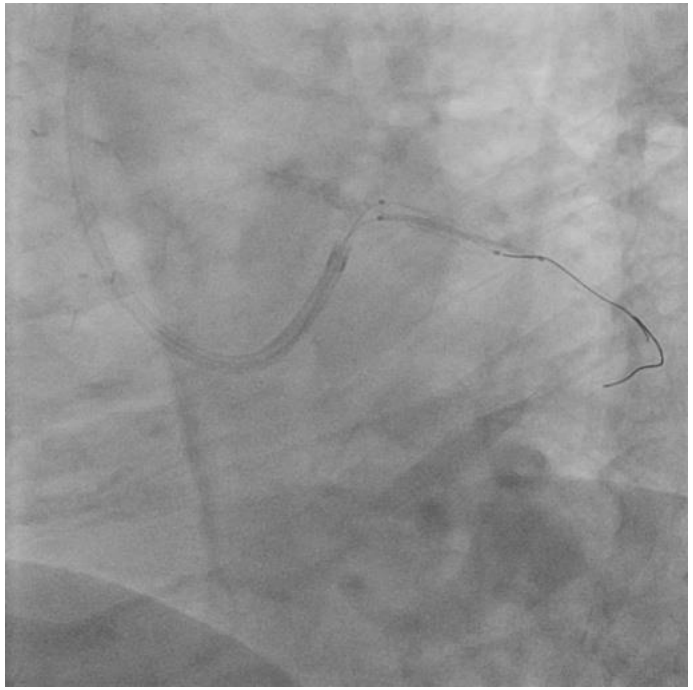
Post-POBA.



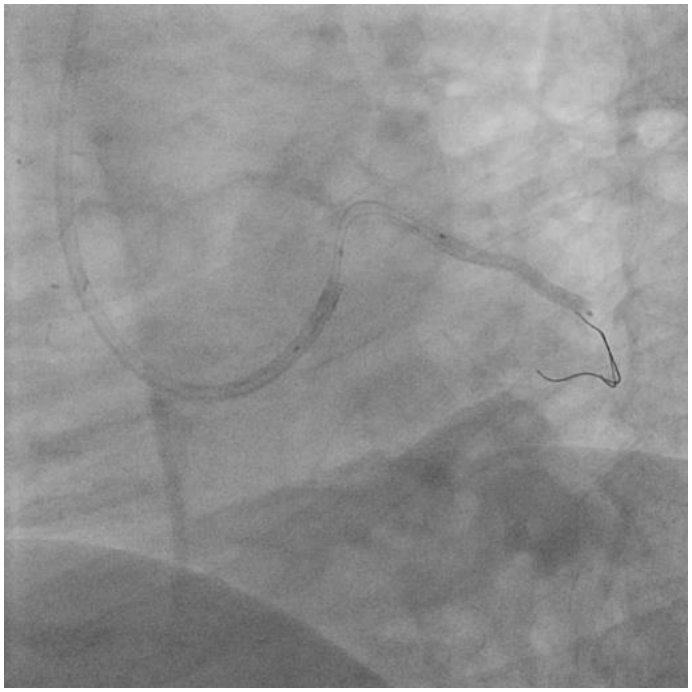
A Promus Premier 2.5X12 mm stent could not be delivered to d-LCX and was implanted at p-LCX.
(Buddy wire or Guideliner was not tried due to severe dissection along the vessel.)

Post 1st stenting.

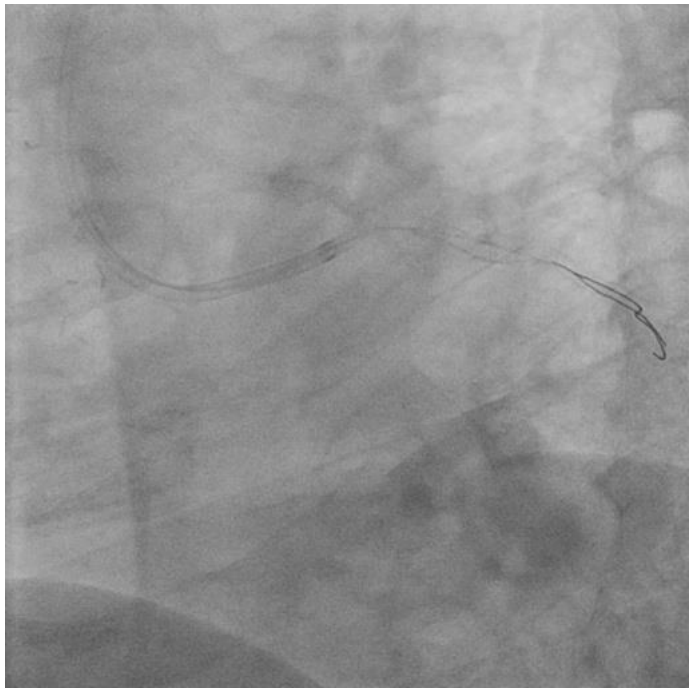




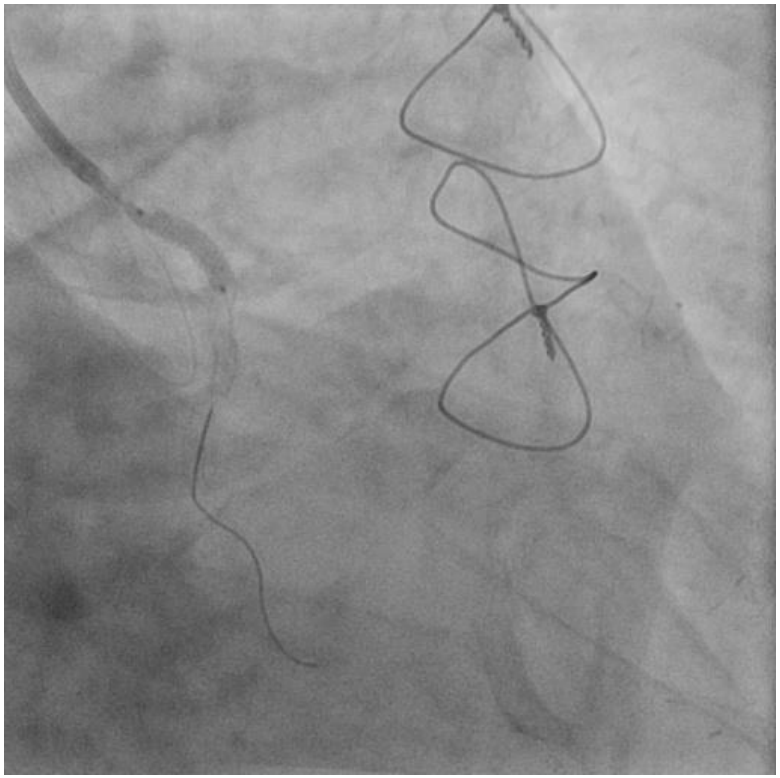
Buddy balloon technique to deliver a Promus Premier 2.5X24mm stent to d-LCX.



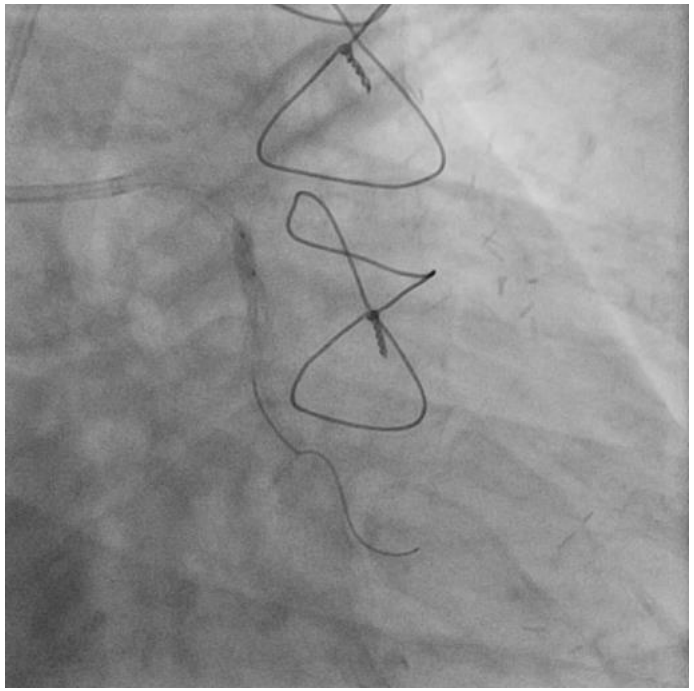
Stent deployment.

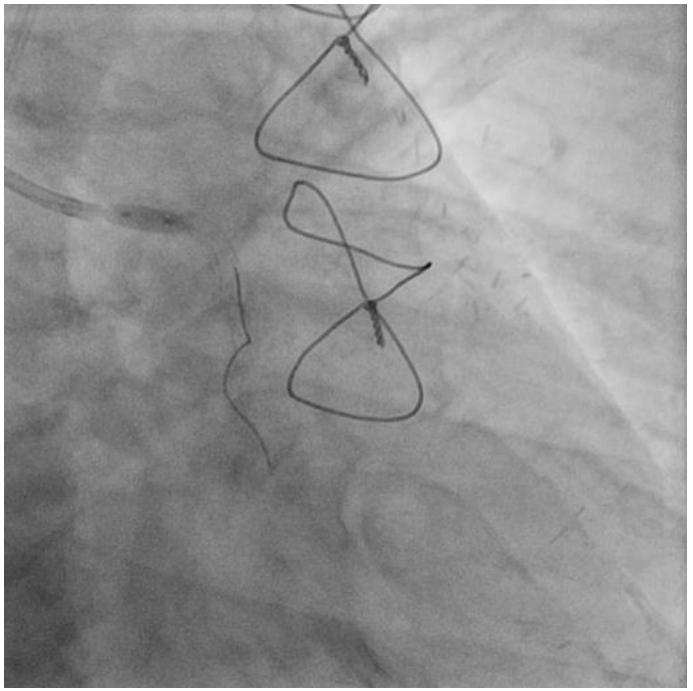


Post-2nd stenting.

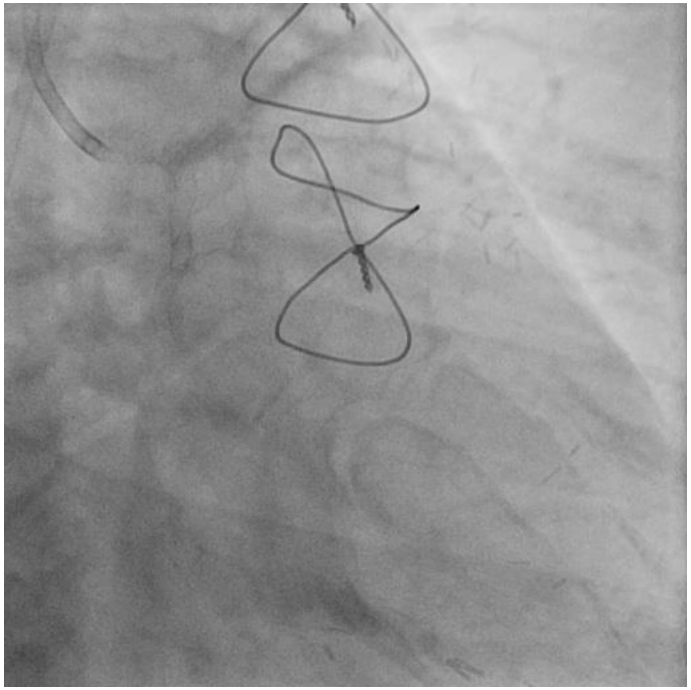


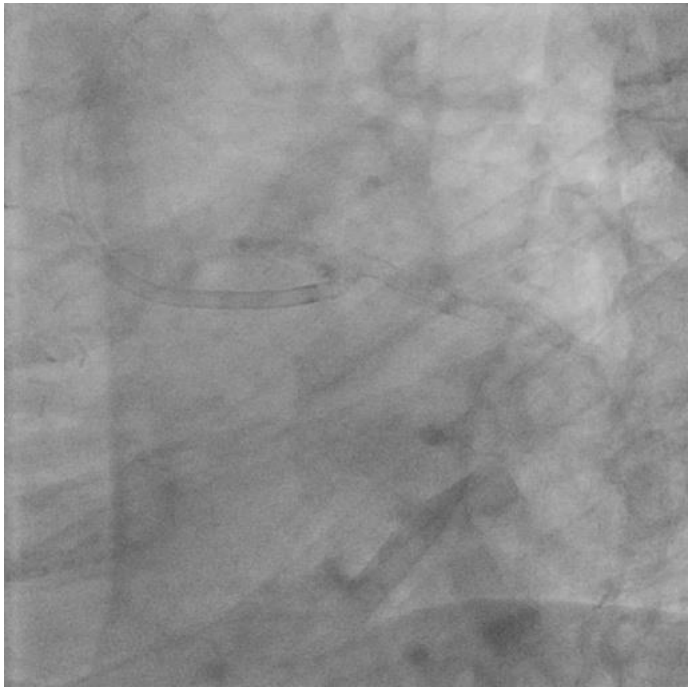
Stenting LM-LCX with a 3X16mm stent.





Postdilatation and POT at LM with a 3.5X8mm NC Quantum Apex balloon.





Final Angio.

Summary

- Rotablation could be performed from the very proximal part if difficulty in wiring into distal vessel.
- When to stop rotablation after multiple attempts is up to operator's judgements. (If constant dripping could wear away the stone, why not rotablators?)
- Among multiple techniques and devices to deliver a stent through a difficult lesion, the appropriate choice is also up to operator's judgements.
- Stenting the proximal part of a diffuse and tortuous vessel sometimes could work, but the risk remains.
- "No complication" is always the first priority in complex lesion intervention.

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