10045

A case of unprotected LMT stenting for true bifurcation with severe calcification.

Case: Eighty-year-old dialysis man was admitted to our hospital due to angina pectoris. He underwent CAG, which showed RCA and LMT stenosis (seg.2 90%, seg.5 distal 90%, Medina classification 1-1-1) with severe calcification. We planned staged PCI to LMT lesion after implantation of EES (3.5/20mm) to RCA stenosis because he rejected CABG. IVUS catheter was passed the lesions of LAD and Lcx and IVUS images showed severe calcification superficially from LMT to Lcx ostium. Although pre-dilatation and kissing balloon inflation was performed with high pressure for LMT bifurcation, LCx lesion wasn't fully expanded due to calcification. Dilatation with non-slipping balloon (3.0mm Lacrosse NSE™) made some cracks in the Lcx calcified lesion. We selected ZES (3.0/18mm) for LMT to Lcx with consideration for bifurcation and bending lesion because of planning Currote stenting. But we couldn't deploy the stent to Lcx due to calcification and bending. We succeeded to deliver a stent to Lcx by use of 5 in 7Fr guiding catheter (Mother-Child technique). After stenting for LMT to LAD with BES (3.5/24mm), we performed final kissing balloon infration to LMT bifurcation. IVUS examination revealed sufficient stent expansion and apposition at bifurcated lesion. Follow up CAG after 9 months showed no stent restenosis.This case demonstrated efficacy of pre-dilatation by non-slipping balloon and use of Mother-Child technique for LMT lesion with severe calcification and bending.