

coraForce™ Provides Support for RCA Occlusion

CASE HISTORY

The patient was a 68-year-old male with a history of exertional chest pain (CCS III), despite optimal antianginal therapy and dyslipidemia. Diagnostic imaging showed a medium, partially reversible perfusion defect of severe intensity in the inferior region of the heart. Due to the progressive nature of his symptoms, despite medical therapy, the patient underwent an invasive coronary angiogram which showed an occluded right coronary artery (RCA) stent, which filled via collaterals from the left anterior descending (LAD) artery.



Baseline angiography

PROCEDURE

Ultrasound-guided cannulation was obtained through both the left and right common femoral arteries. An 8F AL .75 90cm guide catheter was used to engage the RCA and a 7F EBU 3.5 90cm guide catheter was used to engage the left main. Dual injection angiography was performed. The angiogram indicated a high-grade stenosis of the RCA. A previously placed stent appeared to be in the chronic total occlusion (CTO) segment. The distal right coronary artery, right posterior descending artery, and posterolateral branch were visible via LAD contrast injection.

PHYSICIAN



Vinod Nair, MD

Interventional Cardiologist,
Cardiovascular Institute of
the South

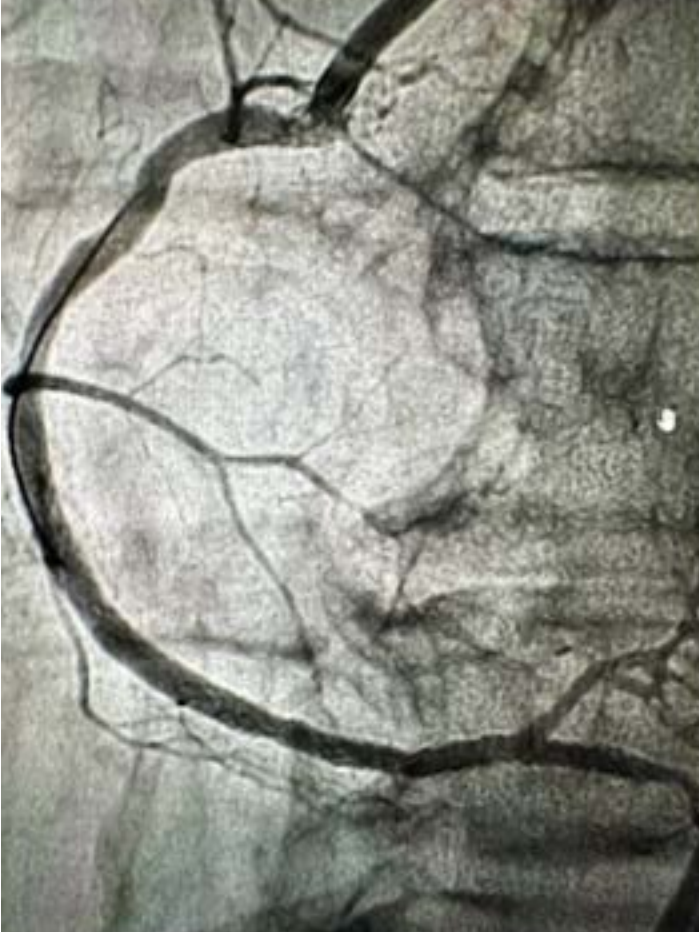
"The coraForce microcatheter was able to engage the proximal cap of the CTO with ease and facilitated successful CTO crossing with the Fielder XTA, without difficulty."

Dr. Nair is a Board-Certified Interventional Cardiologist who received his undergraduate degree from Malabar Christian College. He completed his Internal Medicine Residency in the Bronx in New York City followed by a fellowship at Long Island College Hospital. He subsequently completed his Interventional Cardiology Fellowship at Maimonides Medical Center in Brooklyn, NY. He joined Cardiovascular Institute of the South in 2005.

PRODUCTS USED



coraForce™ Provides Support for Crossing



Post angioplasty

Dr. Nair attempted to cross the right CTO lesion with a Sion® blue guidewire that was unable to puncture through the proximal cap. The decision was made to escalate to a Fielder™ XT-A guidewire with a coraForce™ 135cm microcatheter. The guidewire and microcatheter were able to cross the in-stent CTO. The Fielder XT-A guidewire was exchanged for a Sion® blue. This was followed by IVUS-guided PCI with balloon angioplasty and stenting into the right posterior descending artery utilizing a 2.5 x 38mm drug-eluting stent, followed by balloon angioplasty and stenting of the proximal portion of the distal RCA utilizing a 3.0 x 34mm drug-eluting stent. The proximal stent was then further post dilated to 3.5mm using a noncompliant balloon. A final image was obtained, and the groin access sites were closed.

CASE CONCLUSION

Successful revascularization of an in-stent CTO of the RCA. The coraForce microcatheter was able to engage and cross the proximal cap following a Fielder XT-A guidewire. After repeat IVUS interrogation, good expansion and apposition of both stents and TIMI-3 flow were demonstrated.