

M-CATH Microcatheter Excellent Control in CTO

Case Study n.4

Easy crossing of a mid – RCA

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Introduction

A 65 year old gentleman with stable angina symptoms was found to have two vessel disease on coronary angiography, namely mid LAD and mid RCA. He underwent a first elective PCI to mid LAD and subsequently presented for a staged rotablation to a complex calcific mid RCA lesion (Fig A). His background includes hypertension, hyperlipidaemia, ex smoker, FH IHD and raised BMI.

Case Report

During the first procedure, the operator after treating the mid LAD via the radial approach also had an attempt at the mid RCA. The mid RCA lesion was crossed with a Choice PT wire and subsequent attempts to cross the lesion with a 1.2 Trek semicompliant balloon proved unsuccessful despite use of guideliner to provide maximal support. Decision was then made to stop the procedure and bring the patient back for a staged rotablation to mid RCA using an 8F AL1 guide through the right femoral. The lesion was once again crossed with a Choice PT XS wire and the M-Cath (Acrostak) microcatheter (Fig B) was advanced easily across the lesion. After exchanging the Choice PT XS wire for the rotawire, rotablation was performed using a 1.5 burr (Fig C). the lesion was dilated with a 2.5 mm up to a 3.5 mm semicompliant ballon, followed by a 3.5 mm scoreflex to 16atm. Finally the lesion was stented with a 4.5x18mm zotarolimus eluting stent to 15atm with good result (Fig D).

Conclusions

In complex calcific subtotal occlusions where conventional low profile balloons are unable to cross the lesion, the use of a supportive low profile microcatheter, with superior pushability, such as the M-cath, can facilitate bail out rotablation and an excellent final result.

