

A case in which DCA was effective for a calcified nodule lesion.Tomohisa Sakata¹Kohei Hashimoto¹, Ritsuo Nagano¹, Taro Kotegawa¹, Satomi Watanabe¹, Mariko Shinozaki¹, Koichi Iwamatsu¹,
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The patient was a female in her 60s. She had coronary risk factors including diabetes, hypertension, dyslipidemia, and a family history of myocardial infarction. She visited our hospital because of chest discomfort during effort, which had been getting worse for about one year. Coronary CT showed severe stenosis with heavy calcification. We performed CAG for detailed evaluation, which revealed severe stenosis at the ostium of the LAD#6. Therefore, we planned a staged PCI. IVUS showed an eccentric, severe calcified nodule. We adjusted the position of the guiding catheter, but the wire bias was bad. We decided that effective cutting was not possible with OA or RA. Therefore, we chose to perform debulking with DCA. By shaving the surface of the calcified nodule little by little, we successfully obtained a good lumen area. Finally, we used a DCB and achieved an excellent result. Debulking of severe calcified nodules is important to improve the procedural success rate by good lesion preparation. It also improves acute phase results by preventing poor stent expansion. Furthermore, it is expected to improve long-term vessel patency and mid-to-long-term outcomes. Usually, DCA is used for non-calcified plaque, especially at bifurcation lesions. However, in lesions with bad wire bias, DCA can selectively debulk the target calcified nodule. Therefore, we believe that DCA can be an effective method for these cases.