

¹Seirei Yokohama Hospital

Wataru Yamada¹, Kei Kawai¹, Hidehito Makabe¹, Gen Igarashi¹, Toshihiro Yoshino¹, Keisuke Nakashima¹, Shinmura Takayuki¹, Kazuhiro Ashida¹

Case; A 70s man came to our hospital due to chest pain on exercise. We had suspected him for effort angina pectoris. Double master ECG was a positive result, so we performed coronary angiography. It revealed 90% stenosis with severe calcification at the mid RCA. We underwent PCI subsequently. IVUS showed the hole circumferential severe calcified lesions with acoustic shadow, and some showed narrowing lesions of lumen and border irregular lesions that protruded into the lumen. OCT also showed it more clearly, so we suspected the lesions calcified nodule. Angioscopy showed red and white thrombi on nodular calcification, and it showed white and yellow plaques around there. So, we had diagnosed as calcified nodule. After we used a Lacrosse NSE at calcified lesions, we checked IVUS that calcified lesions was cracked. Finally, we were able to implanted a drug-eluting stent. Calcified nodule is defined as a nodular calcification protruding into lumen overlying superficial calcification with red thrombus. Although IVUS or OCT is used for diagnosis, it is difficult to identify the thrombus of superficial calcification in many cases. Angioscopy is the only modality that can provide the direct view of the lesion, detailed assessment of the lesion characteristics or color tone. In this case, it was also possible to evaluate the thrombus of superficial calcification in detail. It was able to confirm the diagnosis. In addition to the IVUS and OCT, direct intravascular view from angioscopy was effective in diagnosing the calcified nodule.