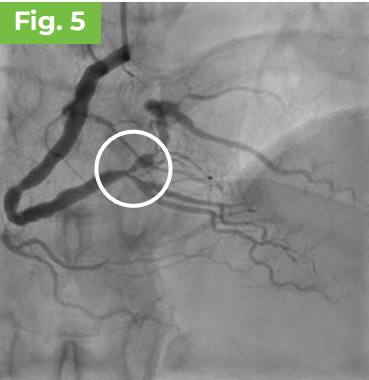


CASE SPOTLIGHT

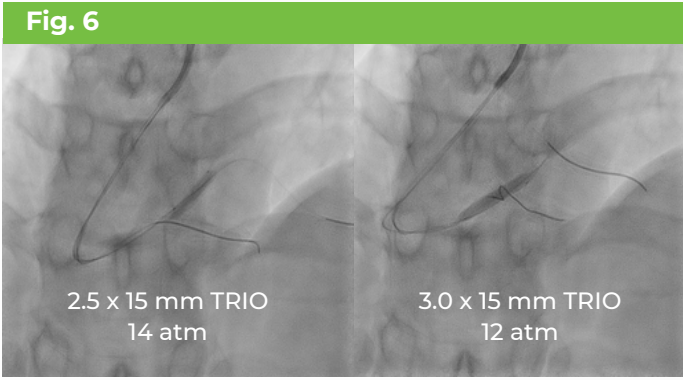
Balloon Dilatation Catheter

Severe stenosis at distal RCA (Figure 5) with IVUS showing fibrocalcific with 2-3 quadrants of superficial calcium was sequentially predilated with the old 2.5 x 15 mm and 3.0 x 15mm Scoreflex® TRIO up to 14 atm (Figure 6), which achieved adequate cracks in calcium and luminal gain documented by IVUS (Figure 7). A 3.0 x 25 mm DCB was applied with an acceptable 20-30% residual stenosis, and the patient was well post-procedure (Figure 8)

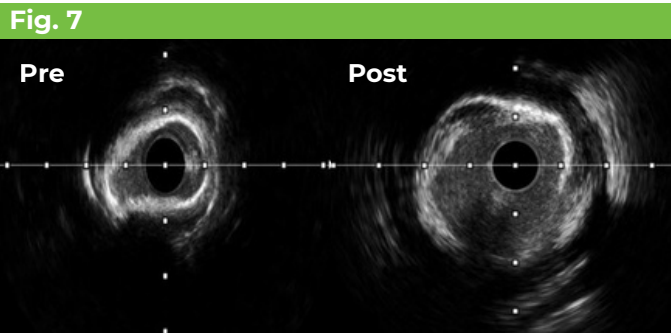
Coronary angiography restudy 3 months after the procedure revealed healed dissection in the LAD with positive remodeling in both the LAD and RCA (Figures 4 and 9).



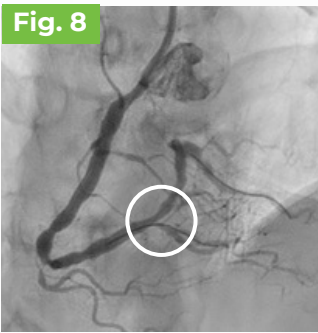
Severe stenosis at distal RCA to pLV



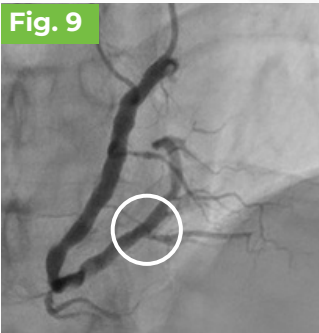
Lesion preparation with 2.5 mm and 3.0 mm TRIO at distal RCA/pLV



IVUS showing superficial calcium (pre) and effective plaque modification (post)



Post-DCB Angiogram



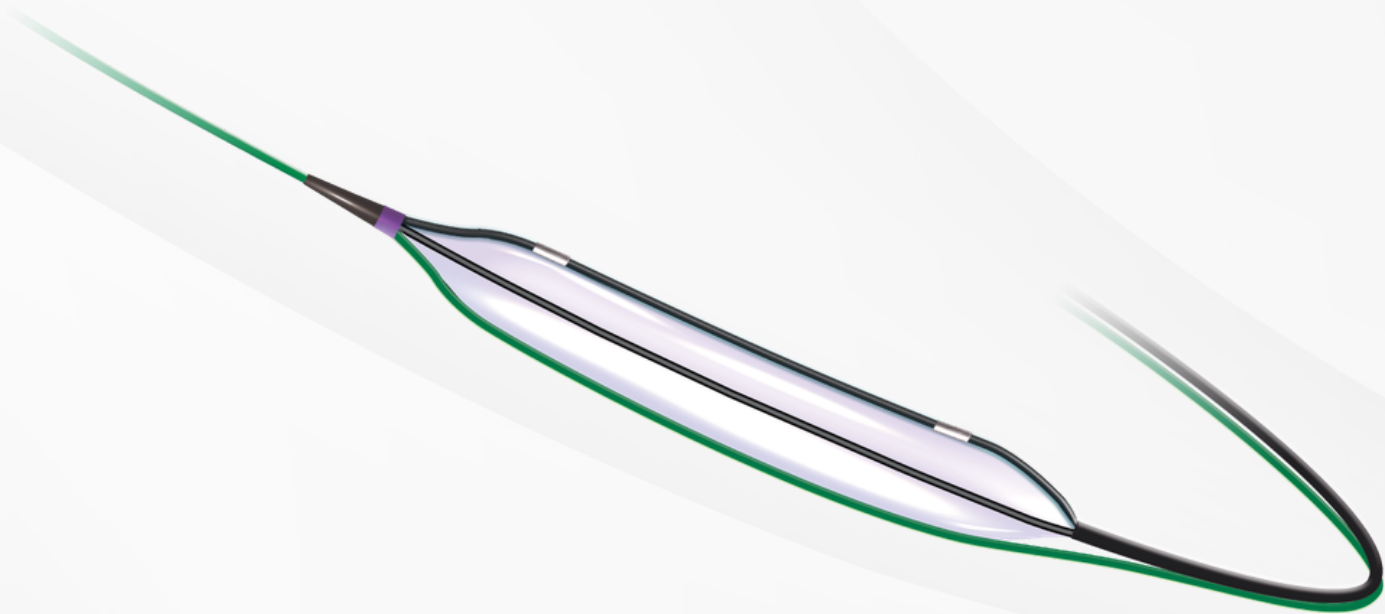
Restudy at 3 months

DISCUSSION

Scoreflex® TRIO with three scoring elements enables effective lesion preparation through focused-force angioplasty, achieving greater lumen gain and controlled plaque modification compared with conventional balloon angioplasty. Its continuous hub-to-tip metallic construction enhances pushability, while the hydrophilic/hydrophobic coating combination improves deliverability in distal and tortuous vessels. The integrated scoring wires and guidewire concentrate force to effectively crack calcified plaque with minimal and controlled dissection. When used before DCB therapy, Scoreflex® TRIO optimizes drug uptake and supports the leave-nothing-behind strategy, resulting in better procedural outcomes and positive vessel remodeling.

scoreflex® TRIO

Balloon Dilatation Catheter



CASE SPOTLIGHT

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CASE TITLE

Leaving nothing behind with Scoreflex® TRIO

CASE HIGHLIGHTS

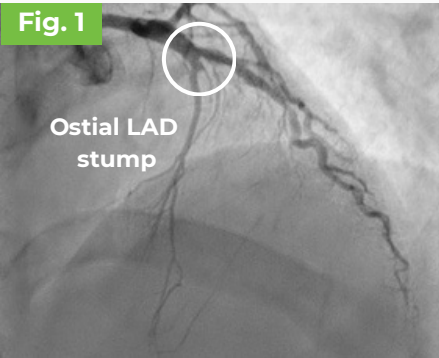
This case featured the use of a drug-coated balloon (DCB) without stenting in a young patient with recent acute coronary syndrome. The de novo lesion was prepared using Scoreflex® TRIO, followed by DCB application to achieve full revascularization of the diseased vessel, though with visible minor dissections. Restudy 3 months after the initial procedure revealed healed dissections with positive remodeling of both LAD and RCA.

CASE DETAILS

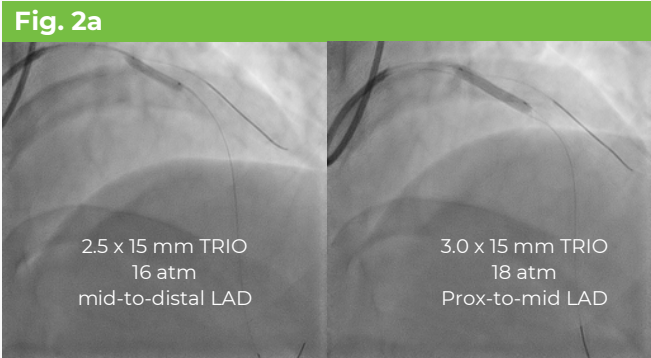
- 34 years old gentleman who is an active smoker with dyslipidemia presented with Non-ST Elevation Myocardial Infarction
- Coronary angiogram revealed chronic total occlusion of the ostial-proximal LAD with diffuse disease from proximal to distal LAD and severe (70-80%) stenosis over the distal RCA extending to the pLV branch

PROCEDURE

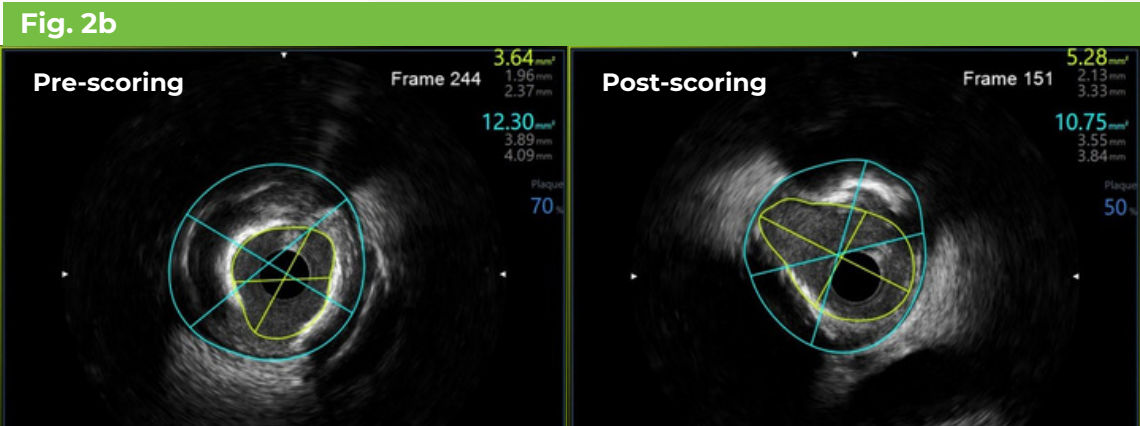
The CTO in LAD was crossed with Fielder XT-A and a microcatheter. LAD was diffusely diseased, and IVUS revealed fibrocalcific morphology (2 quadrants of calcium) more over the CTO segment and mid LAD (Figure 1), which was then predilated with 2.5 x 15 mm and 3.0 x 15 mm Scoreflex® TRIO (Figure 2a). IVUS showed the increase of MLA post-scoring balloon (Figure 2b). With adequate luminal gain after cracks in calcium and minimal residual stenosis, 2 DCBs (2.5 x 40 mm at mid-to-distal LAD and 3.0 x 40 mm at proximal-to-mid LAD) were applied.



CTO ostial-proximal LAD

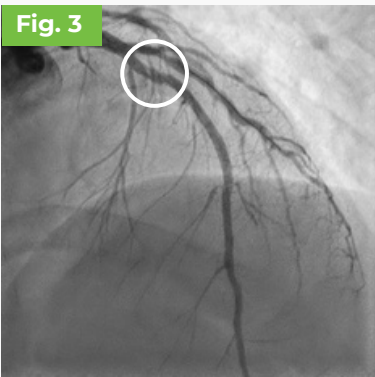


Cracking of calcium with two Scoreflex® TRIO

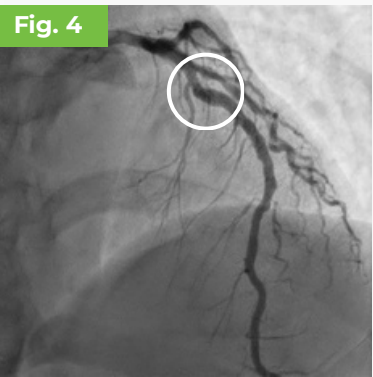


IVUS Imaging for LAD lesion

Post-DCB angiogram showed non-flow-limited dissection at proximal LAD (Figure 3) without further treatment. Restudy at 3 months showed that the dissection had healed with positive remodeling of the LAD (Figure 4).



Non-flow-limiting dissection at proximal LAD after DCB



Healed dissection in LAD after 3 months