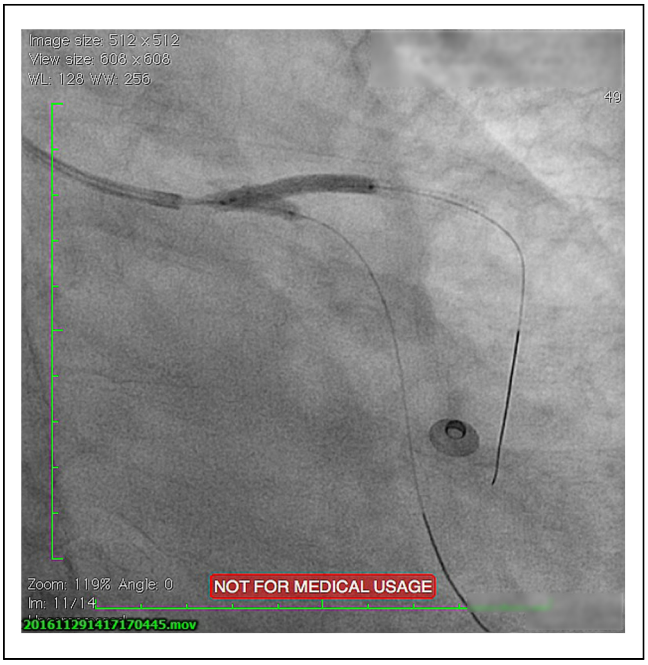

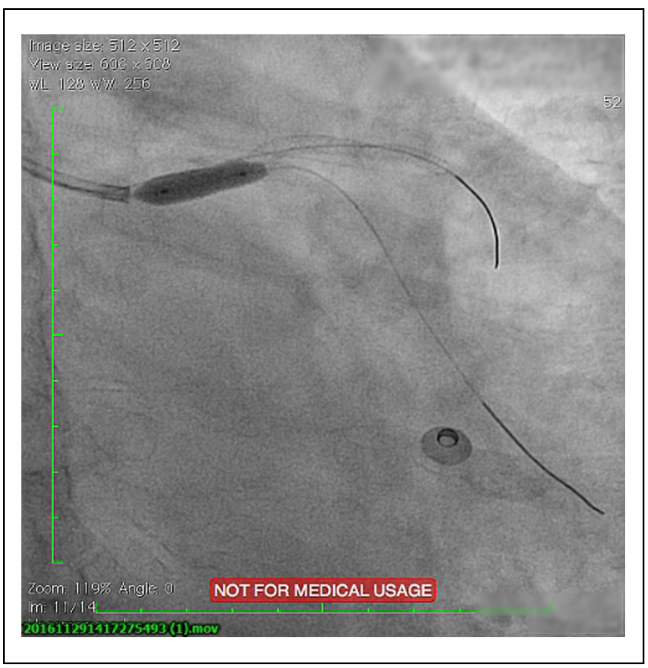

Case Summary. We perform high risk PCI bifurcation calcified LM-LAD-LCX lesion with DK-Crush technique even with severe chest pain and hemodynamic instability successfully with a good result, we suggested use left radial artery access because more easily to maneuver and do final kissing balloon technique to get a better outcome.

TCTAP C-074

Complex Distal LM PCI by Single Stent Strategy

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[CLINICAL INFORMATION]

Patient initials or identifier number. MB

Relevant clinical history and physical exam. Mrs. M 40 year-old, non-hypertensive, non-diabetic housewife admitted with compressive chest pain for 10 hrs. She mentioned there was an exertional chest pain for few weeks and it relieved on rest but this time pain was persisting even on rest. ECG showed T inversion in anterior leads and based on positive Troponin I. She diagnosed as a case of NSTEMI.

Relevant test results prior to catheterization.

ECG - ST depression in anterior lead with slight ST elevation in aVR (01A JPG)

Echo - Anterior wall hypokinesia, EF- 55%

RBS - 7 mol/l

Trop I- positive

Relevant catheterization findings.

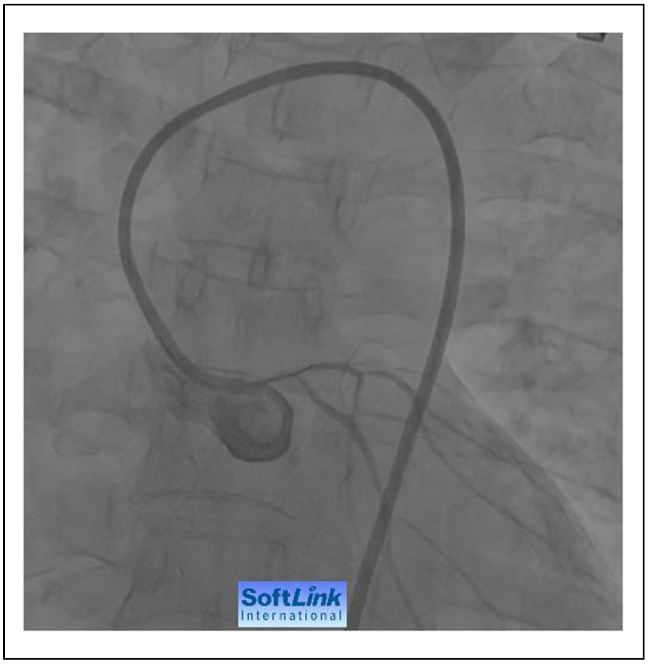
1) Tight left main coronary stenosis from LM ostium to distal LM bifurcation (Fig 1)
2) LAD: 60-70 narrowing in Proximal segment involving the D1 (Fig 1,)
3) LCX : Origin 30-40% (Fig 1,)
4) RCA normal (Fig 2)

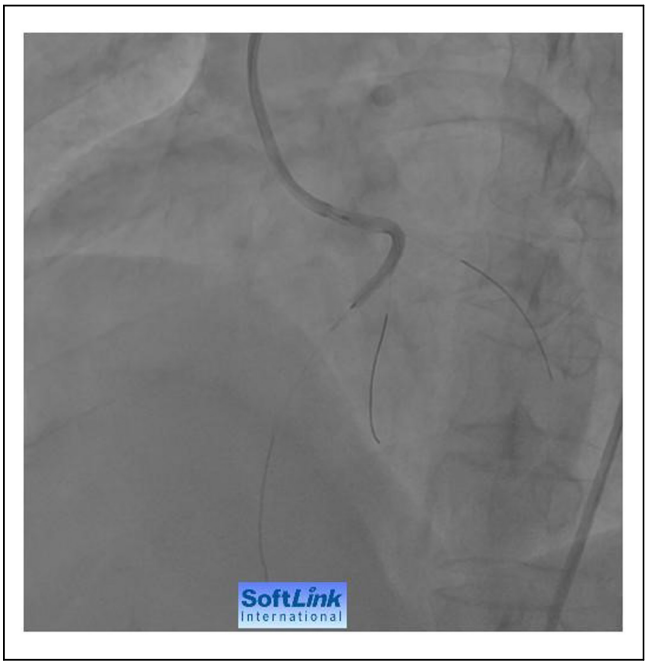
[INTERVENTIONAL MANAGEMENT]

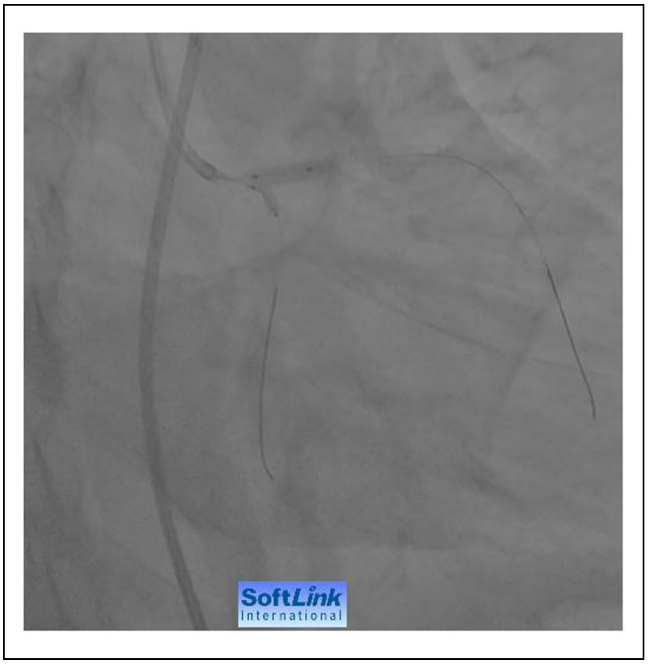
Procedural step. Aspirin 300 mg and Clopidogrel 600 mg before the procedure.

PCI LM- Placed 7F JL 3.5 Guide catheter non selectively into LM ostium. I/V bolus heparin. By keeping Guide catheter non-selectively one run through the wire was inserted into LAD and another run through a wire into LCX. (Fig MB 04). Pre-dilatation, DES 2.75 x 48 mm (LM-LAD),provisional, stent cross-over, (Fig MB 06).Post-dilatation.POT.There was plug shifting into LCX. Wire recrossing. Kissing balloon inflation.2nd POT in LM with 3.5 mm NC balloon@18 atm. The final result was excellent (Fig MB 07).

Hospital stay uneventful, discharged with Aspirin 150 mg and Clopidogrel 75 mg,







Case Summary. Sometime PTCA wire may be inserted by keeping the guide catheter placed non-selective.

RAD caudal, AP Cranial, LAO Cranial views should be checked for proper coverage of LM ostium.

Single stent provisional strategies are to be preferred for the majority of left main bifurcation lesions.

By starting with a provisional approach, all (sensible) options remain open to you.

TCTAP C-075
What to Do

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[CLINICAL INFORMATION]

Patient initials or identifier number. Mr. X

Relevant clinical history and physical exam. A 40 years old male, hypertensive, diabetic, smoker with a strong family history of IHD, complaints of chest pain CCS-III. There was no shortness of breath. On examination, a patient is not anemic. Pulse was 68/min and regular, Blood pressure-130/76 mmHg. Planned for a coronary angiogram.

Relevant test results prior to catheterization. ECG shows T in V1-V6. Echo reveals regional wall motion abnormality with LVEF -52%.CXR PA view- Normal. CBC- normal. S. Creatinine- 1.0 mg/dl.S. Electrolytes- Within normal range. HBsAg-Negative.

Relevant catheterization findings. LMCA-Distal LMCA 30-40% narrowing. LAD-Critical lesion-Ostio proximal LAD (90-95%), LCX- Shows mild tapering at its ostia (20-30%), Ramus small size vessel with 40-50% at its ostia. RCA - Free of significant disease. Syntax score-32.

[INTERVENTIONAL MANAGEMENT]

Procedural step. EBU 3.5 7F guiding catheter taken. LAD & LCX were wired. LAD was predilated. Plaque shifted to ostial LCX. Vessel size mismatch in LM & LAD so single stent strategy was abandoned. 4.0 x 24 DES from LM to LCX deployed. Post dilatation did in LCX. Rewired LAD through the stent strut and dilated. 3.0 x 38 mm DES from LM to LAD deployed. Post dilatation done in LAD. Kissing balloon dilatation done. IVUS revels under an expansion of LAD proximal stent. POT done in LAD. Final kissing balloon dilatation done. Final, angiogram shows LMCA, LAD & LCX were well revascularized with TIMI-III flow.