1016　Aggressive debulking strategy for LAD CTO in young male

[Target Lesion]

LAD-CTO with 40’s year-old male

[Strategy]

40’s year-old male complained chest pain during exertion, CAG showed LAD CTO with about 20 mm length. So PCI to RCA-CTO was attempted (J-CTO score 1) with normal renal function.

1. Antegrade (8Fr) and retrograde (7Fr) was set up.
2. Visualize CTO entry with IVUS from D1 or septal
3. Antegrade wiring with DLC and IVUS
4. Antegrade wiring with non-tapered CTO wire(including parallel wire technique) parallel wire technique
5. Retrograde wiring with non-tapered CTO wire(including knuckle wire technique)
6. rCART
7. stenting, if necessary debulking.

[Final Result]

1. success
2. IVUS from septal could only visualize CTO entry.
3. Ategrade wiring with Miracle Neo3 could get distal true lumen.
   a. IVUS showed discrepancy of vessel size and soft plaque characteristics.
   b debulking with DCA (atherocut M size) was performed with several cut.
   c flap was created after scoring balloon dilation (Wolverine3.25/10), however vessel was enlarged.
   d I decided to debulk flap with DCA (atherocut M size) was performed again with intentionally directed by new method for plaque orientation, to succeed removal of flap
   e Finally, enough lumen was obtained and DCB was delivered to end it with stentless.