There was no pinching of the LCX ostium and flow into LCX was TIMI 3. Hence the LCX wire was removed, Recross into the LCX and final kissing was deferred as the LCX appeared normal.

Case Summary.
1. What was the cause of the proximal narrowing - Spasm, Dissection, Thrombus or Plaque migration
2. Minor disease of the ostioproximal LAD was overlooked. Possibly this has contributed to the plaque migration or dissection.
3. Direct stenting was an inappropriate strategy. Prior balloon dilatation may have warned of the problems to follow and better preparation for a different stenting strategy.
4. Does an LMCA to LAD stenting necessarily need to have a recross into the LCX and a final kissing balloon dilatation even with good flow into the LCX.
**Relevant test results prior to catheterization.** He consulted with general practitioner upon which ECG showed within normal limit but exercise tolerance test was positive at stage II. His LVEF 60% with no RWMA. His hemogram, LFT, and KFT was normal.

**Relevant catheterization findings.** The LMCA was normal. The ostial LAD had lesions ranging from 70-80% stenosis with chronic total occlusion after D2. The LCX had ostial 60-70% lesion. There was a type A lesion in mid RCA. Then patient was strongly recommended for CABG. But repeated denying of patient we planned for elective PCI with discussion

**[INTERVENTIONAL MANAGEMENT]**

**Procedural step.** Trans-femoral
- Guide Catheter: JL 3.5 (7F)
- Balloon Catheter: 1.5x15, 2.5x09, 3.0x09.
- Stent: 3.0x15mm Endeavor Resolute at 12 ATM, 3.0x20mm Taxus Liberty at 12 ATM.

A 7F sheath was inserted through right femoral artery. The left coronary ostium was engaged with a 7F JL catheter with 3.5 cm curve. Two 0.014 inch BMW and intermediate guide wires were inserted into LAD and LCX respectively. 1.5mm x 15 mm Balloon was used to predilate LAD initially then 3.0mm x 09mm and 2.5mm x 09mm Balloon were used sequentially and serially LAD & LCX ostium Respectively. After Balloon dilatation of both LAD & LCX the first stent Endeavor Resolute 3.0x15mm was advanced into LAD. Then second stent 3.0x20mm Taxus Liberty advanced into LCX. Both stent are positioned and V-stenting done. Then final result was good with TIMI III flow.

Symptoms of chest pain completely resolved after PCI. Patient remained asymptomatic during the latest follow-up (after 7 month) at our patient clinic.
Conclusions: Though it was ideal case for CABG we did it according to patient’s choice. Sometimes we have to accept the reality despite the gap between expectation & limitation.

TCTAP C-045  
Successful Revascularization of Left Anterior Descending Artery with a Special Ruptured Plaque  
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[CLINICAL INFORMATION]  
Patient initials or identifier number: 72 year old female  
Relevant clinical history and physical exam: Effort chest pain for 3 month. No hypertension and Diabetes mellitus. Without any coronary risk factors.

Relevant test results prior to catheterization: Echocardiography showed good left ventricular function with an ejection fraction of 55%. Baseline ECG showed ST-segment depression in V1-V3.

Relevant catheterization findings:  
1. Left coronary angiography showed proximal LAD 80% stenosis with plaque rupture.  
2. Right coronary angiography showed diffuse 20-40% stenosis from proximal to distal part. 90% stenosis in PL ostium.  
3. IVUS exam show proximal LAD stenosis with plaque rupture.

[INTERVENTIONAL MANAGEMENT]  
Procedural step:  
1. 7F sheath was inserted through right radial artery and the left coronary (LAD) was engaged with a 6F EBU3.5 guide catheter.  
2. BMW wire and IVUS catheter was positioned in LAD.  
3. Failed wire the sidebranch (SB) with a balloon in LAD.  
4. Performed angioplasty of the proximal-mid LAD (the lesion was predilated with a 2.0*15 mm balloon. Then, a 3.0*28mm stent was deployed from proximal-mid LAD).  
5. The patient chest pain. The angiography after stent show the SB total Occlusion.  
6. Rewire the SB with micro catheter and pre-dilatation the SB ostium with a 1.5*15mm and 2.0*15mm (8-12 atm) sprinter balloon.