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PCI for heavily calcified tortuous RCA lesion applying Rotablator and anchoring technique using 6 Fr. guiding catheter

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66 years old male was admitted for CHF, anterior OMI on Aug 29 2009. He had background of diabetes mellitus for 20years and was found having peripheral artery disease in April 2009. 2-D echo showed diffuse severe hypokinesis with LVEF 35%. Coronary angiogram showed : RCA was shepherd crook shaped, severely calcified. Peripheral angiogram showed : Right radial occlusion, bilateral femoral severe stenosis . Angioplasty for RCA was attempted on Oct 5 2009. In view of peripheral artery status, right brachial 6Fr approach was selected. We also keep in view of Inserting an IABP through left brachial artery, if there is hemodynamic instability during procedure. We engaged RCA with 6Fr Wave 3 catheter, a guide wire (Runthrough HC) could cross the lesion, however, due to severe calcification, balloon (Tazuna 2.0/15 mm) could not pass through the lesion. Tornus catheter was tried, balloon still could not pass through. Therefore, we decided to apply Rotablator. Rotablator wire was successfully inserted through FINECROSS. After 1.5mm-1.75mm burr ablation, 2mm Tazuna balloon successfully passed through lesion, however due to shepherd crook shape, TAXUS 3.0/16mm could not pass the lesion, we decided to apply the anchoring technique. Since there is no appropriate side branch, a parallel BMW wire was inserted till the distal part of RCA, along which a 3.0 mm Tazuna was deployed at distal part of RCA (Forward anchoring technique), then TAXUS was successfully inserted and expanded. Finally good dilatation was achieved with no complication.