

2002 The successful bail-out from CROSSER stuck in severe calcified SFA-CTO.

【Target Lesion】 SFA-CTO

【Strategy】

1. distal puncture (POP/ATA)
2. retrograde wire (including RWE/knuckle wire technique)
3. antegrade wire (including AWE/parallel wire technique/knuckle wire technique)
4. rCART or CART, if possible
5. POBA or stenting

【Final Result】

Several attempts of distal puncture at POP/ATA were all failed.

Antegrade wiring with ICHIBANYARI PAD2 + Cruise was started.

Antegrade wiring with Chevalier14 0.014 PL-X could cross until mid-CTO lesion due to severe calcification.

After CROSSER ablation, POBA with ULTRAVERSE 1.25*15mm until crossed lesion was performed.

Naveed 4 Hard15 made antegrade wiring to proceed distal, and CROSSER ablation and POBA with WALKER RX 2.0*20mm was performed.

Naveed 4 Hard30 made antegrade wiring to cross CTO lesion.

IVUS showed this route crossed sub-intima at distal.

After changing antegrade wire to Crusade PAD, Naveed 4 hard 15 was successfully crossed in true intima with parallel wire technique. And CROSSER ablation was performed.

CROSSER could cross CTO lesion, but could not be retrieved due to severe calcification.

Antegrade wiring with hard 0.035inch wire hip which was shaped mandatory could pass CTO lesion with spinning, and this space made WALKER RX 2.0*20mm to pass successfully.

CROSSER was successfully removed with no difficulty

POBA with Peripheral Cutting Balloon 6.0*20mm, stenting with ELUVIA 7.0*120mm/ELUVIA 7.0*80mm/ELUVIA 6.0*120mm, and in-stent post-dilation with Senri 7.0*100mm was performed.