Successful PTA for Severely Calcified SFA CTO Lesion with Full Moon Face Calcification

Jae Young Cho, MD
Cheol Woong Yu, MD, PhD

Department of Cardiology
Korea University Anam Hospital, Seoul, Korea
Disclosure

Speaker name:
Jae Young Cho

I have the following potential conflicts of interest to report:

- Consulting
- Employment in industry
- Stockholder of a healthcare company
- Owner of a healthcare company
- Other(s)

I do not have any potential conflict of interest
• M/81

• Effort chest pain and Right side claudication
  – RF stage III IC

• Risk factor
  – HTN, DM, dyslipidemia

• Past Hx
  – PTA for Lt SFA CTO due to CLI 3 months ago

• ABI: Rt-0.61 Lt-0.86

• CAG; 3VD, EF 38%, mild TR, MR

• Dx; NSTEMI with ICMP, PAD

• Successful PCI for p-mRCA CTO, p-mLAD, LCX os

• Scheduled PTA for Rt side
Contralateral antegrade approach with 6Fr Balkin sheath via Lt CFA

035 Terumo J-tip wire
5Fr Glide catheter
Also failed with 014 Astato30 wire and CXI microcatheter
TruePath CTO devices
Astato30 guidewire could not still penetrate the calcified lesion after atherectomy.

External percutaneous needling with 18 gauge puncture needle was performed to crush calcification.
014 Astato30 guidewire
CXI microcatheter
Balloon pre-dilatation
5.0x120mm (Abbott, Admiral)
Mid SFA stenting
5.0x150mm (Abbott, Supera)

Proximal SFA stenting
5.0x80mm (Abbott, Supera)
Final angiography
Post PTA for Rt SFA CTO

• ABI
  Rt-0.61  Lt-0.86
  → Rt- 0.98  Lt-0.74

• Sx improved to RF stage I
Summary

• One of the most difficult situations in peripheral intervention is heavy calcification.

• Centrally occupying calcification or full-moon calcium is the greatest obstacle for successful revascularization because even dedicated atherectomy devices such as Turbohawk are not useful due to the absence of intravascular lumen.

• Specially designed atherectomy devices or external calcium piercing to establish cracks in the calcified plaque can enable advancement of devices and improve the technical success rate.
Thank you for your attention!
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