

**Case Summary.** This case represents the possibility that hinge motion could make coronary artery dissection at the edge of stent. We found the dissection thirty minutes later despite IVUS couldn't show any injury in the first PCI. It may be a risk factor to place stent edge in tortuous vessels with hinge motion. Additionally, a biolimus-eluting stent (NOBORI, TERUMO) has thicker strut (125  $\mu$ m) than other second-generation drug-eluting stents, which may be also the risk of the phenomenon.

**TCTAP C-112**  
**A Complex Calcified Lesion: A Lesson Learnt Twice!**

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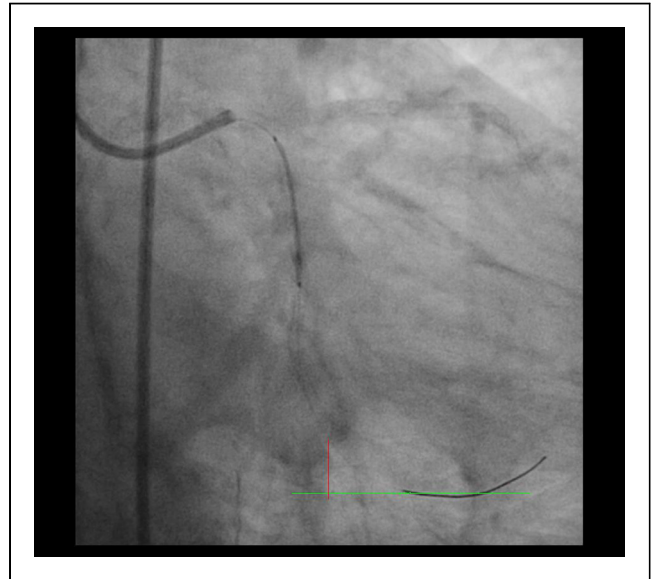
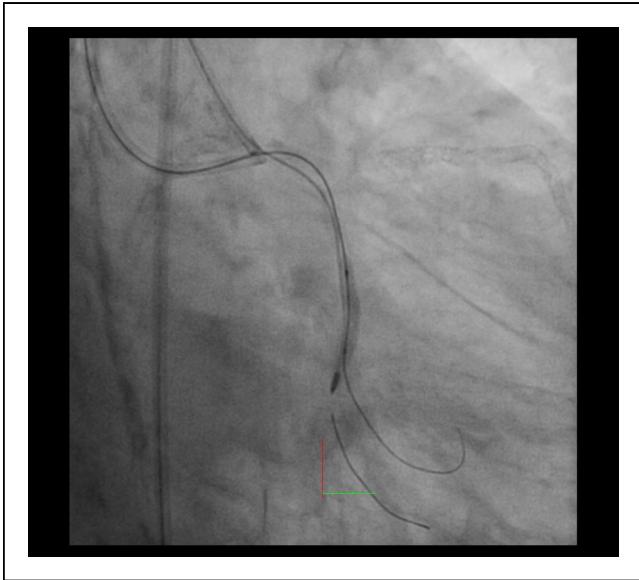
**[CLINICAL INFORMATION]**

**Patient initials or identifier number.** DDC

**Relevant clinical history and physical exam.** 83 year-old man with cardiovascular risk factors of DM, HTN and HLP. He had past history IHD with previous PCI done in 2000. He presented 3 years ago with recent onset of chest tightness on exertion and coronary angiography showed triple vessel disease. LAD and RCA were both stented with DES. LCX was calcified and diffusely disease and was left for medical treatment. 8 months later he presented with exertional angina and he was admitted for coronary angiography.

**Relevant catheterization findings.** Coronary angiography showed both LAD and RCA stents were patent. The LCX was diffusely disease with significant lesions from proximal to distal.

The decision was for PCI to LCX.



**[INTERVENTIONAL MANAGEMENT]**

**Procedural step.** Right radial approach with used with 6 French XB 3 guiding catheter. LCX was wired but the balloon was difficult to pass to the distal lesion despite using buddy wire technique. 1.0 mm balloon also failed to cross. Wire was exchanged for Rotalink wire and 1.25 mm burr was used. However, the rotablator burr was stuck in the mid LCX at first pass. Attempted to pullback was unsuccessful but the burr was able to push forward. A few runs were made to the distal LCX. With a bit of force the burr was removed from the vessel.

Although 2.0 mm balloon was able to dilate the proximal and mid LCX, there was another tight spot in distal LCX. Same burr was used to for the distal LCX. The burr was again stuck in the distal LCX after the first pass. However this time, it was not possible to remove even with brute force. The distal LCX flow was compromised and patient was having chest pain. A 7 French XB3 catheter was introduced through right femoral approach and LCX was wired. The intent was to wire the LCX passing the stuck burr and put a balloon down to dilate the lesion and release the burr. However the wire was unable to go distal LCX but a side branch near the stuck burr. Balloon was delivered and dilated within the LCX near the burr. After the dilatation, with some force, the rotablator burr was successfully removed from the LCX.

The lesion was rewired and with high pressure NC balloon, the lesion was successful dilated and stented with 2 DES.



**Case Summary.** Severely calcified lesion is challenging and procedure may be prolonged or even failed. In our case, the lesion was severely calcified and rotablation was mandatory to achieve an optimal outcome. Even with the smallest burr, it was stuck, not once but twice, in the LCX.

There are many methods to remove stuck burr. If a wire and balloon can pass the stuck burr, dilatation at the site will release the burr. However, the lesions are usually too tight for anything to cross. Balloon dilatation adjacent to the stuck burr may also break the calcium at the plaque and release the burr. In our case, there was a side branch near the burr which we could use to dilate and release the burr.

**TCTAP C-113**

**A Lesson to Learn from an Octogenarian with STEMI**

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**[CLINICAL INFORMATION]**

**Patient initials or identifier number.** WSK

**Relevant clinical history and physical exam.** Ms. W was 85 years old with past medical history of diabetes mellitus, hypertension and dementia.