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A case of intractable acute inferior myocardial infarction combining a large amount of thrombotic lesions with heavy calcified lesions.

[Case]The patient is a 61-year-old man with a lung cancer history who've been undergoing chemotherapy. He presented acute chest pain in the precordial region before going to bed. Urgent CAG revealed that RCA#1 showed a subtotal occlusion with a severe calcification, and RCA#3 showed a total occlusion with a large amount of thrombus. In addition, proximal RCA showed an anatomical shepherd's crook shape, suggesting grave difficulties in treatments. Aspiration using Thrombuster catheter failed to pass through due to the calcified lesions shown in RCA#1. The severe napkin-ring-shape calcified lesions also caused the balloon burst, when we performed the pre-dilatation with 3.5mm High-Pressure Balloon. We decided using Rotablator to debulk a heavy calcified lesion shown in RCA#1, nevertheless the culprit lesion in RCA#3 was no coronary flow. Combining external pacing and IABP supports, the treatment employed Rotablator 1.75mm for debulking the heavy calcified lesions. After this process, the Thrombuster catheter was able to pass the culprit lesion, a 3.5mm long balloon was used to hold down the whole thrombotic lesion. To stabilize the coronary flow and hemodynamics, we selected the stenting strategy for thrombotic RCA#3 lesions with a Ultimaster stent 4.0mm/24. And then, we deployed Xience stent 4.0mm/15 at RCA proximal, and add the post dilatation with Emerge 5.0mm balloon.[Conclusion]This case demonstrates the successful use of rotational atherectomy to facilitate dilatation and revascularization of a heavy calcified lesion in patient with acute inferior STEMI.