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Hard rock woman

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81 Y-O female was consulted with intermittent claudication on may 2012. Angiographical findings were CTO at #1, 99% stenosis at #11 and 90% stenosis in left SFA. After PPI, she complained chest oppression on effort, so PCI to the CTO was planned. 6Fr JR4 guiding catheter was cannulated from lt. radial artery. and AL1 for contra-lateral injection was used. Although Wizard 3 was passed the CTO without difficulty, but Corsair could not pass the proximal cap. Finally, Torunus pro could pass the CTO, then Wizard 3 was exchanged with Runthrough NS, however, 2.0mm OTW balloon could not cross the entry point, and the system was collapsed. To enhance the back up force, guiding catheter was exchanged to UG3ST. Fortunately Runthrough NS could pass the CTO through the channel made with Tornus. The 1.0mm*6mm balloon(sapphire) could cross the reision, nevertheless the 2.0mm*20mm balloon was ruptured at the nominal pressure. A non-compliant balloon(iBP22) was not dilated in spite of high pressure(26 atmospher). After all, Rota-Link plus 1.5mm was effective for proximal cap modification. IVUS examination revealed napkin-ring like calcification in the proximal cap, and the wire crossed the true lumen in the CTO. Rota-link Plus 1.75mm was also going from proximal to distal site of CTO. Accordingly, 2.5*30mm compliant balloon(Lacross) could dilate proximal cap with nominal pressure. Finally Xience prime 2.5*38mm , 3.0*38mm and Xience V 3.5*18mm ware deployed from #3 to RCA ostium.