

# coraForce® Provides Support to Cross a Distal Right CTO

## CASE HISTORY

A 55-year-old male with a pertinent past medical history of coronary artery disease, diabetes, hyperlipidemia, and tobacco use presented to our office with complaints of retrosternal exertional chest pain with physical activity. The patient was referred for a left heart catheterization which indicated two-vessel disease, including in-stent left anterior descending (LAD) disease as well as an in-stent right circumflex artery (RCA) chronic total occlusion (CTO). The patient underwent LAD percutaneous coronary intervention (PCI) followed by brachytherapy and returned for complete revascularization of his RCA CTO.

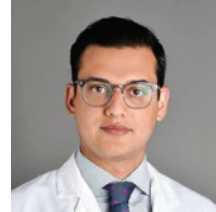


Baseline angiography

## PROCEDURE

Right radial access was obtained and a 7F sheath and 7F 3D right guide were placed into the RCA. Additional access was secured with a 6F sheath in the left radial and an EBU 3.5 guide catheter was placed into the left main. Dual injection was performed for improved visualization of the chronic total occluded (CTO) segment.

## PHYSICIAN



### Nygal Borges, MD, ACC, AHA

Interventional Cardiologist, Peripheral Endovascular Interventionalist, Cardiothoracic Imaging at Atrium Health Sanger Heart & Vascular Institute Kenilworth

*"CoraForce tracked well through distal RCA ISR CTO and was able to torque very well through tough lesions."*

Dr. Borges was valedictorian at the University of Kentucky College of Medicine. He completed his residency at Vanderbilt University Medical Center and his fellowship in cardiovascular disease at the Cleveland Clinic. Dr. Borges specializes in complex coronary artery disease, high-risk coronary interventions, chronic total occlusions, structural heart interventions and peripheral vascular interventions.

## PRODUCTS USED



## coraForce® Provides Support for Crossing

A SION blue™ guide wire was placed through the right radial guide to the proximal cap of the RCA CTO. The SION blue was unable to penetrate the proximal cap. Further wire escalation was performed. The proximal cap was crossed using a Gaia Next® 3 guide wire and coraForce® microcatheter. The wire was able to navigate down into the posterolateral branch with the coraForce following. After crossing with the coraForce, the wire was exchanged for a SION blue wire. The vessel was dilated with several noncompliant balloons to obtain full expansion. The posterior descending artery was then able to be wired and dilated with a balloon. IVUS imaging was performed and indicated that the previously deployed stent was undersized.

### CASE CONCLUSION

Aggressive balloon dilation was done and stents placed from the right posterior descending artery (RPDA) back to the mid RCA. A 2.75 mm x 28 mm drug eluting stent (DES) was placed in the RPDA extending into the RCA. The distal RCA was postdilated with a 3.25 mm NC balloon followed by the placement of a 3.5 mm x 24 mm DES. IVUS images were obtained to ensure proper sizing and apposition of the stents. All stents were post dilated with non-compliant balloons and appeared well apposed and expanded. The final angiogram demonstrates TIMI-3 flow with minimal stenosis and no evidence of complications.



Post angioplasty