

C036

Effective Rotablation before the CTO wiring led to success procedure

**【Relevant clinical history and physical exam】**

A 67-year-old man was admitted our hospital due to NSTEMI. Emergency CAG was performed. The CAG showed proximal LAD CTO, mid LCX 90%, distal LCX 99% delay and mid RCA 50%. Therefore PCI was performed for culprit lesion, LCX. Four months later, follow up CAG was performed. Mid RCA lesion was progressed, severe stenosis. So PCI was performed for RCA. More two months later, PCI was performed for RCA CTO. Coronary risk factors were diabetes, hypertension and dyslipidemia.

**【Relevant test results prior catheterization】**

Baseline ECG showed flat T in II, III, aVF. Echocardiogram revealed severe hypokinesis at mid to apical posterior with LV function (ejection fraction 59.9%).

**【Relevant catheterization findings】**

Left angiogram showed CTO lesion at the proximal lesion. The separate cornus branch fed distal LAD.

**【Procedural steps】**

The target lesion was proximal LAD CTO. An 8Fr VL3.5 SH was engaged in the LCA. A 5F diagnostic catheter JR4 was engaged in the separate cornus branch. There was a septal branch at just proximal CTO lesion. A SION Blue crossed the septal branch. A SASUKE was tried to advance the septal branch to get strong back-up for CTO approach. However the SASUKE could not advance the septal branch because of severe calcium at proximal LAD. Therefore 1.5mm Rotablator was ablated at the proximal LAD. After that, the SASUKE could advance the septal branch. A Conquest Pro was punctured at the CTO lesion. Fortunately, the wire crossed the true lumen. 2.0mm Rotablator was ablated at the proximal LAD. Two drug eluting stents were implanted from LMT to mid LAD and KBT at LAD and LCX. Finally, successful revascularization was achieved.

**【Conclusions】**

Rotablation to just proximal CTO lesion before CTO wiring was effective for the successful procedure.