If one is blind and weak -> Hit and run...

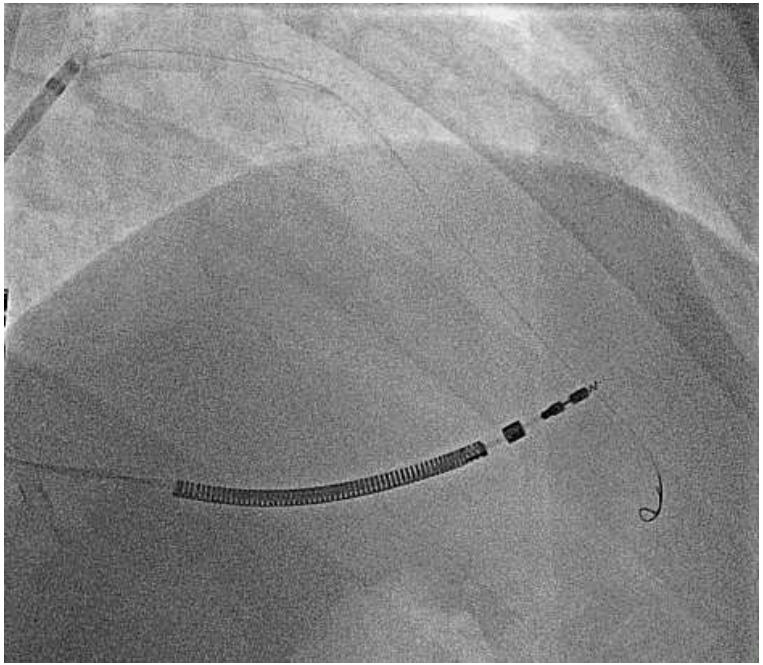
Shockwave for prox cap puncture facilitation

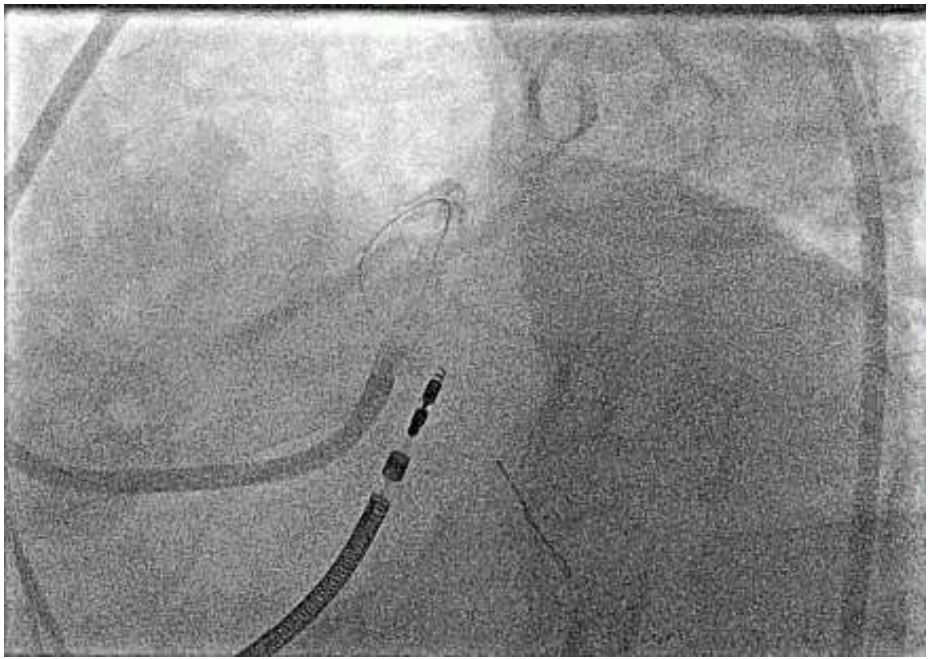
Konstantin Schwarz

Sankt Pölten, Austria

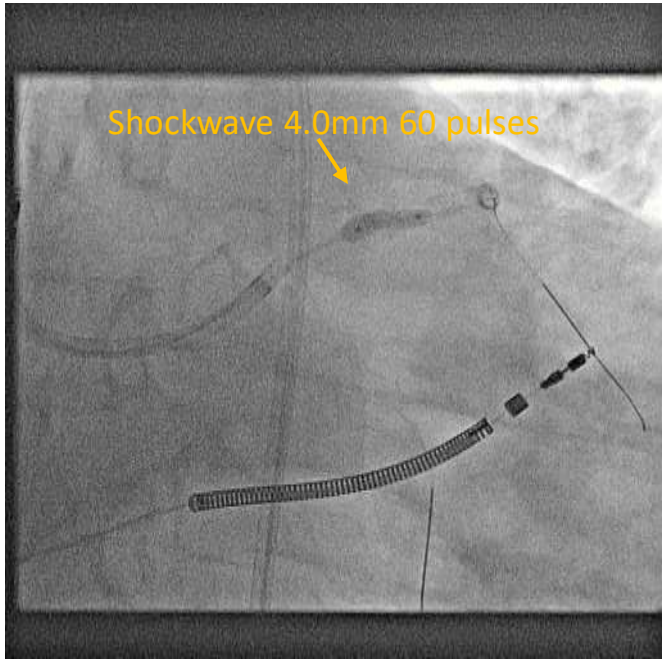
66m CCS2 and dyspnea
HFrEF, ICD, viability +

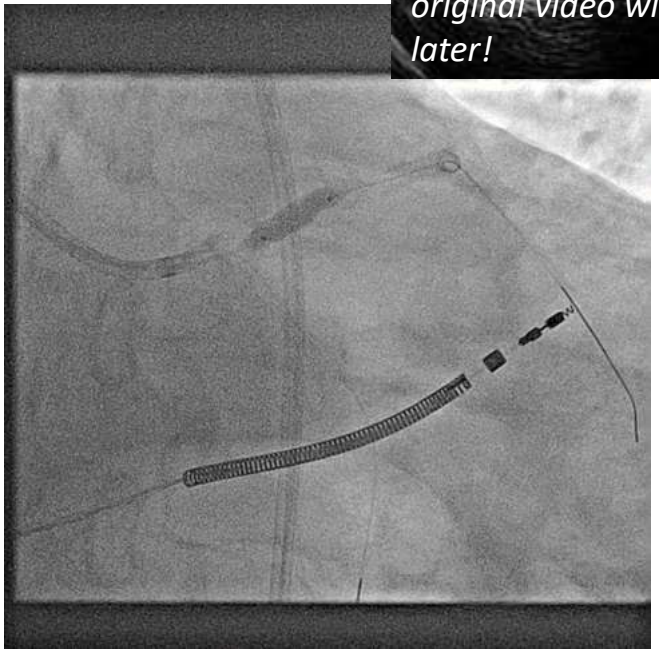
1st diagonal flush occluded, prox cap unclear (IM?)





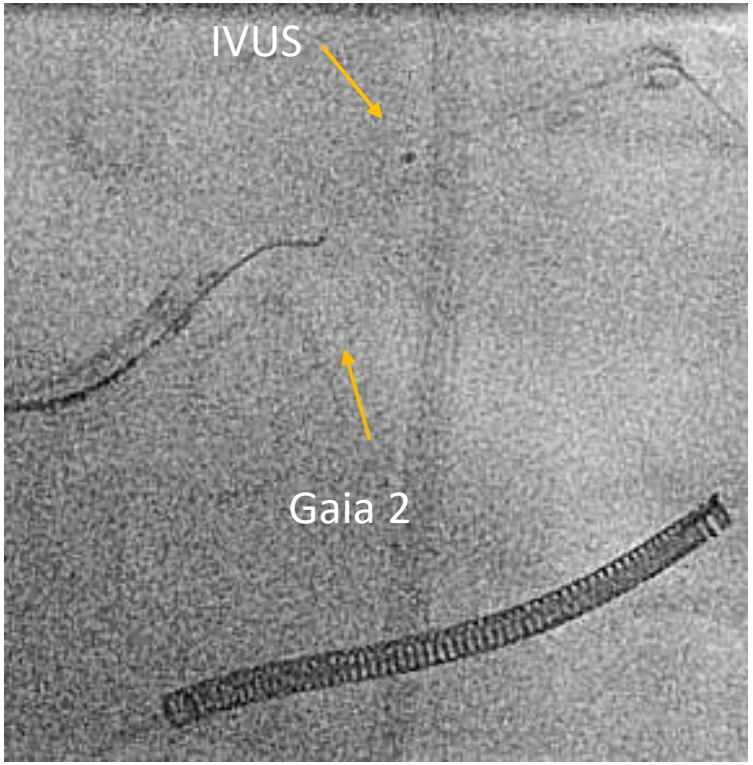
- 8F femoral and 6F radial (BP monitoring and ready for ping-pong , no collaterals from right)
- IVUS prox LAD **360^{o} deep calcium**, diag origin (pCap) **not visible**



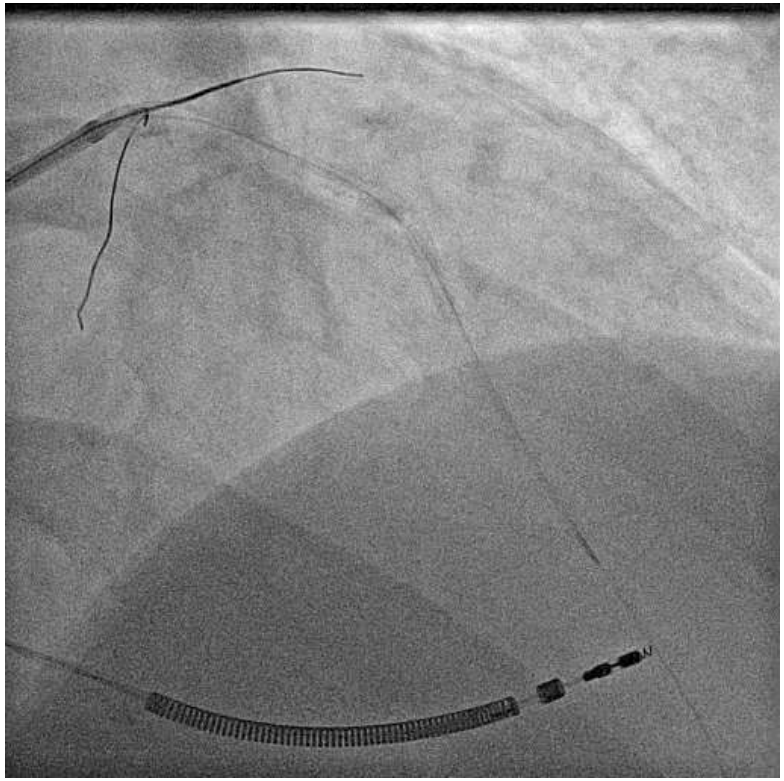


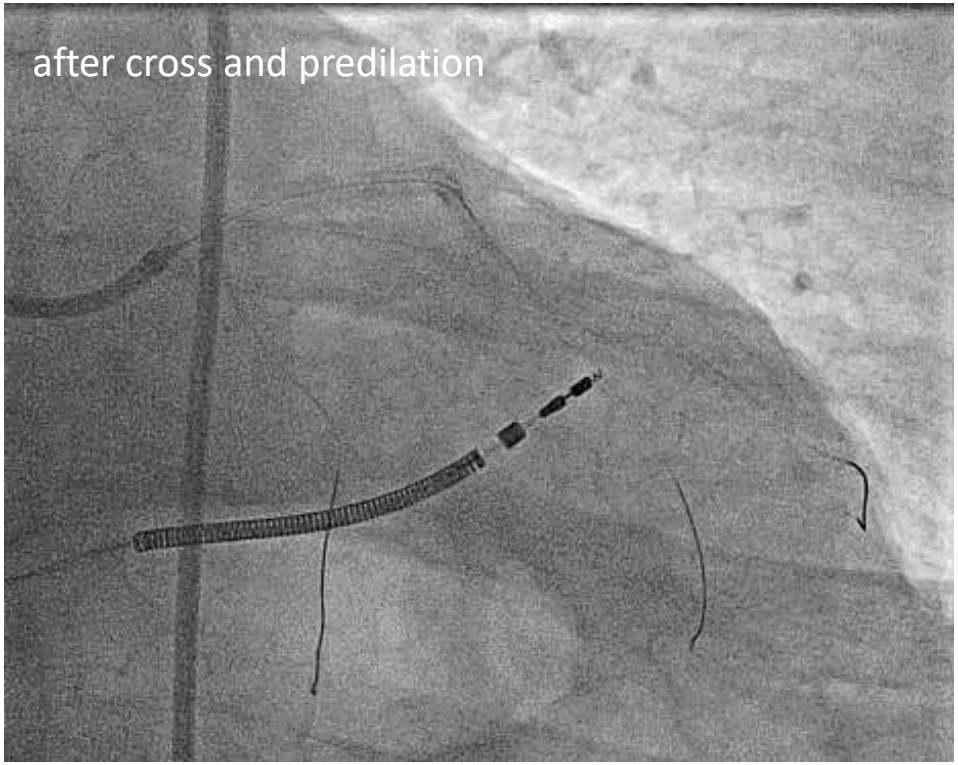
re-IVUS
Cap puncture with Gaia 2 (TP spiral)

Post IVL Bifurcation/Diag origin better visible

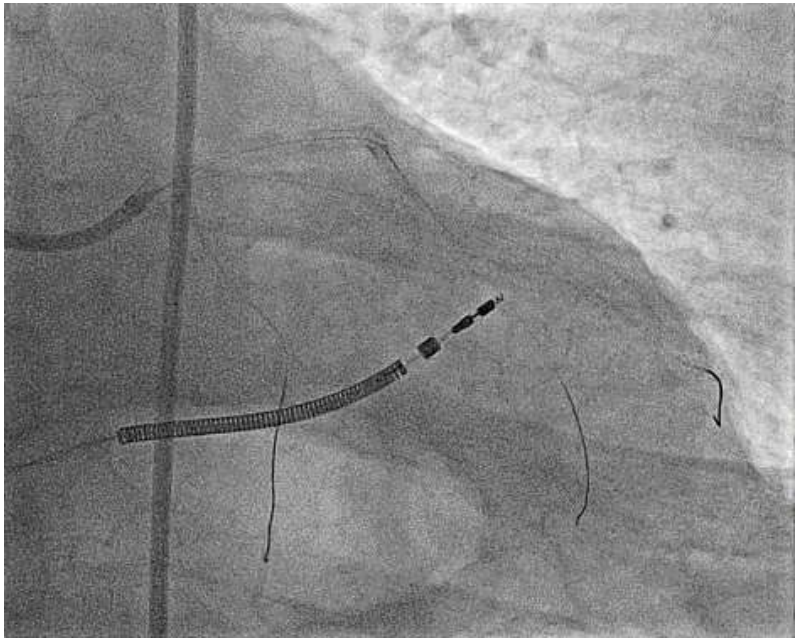


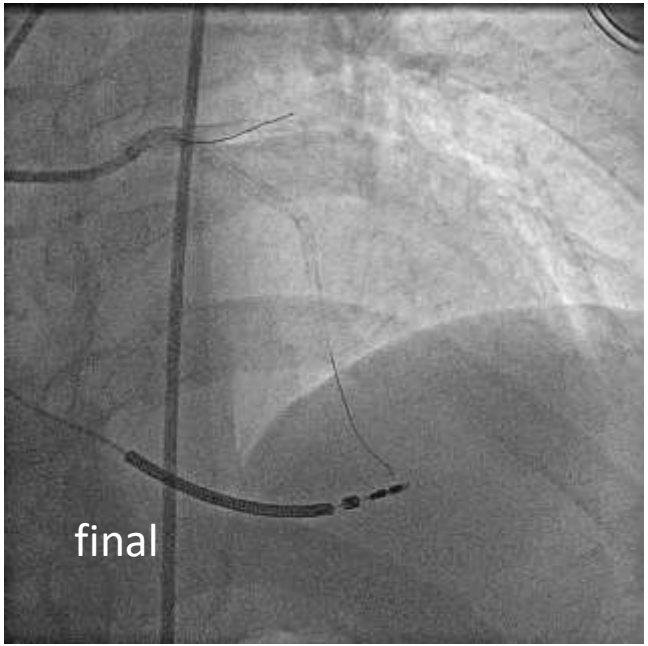
TP spiral
Gaia 2 in > gladius MG > gaia 3 > gladius MG





DK NanoCrush

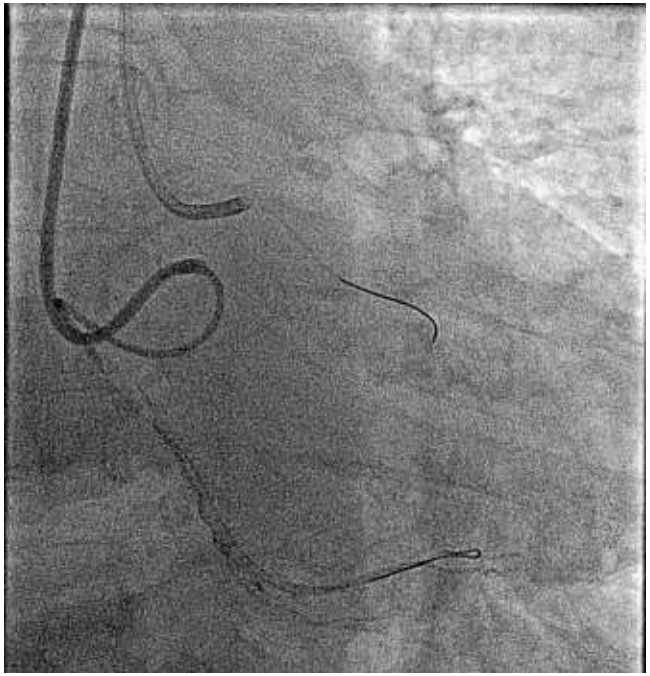


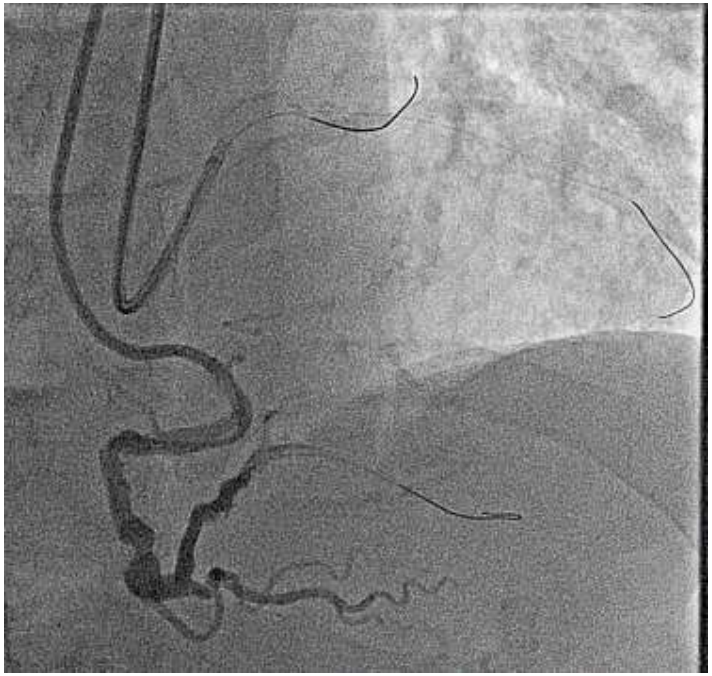


CASE 2

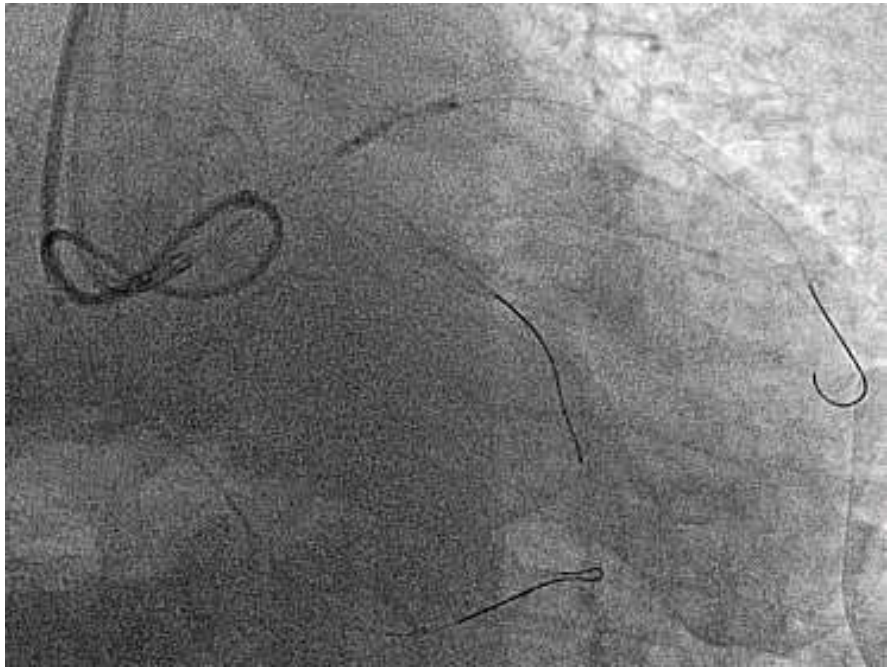
76m
PMH tb added
1x Failed previous attempt

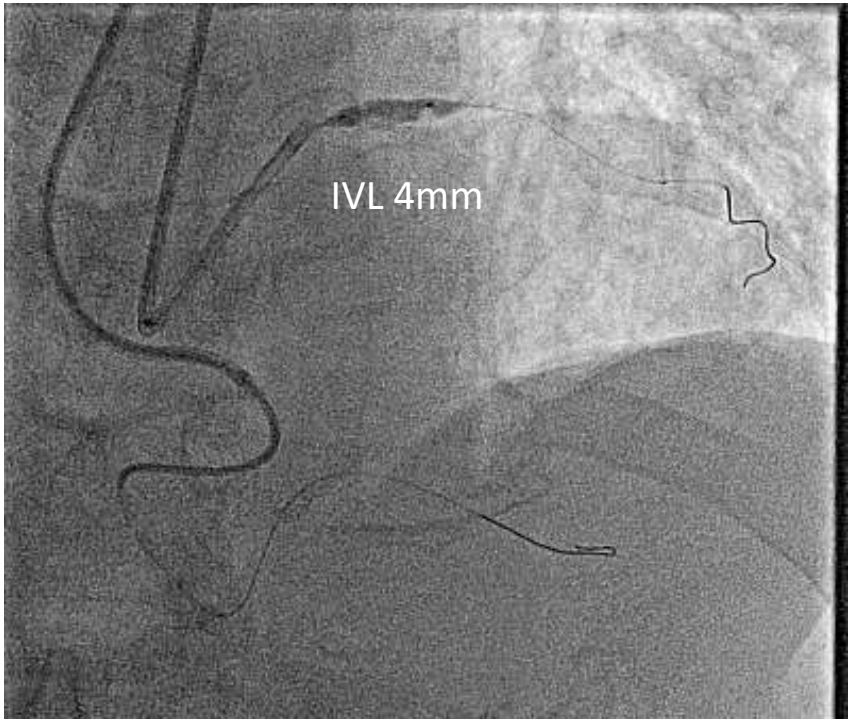
Occluded LAD, heavily calcified
Biradial 7F

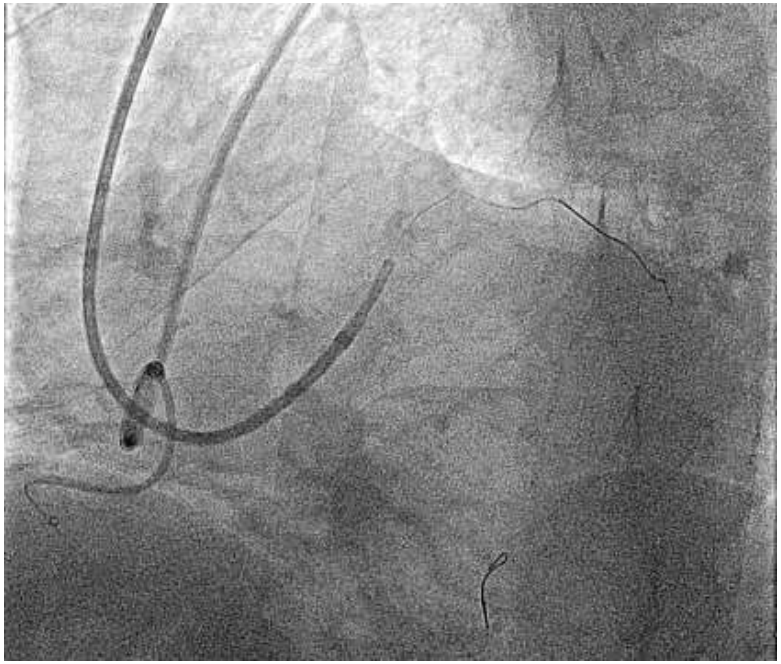




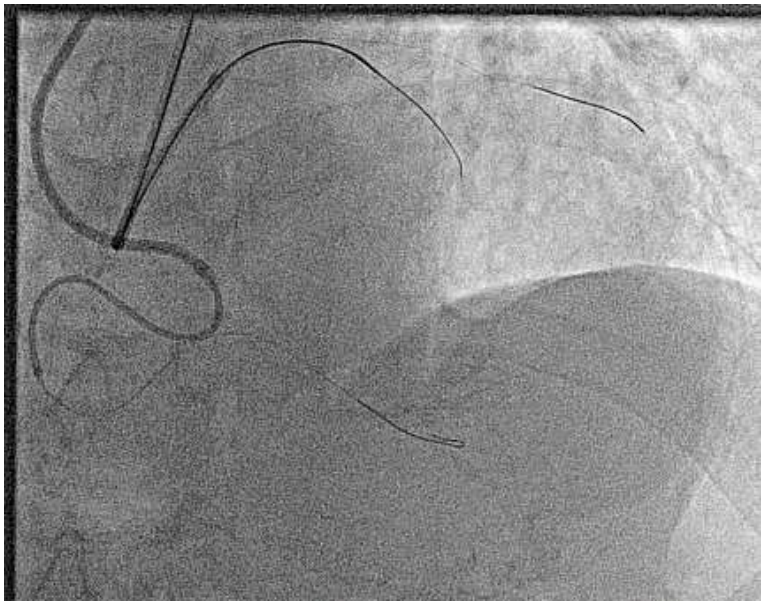
Wire in diag and 2.0 NC balloon predil- dog boning … **OPN** 2.0 40atm > **Shockwave** 4.0 - 80 pulses



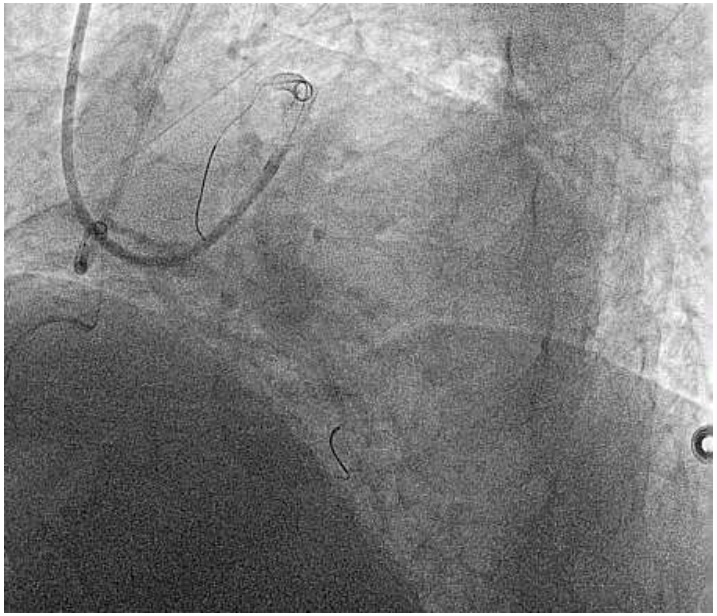


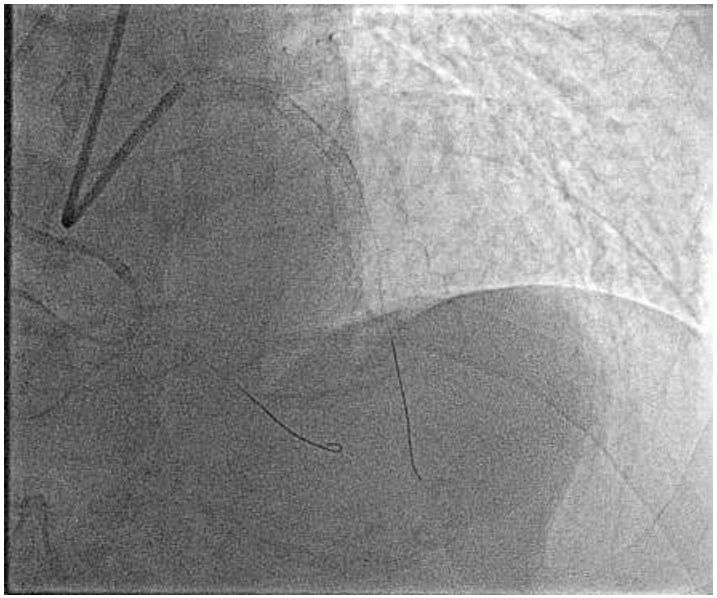


Prox cap via Ca fractures
with
Gladius MG (corsair pro)



Final





Summary

Intravascular lithotripsy in SB =

useful adjunct for **visualisation** and to **facilitate puncture** of flush occluded CTO caps

360^{o} deep calcium in SB and no clear bifurcation

--> consider IVL early to disrupt Ca and identify bifurcation=proximal CTO cap

Thank you