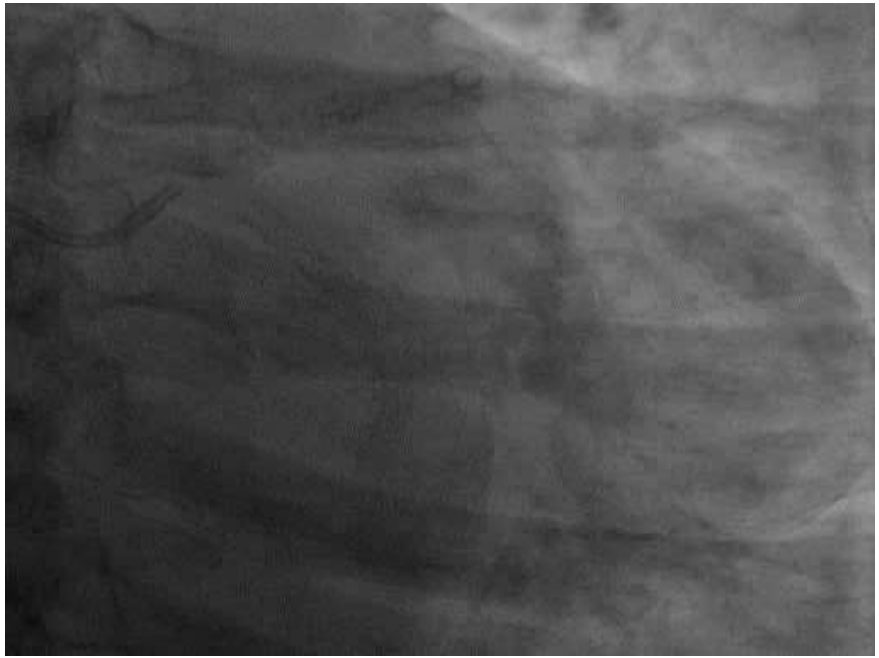
When your weapon turns back to your chest!!

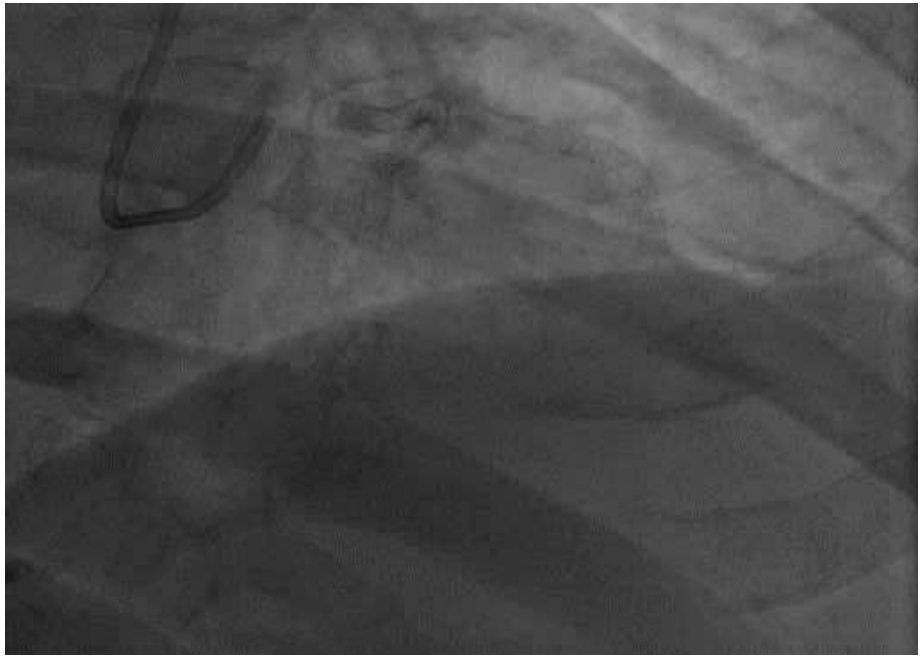
- A case of incarcerated rotaburr

Brief History

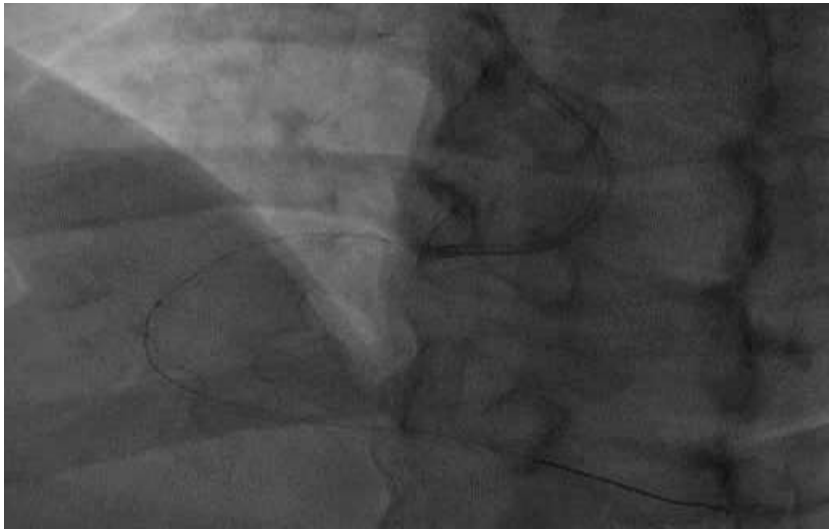
- 63 y , male
- HTN and Type 2 DM
- SCAD , +ve TET
- 2 weeks before he did PCI with DES to p-m LAD and m-d LCX
- Echo : No RWMA , Mod MR , DD grade 2 ,LVEF 65%
- ECG :Non specific ST-T wave changes
- Target lesion : fix RCA CTO
- Strategy : Antegrade wire escalation, consider ADR

Coronay angiography

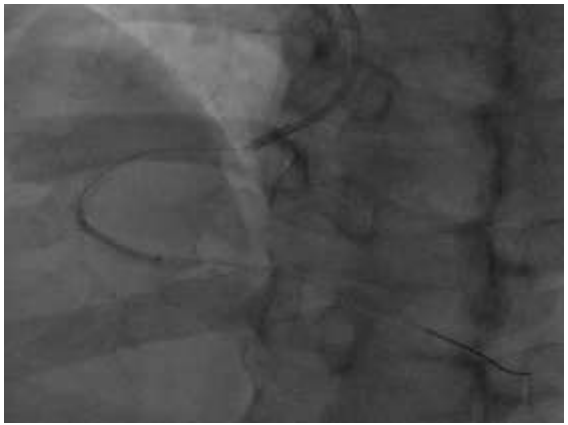


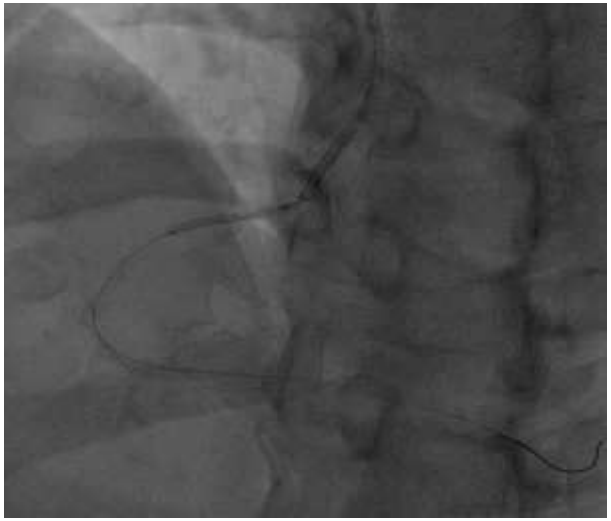


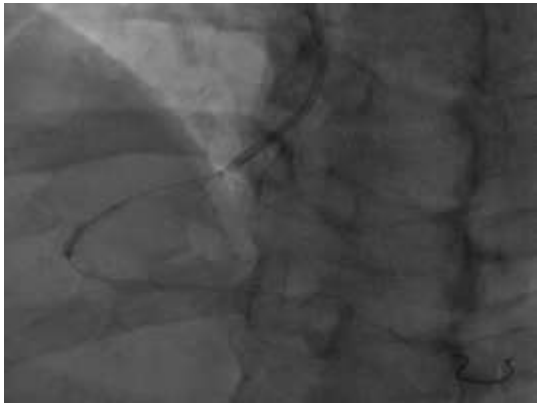
Using 7F SAL1, Sion blue GW successfully crossed to distal PDA with support of Finecross



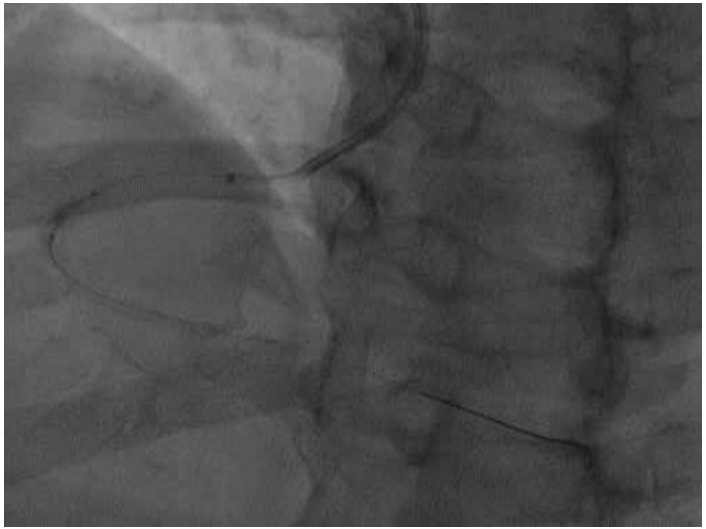
Balloon advancement with guideliner support, But still some waist in mid RCA



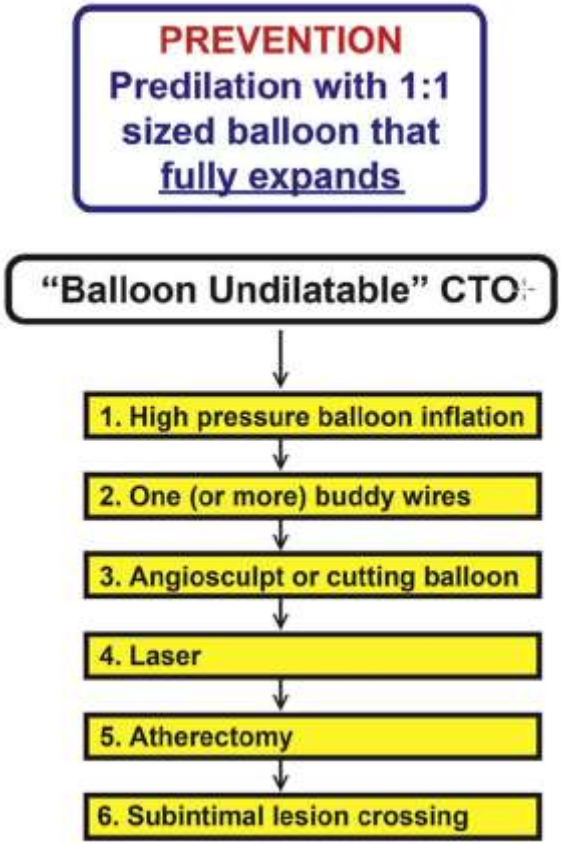




NC Emerge 2.0x15mm upto 26 atm

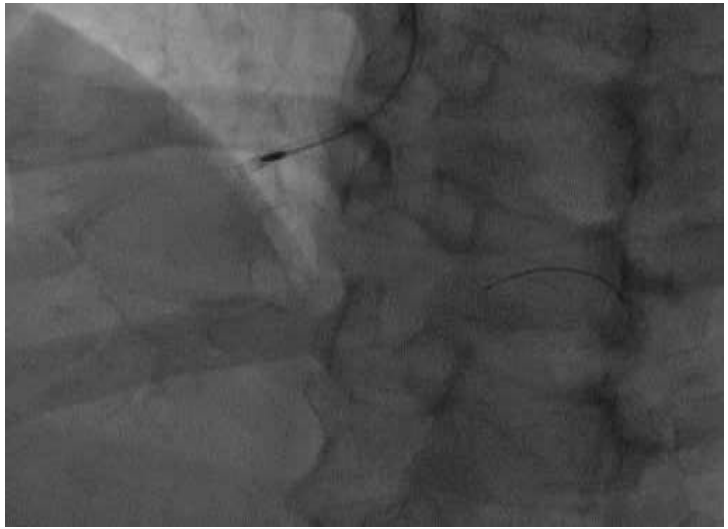


Undilatable lesion
(by Dr.Brilakis)

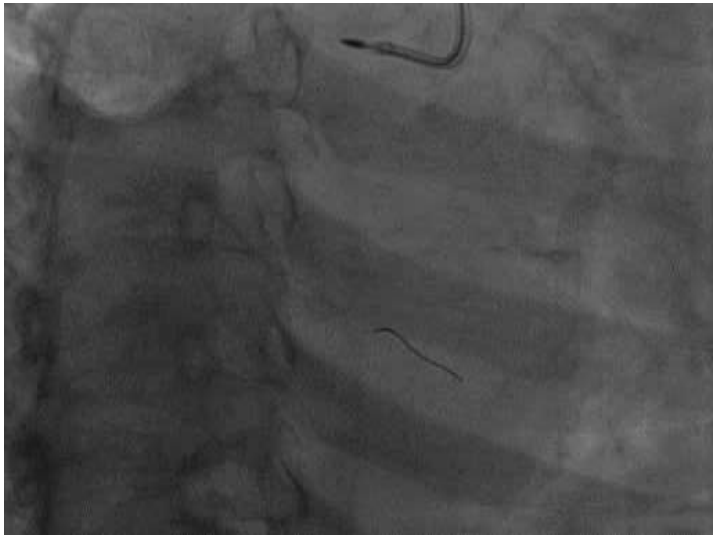


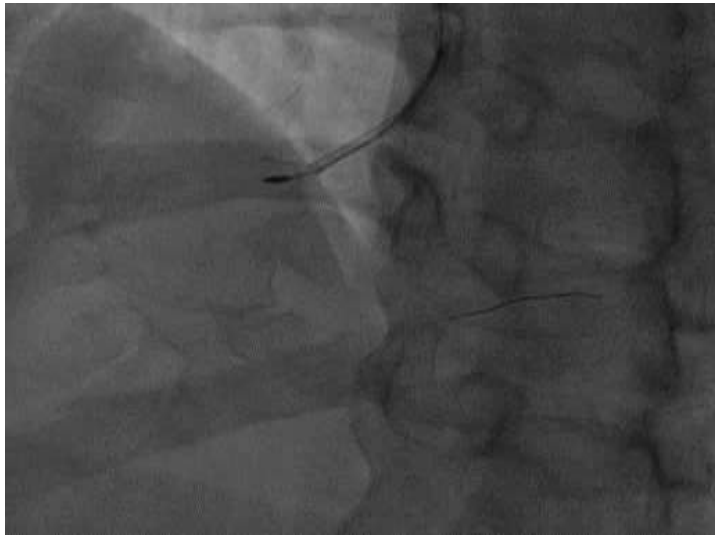
Rotablation

1.5 mm burr at 180.000 rpm for 30 seconds x 3times , Bradycardia , transient 2:1 block intermittent with complete A-V block which recovered spontaneously after stoppage rotablation
Atropine 1mg given

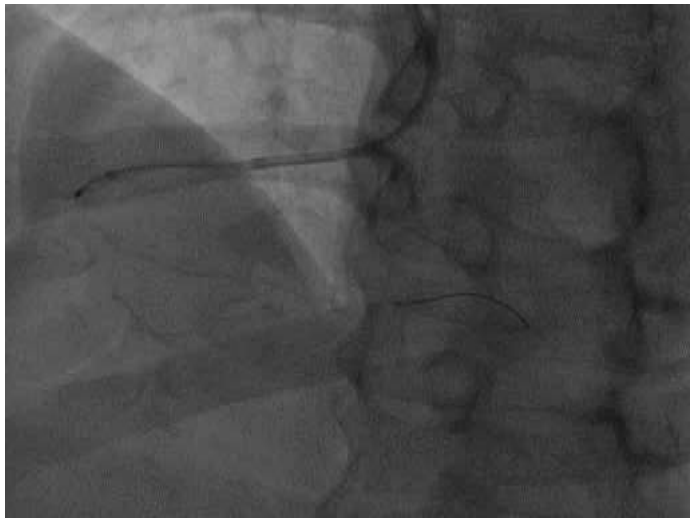


Os-RCA dissection was noted





Finecross was used to exchange rota wire to sion again then Corsair MC

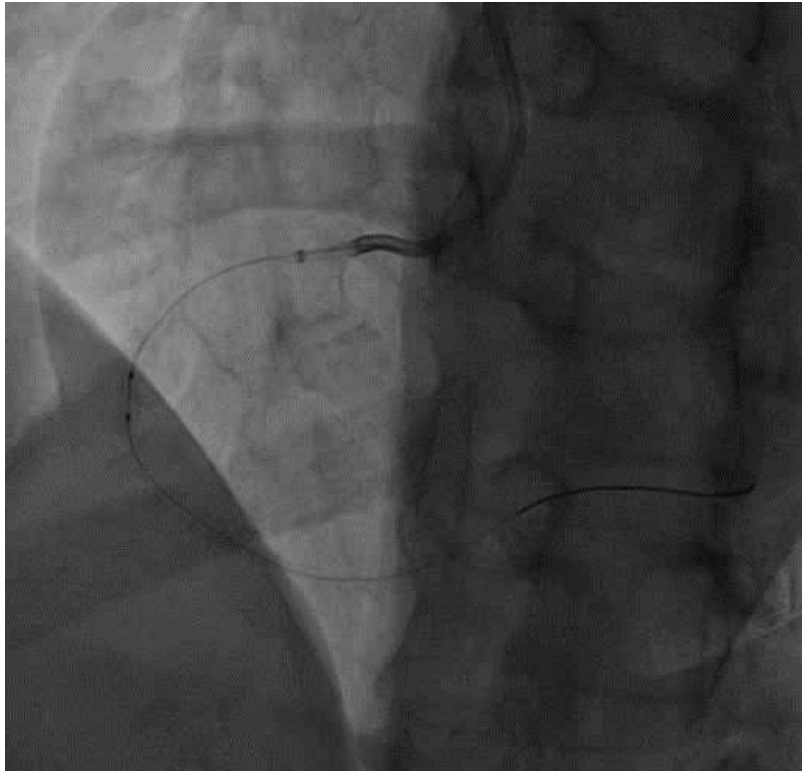


Turnpike gold

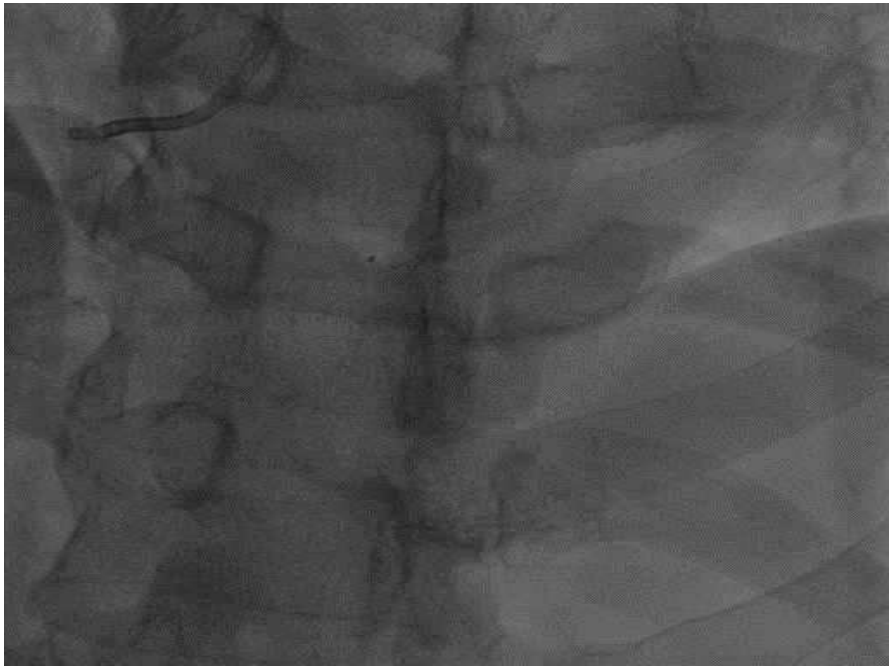
Turnpike stuck in m-RCA and was removed by advancing Guideliner

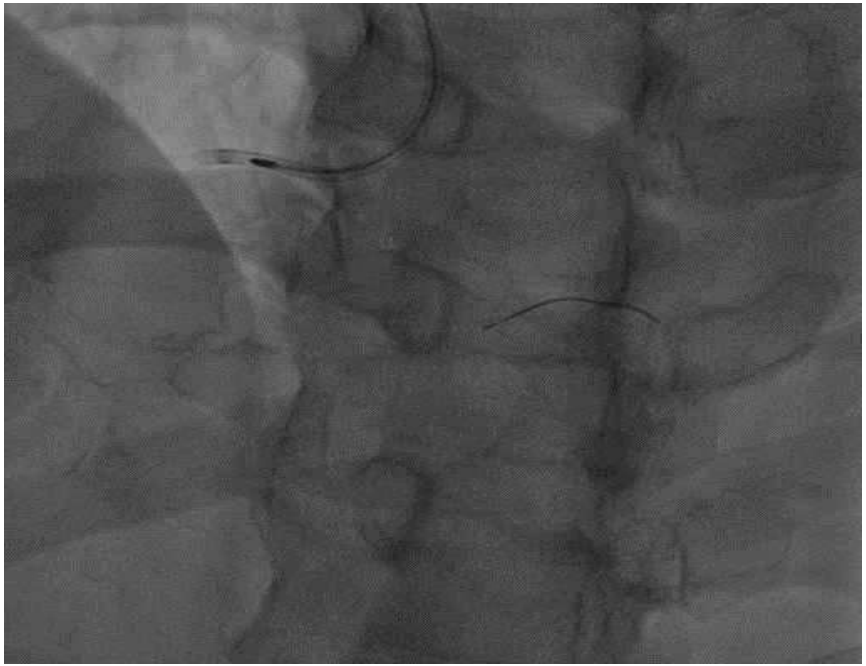
NC Trek 2.5x15 and NC Emerge 2.5x8 mm upto 18 atm failed to open the lesion at m-RCA

grenadoplasty

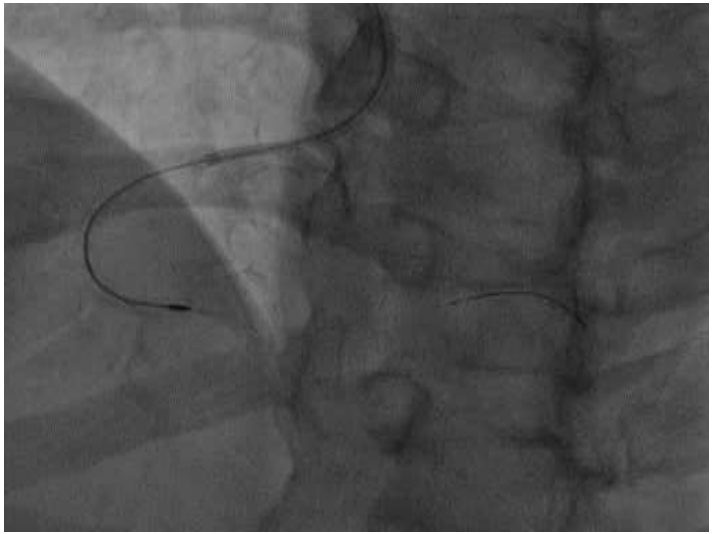


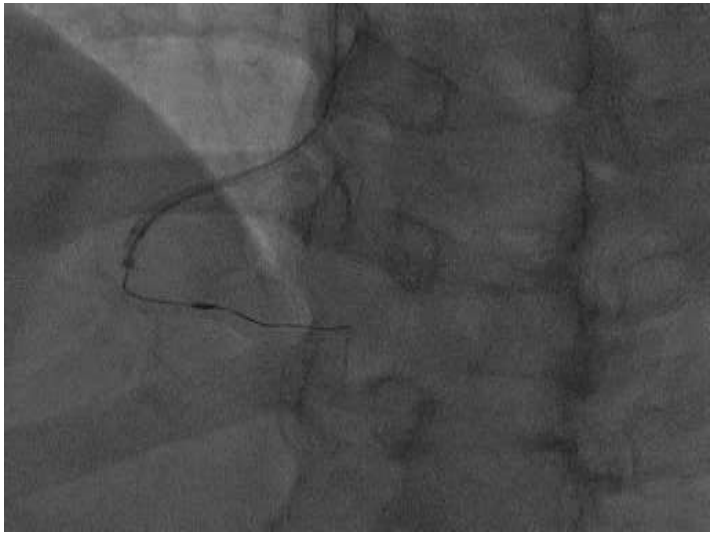
Sion GW was changed to rota wire (with Finecross), 1.25 mm Rotaburr was used at 180.000 rpm





but it was incarcerated at the calcified lesion
Rota retrieval by 5F ST01 and 5.5F guideliner

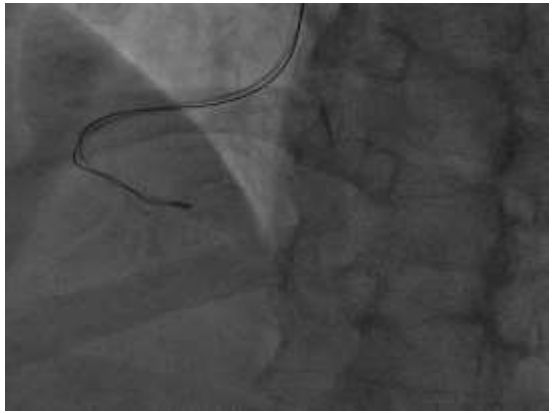


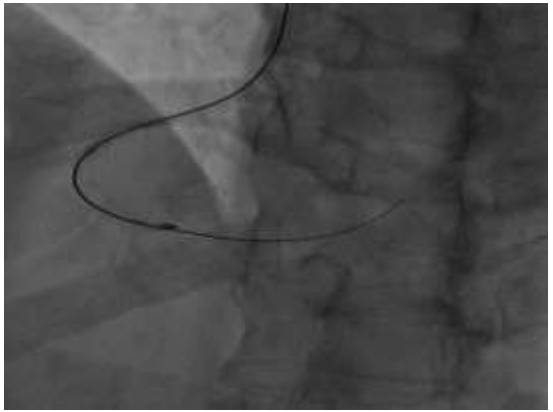



STOP | START
DISASTER RECOVERY PLAN

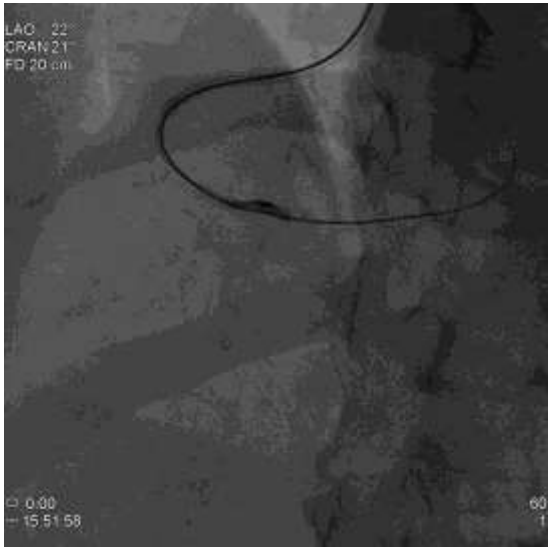
- Rotaburr was cut, Y-connector removed, ST01 advanced under non invasive BP monitoring

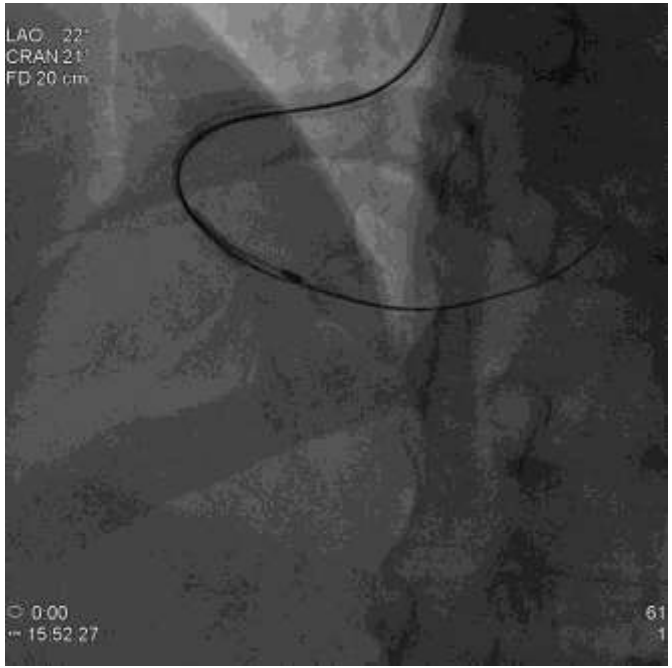
UB3 was tried to cross to distal RCA but failed
and conquest pro successfully passed subintimally at trapped burr site



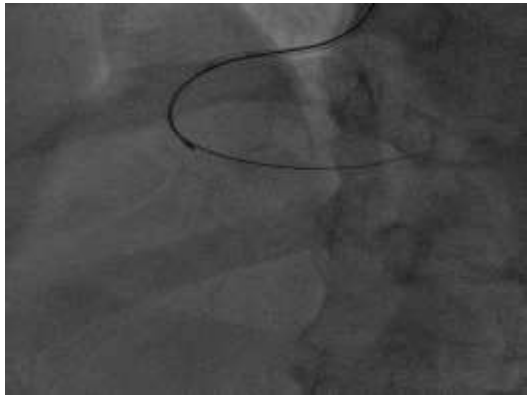


Sapphire 1.0x5mm then 1.2x6mm at burr site and Mini Trek at m-d RCA

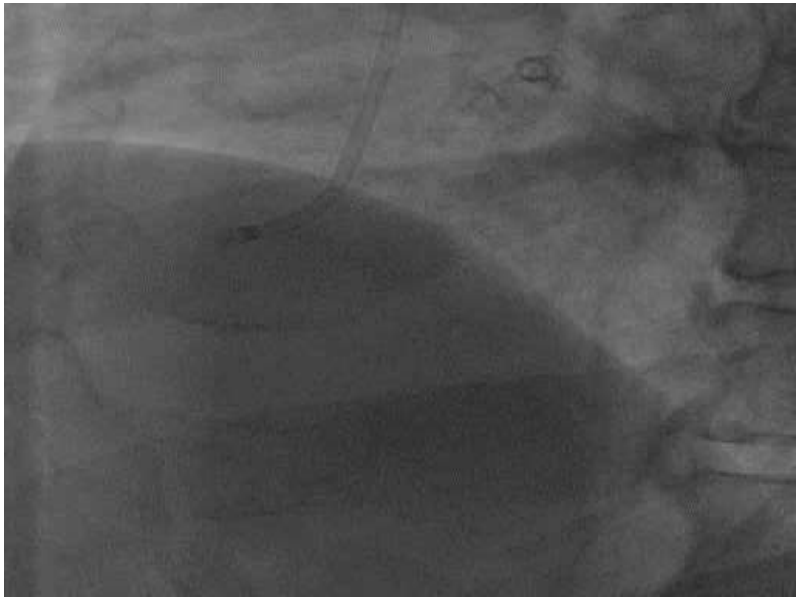




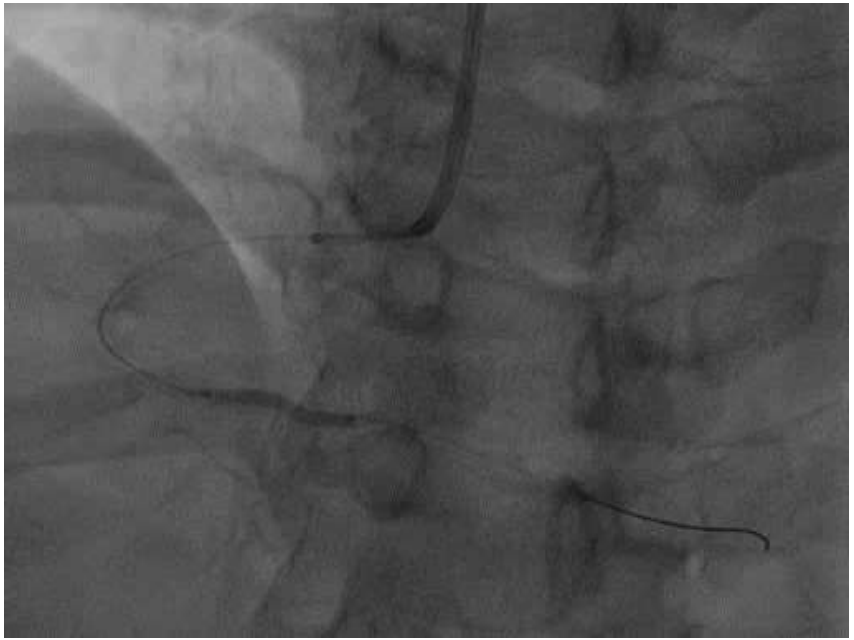
Rotaburr was successfully removed with guidewire waithdrawn together smoothly using another ST01



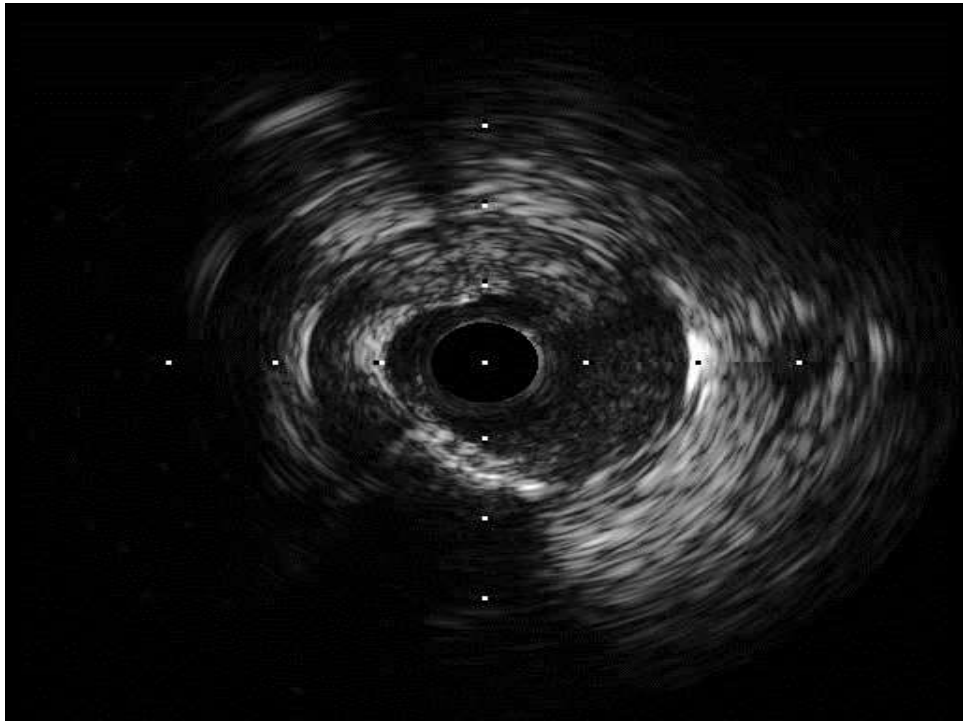
Spiral ostial dissection was noted
(catheter jump in during burr retrieval) catheter was changed to 6F JR4



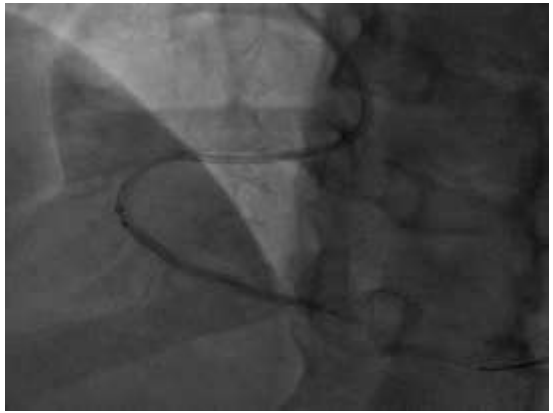
Runthrough guidewire was davnced to distal PDA
predilatation under guideliner support
Accuforce 2.5x15mm upto 20 atm

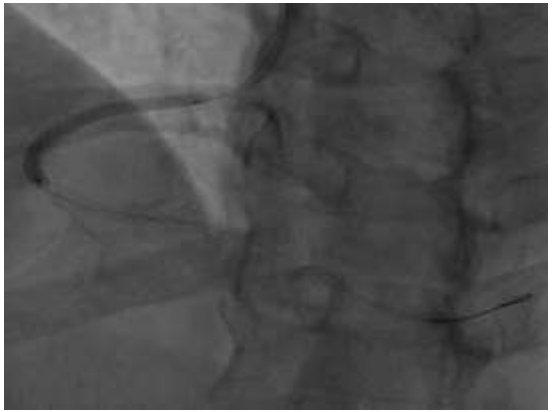


IVUS

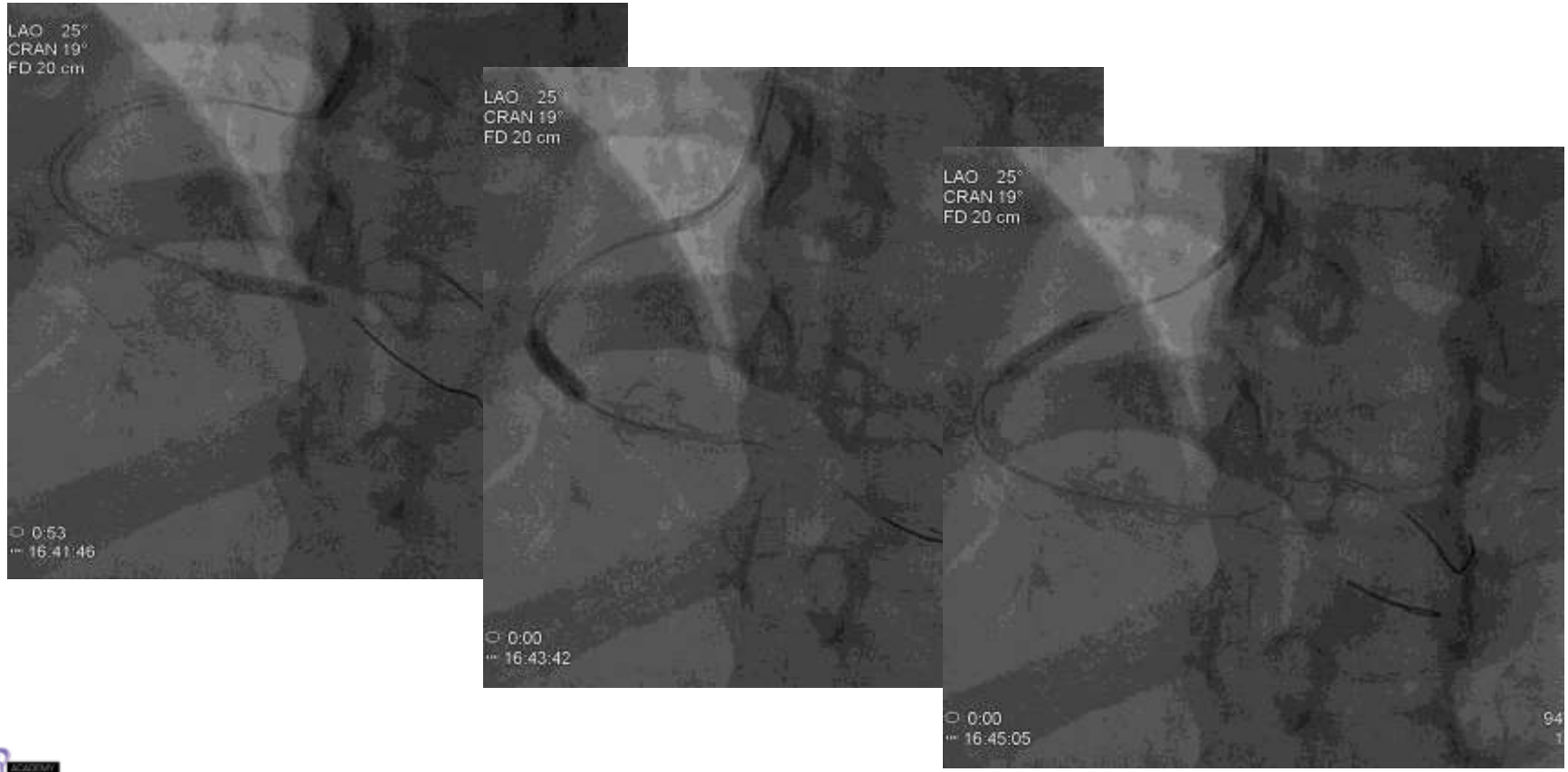


2 long DES Xience 2.5x48 and 3.0x48 mm from distal to ostial RCA upto 16 atm

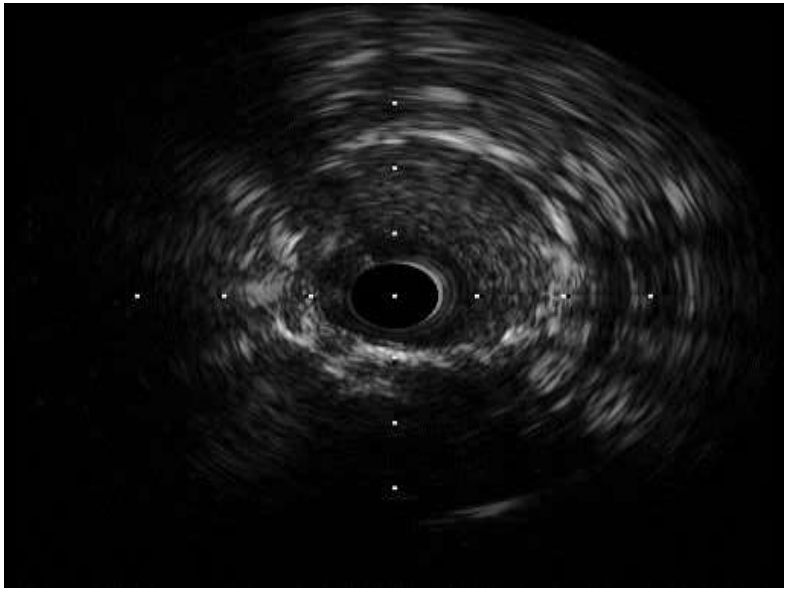


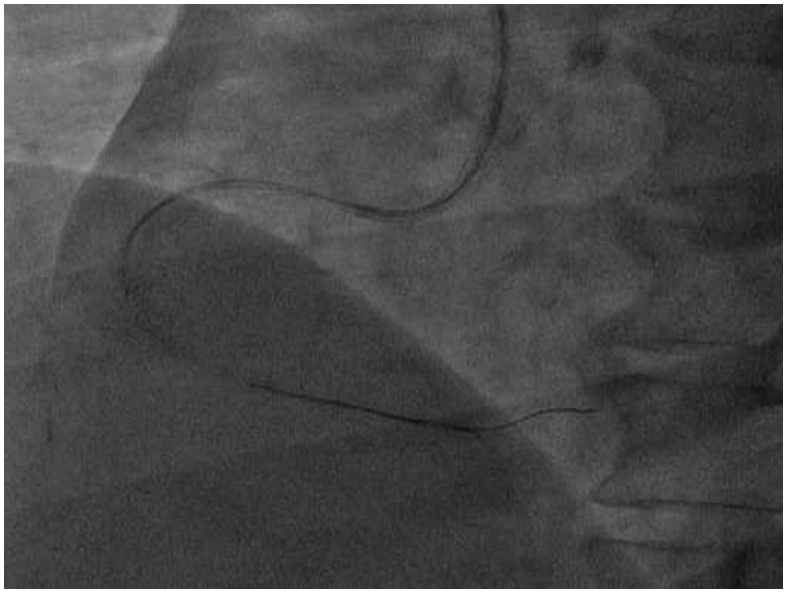


Postdilatation with Accuforce 3.0 for d-RCA , 3.5 mm for m-RCA and 4.0mm for p-RCA

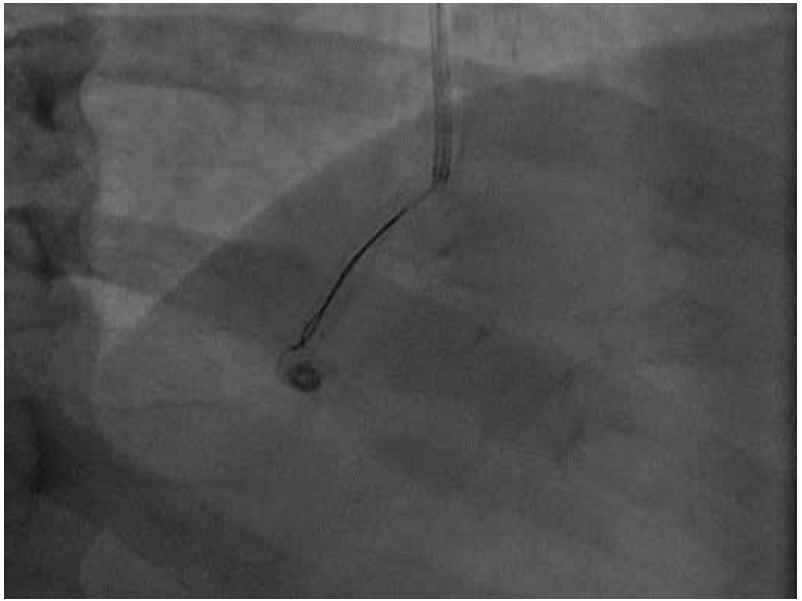


Repeat IVUS; good apposition , no stent edge dissection





Final Result



Take Home Message

- ✓ Dealing with heavy calcification is still a big WAR which needs various WEAPONS to deal with.
- ✓ Having good PLAN with good alternative plans is the key of success
- ✓ You should know how to deal with every complication using appropriate tools.
- ✓ When dealing with complications, first step is to keep calm and think carefully; What is the PROBLEM ? How to fix?

Thank You