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A 78 year old male with history of Type 2DM for 10 years, presented with Chest heaviness associated with dyspnea for last 3 days. ECG showed sinus rhythm with LBBB (QRS 140msec), Echo showed LV global hypokinesia with severe LV systolic dysfunction LVEF 30%. He was diagnosed to have ACS- NSTEMI, Acute LV failure. He was managed with dual antiplatelets, statins, anticoagulation and IV decongestive therapy. Hb was 12g/dl, Creatinine was 1.0 mg/dl. Coronary angiogram showed TVD with Proximal LAD has 70% lesion, Lcx was normal and RCA was dominant with mid 90% lesion with severe calcium and 70% lesion proximal PDA and PLV. Initially IABP was inserted in view of Severe LV systolic dysfunction and OCT was done in RCA, which showed Eruptive calcific nodule and nodular calcium in mid RCA. Hence orbital atherectomy was done with 1.25mm and OCT showed sanding of nodular calcium, later NC balloon was used to predilate and then stented with Xience Sierra 3.5 x 38mm in mid RCA and 3.5 x 18mm in Distal RCA with the help of guide extension catheter (Guide plus II). Post stenting RCA was post dilated with NC balloon 3.75 x 12mm at 16atm. Final OCT in RCA showed good stent areas.

For LAD physiological test with IV adenosine was done and FFR showed 0.77, OCT showed circumferential superficial thick calcium, which was predilated with NC balloon 2.75 x 12mm at 16atm. Mid LAD was stented with Xience Sierra 2.75 x 24mm and post dilated with 3 x 8mm NC balloon.

post procedure he was hemodynamically stable and repeat echo after one month showed improvement in LV systolic function from 30% to 50%