

2.0 x 12 mm Tazuna, The first kissing balloon dilatation done with 2.75 x 12 mm Mini Trek in LCX, 3.5 x 12 mm NC Trek in LAD. Again LAD ISR predilated with 3.0 x 12 mm mini trek balloon, Mid LAD stenting done with 3.0 x 38 mm Synergy Stent. LMCA to LAD stenting was done with 3.5 x 16 mm Synergy Stent, Final kissing balloon dilatation done with 2.75 x 12 mm NC trek (LCX), 3.5 x 12 mm mini trek balloon (LAD), POT of LMCA done with 4.5 x 12 mm Europha NC Balloon, Post procedure IVUS showed well apposed stent struts, The final result was good with TIMI-III flow without any complications.



Case Summary. RESTART study reported that late stent thrombosis (LST) defined by ARC was caused by aggressive hyperplastic restenotic process.

The present study showed that calcified plaque co-existed with red and white thrombus in a case of definite LST.

TCTAP C-184

Intra Vascular Ultra Sound Guided ROTA Stenting of In-stent Restenosis of Left Anterior Descending Artery and Double Kissing-crush Stenting of Left Main Coronary Artery Bifurcation



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[CLINICAL INFORMATION]

Patient initials or identifier number. KR

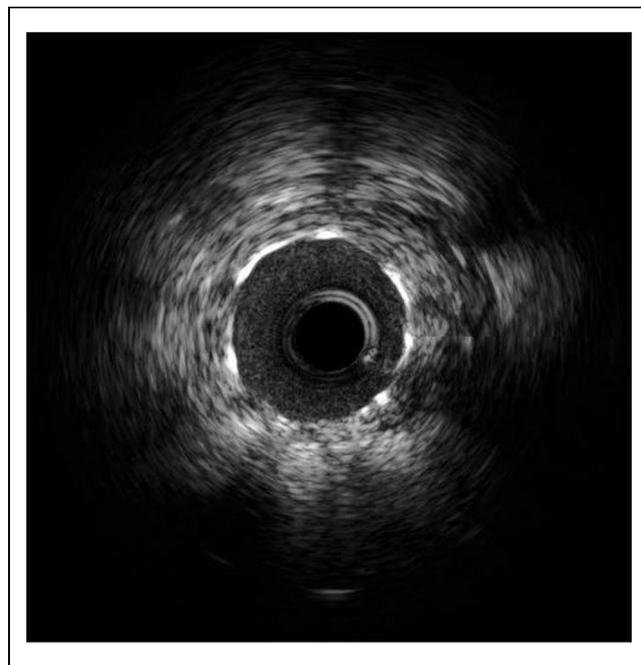
Relevant clinical history and physical exam. A 57 years old male known hypertension, diabetic presented with complaints of chest pain since few days, Coronary Artery Disease Unstable Angina, Post percutaneous coronary intervention was done to Left Anterior Descending coronary artery in 2002, 2D Echo revealed Mild Left Ventricle dysfunction with Ejection fraction was 48%, Coronary Angiogram revealed Double Vessel Disease.

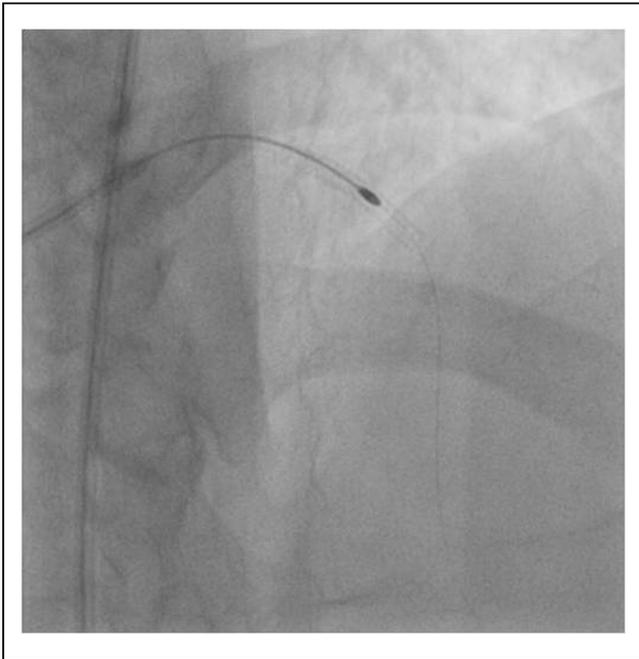
Relevant test results prior to catheterization.

Relevant catheterization findings. Coronary Angiogram revealed Left Anterior Descending Coronary Artery-Mid In Stent Restenosis 70-80% long segment lesion, left circumflex artery Ostium 90% lesion.

[INTERVENTIONAL MANAGEMENT]

Procedural step. LMCA engaged with XB 3.5-7Fr guiding catheter, Coronary Angiogram revealed Left Anterior Descending Coronary Artery-Mid In Stent Restenosis 70-80% long segment lesion, left circumflex artery Ostium 90% lesion. 0.014" BMW wire was kept in LAD, Pre procedure IVUS showed Large amount of calcium around 280 degree. Plan rotablation followed by LMCA to LAD and LCX stenting with DK-Crush technique. Rota floppy wire was kept in LAD, Rota Floppy wire was kept in LAD and Rotablation done with 1.5 Rota Burr, LAD predilatation done with 2.0 x 12 mm Mini Trek, 2.5 x 10 mm Tazuna balloons, LCX predilatation done with 2.5 x 10 mm Tazuna, 2.5 x 10 mm Tazuna kept in LAD across LMCA then LCX stenting done with 2.75 x 16 mm Synergy stent, LCX stent balloon removed and LCX was crushed with 2.5 x 10 mm Tazuna, LCX Post dilatation done with





Case Summary. ISR of LAD due to neoatherosclerosis associated with calcification which can be treated with IVUS guided ROTA stenting. IVUS was used for optimization of PCI to get the best possible short term and long term results.

DK-Crush stenting of LMCA was done due to better long term results in the DK-Crush study.

Synergy stents was used due to favorable data from recently-reported studies.

TCTAP C-185
The Role of Optical Coherence Tomography in Decision Making During the Acute Phase of Spontaneous Coronary Artery Dissection

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[CLINICAL INFORMATION]

Patient initials or identifier number. TB

Relevant clinical history and physical exam. A 69 year-old woman with a history of treated hypertension, presented with sudden onset chest pain, at rest, and evidence of ST-segment elevation in the inferior leads of a 12-lead electrocardiogram. Thus, urgent coronary angiography was performed.

Relevant test results prior to catheterization.

Relevant catheterization findings. Urgent coronary angiography demonstrated a normal left coronary system but an abrupt lumen calibre reduction extending from segment 2 of the RCA into the PDA, with preserved TIMI-3 flow and the PL branch of the RCA was sub-totally occluded (file 1).

[INTERVENTIONAL MANAGEMENT]

Procedural step. We proceeded to evaluate the RCA with OCT. Imaging was challenging due to catheter-induced complete luminal occlusion and consequent difficulties clearing the imaging field of blood, however, dissection is observed at the level of the external elastic membrane with a low attenuation area observed behind the collapsed intima-media complex (file 2A and B). The collapsed intima-media complex may be misinterpreted as a ‘diseased’ segment but measurement of the medial area and comparison with a normal reference segment confirms equivalent areas and strengthens the diagnosis of intramural compression, particularly when observed in associated with luminal contour folding (file 2C-F).

The patient suffered a transient worsening of chest pain and ST-segment changes while the OCT catheter was distally occlusive. Interpretation of the angiographic and OCT findings suggested a diagnosis of spontaneous coronary artery dissection (SCAD) without intimal disruption and led us to take a relatively conservative strategy (POBA) of the mid and distal segments of the RCA to enhance distal

flow. Angiographic assessment post-POBA, revealed evidence of an iatrogenic dissection in the mid vessel, with preserved TIMI-3 flow in all branches (file 3). At this time, the patient was hemodynamically stable and asymptomatic, therefore further intervention was avoided. Repeated angiography, on day 7, demonstrated improved luminal calibre in the affected segments and re-canalisation of PL branch (file 4).

