C-05

A case of RCA and LAD double CTO with LMT lesion which needed a calcified debulking for severe calcified lesions

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A 70 year-old male patient was presented with dyspnea on effort. He was admitted into our hospital for HF with IHD. The echocardiogram showed low ejection fraction of 40%. CAG revealed that RCA mid (seg.3) and LAD proximal (seg.6) had a chronic total occlusion (CTO) with LMT significant stenosis. The syntax score was 33, indicating a complex lesion background.Initially, we conducted the antegrade-PCI of the RCA CTO due to LMT lesion. It was difficult to pass through the guide wire at the RCA#3 CTO exit by the bend lesion. Therefore, we switched to IVUS guide wiring and succeeded in passing the wire through the CTO lesion. And then, we deployed DES at RCA mid to proximal part.One month later, we performed PCI to the LAD proximal to mid CTO with severe calcified lesions and LMT significant stenotic lesions. Gaia Next 1 entered the false lumen at the CTO exit, so we switched to the parallel wire technique using UB3 and succeeded in passing through the CTO exit. However, Zinrai 0.75mm/4 balloon failed to pass due to severe calcification at CTO exit. Although Tornus Pro and Guide extension were used, it was difficult to pass through the lesion.Therefore, we attempted to pass the CTO exit using a Rota floppy wire and debulked the heavy calcified lesion using a Rotablator 1.5mm to 1.75mm burr. Finally, we performed over lap stenting using DES from LMT to mid LAD.