COMPLEX (TCTAP C-110 TO TCTAP C-130)

TCTAP C-110
PCI in Impending Cardiogenic Shock Tackling Multiple Culprit Lesions
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[CLINICAL INFORMATION]
Patient initials or identifier number. K.K.
Relevant clinical history and physical exam.
83 Years old male diabetic Admitted in Triage with prolonged chest pain along with sweating, breath lessness for the preceding one hour
History of Crescendo angina since the last one month
Recurrent rest chest pain since the last three days
On Exam Pulse 110/min, RR 28/min BP 90/60mm Hg Chest: Bilateral basal crepts upto mid scapular region

Relevant test results prior to catheterization.
ECG - Q in V5,V6, 4mm ST depression in V1-V6, down sloping ST depression in II, III, aVF, T inversion in V1-V6. Echo - Severe LV Systolic dysfunction EF 30% RWMA in all three territories, Mod MR.
Hb 14gm % TLC 8600, P 76, L24 Platelets 2,50000 Blood Sugar 256mg % Serum Creatinine 1.3 mg % ABG Hypoxia with compensatory metabolic alkalosis Trop I 52 IU

Relevant catheterization findings.
Left Main Normal LAD Near total Occlusion after Di Di Large vessel, Diffuse 80% stenosis at origin LCx Non Dominant 100% Occluded in mid portion, OM1,OM2 filling retrogradely RCA Dominant Diffusely diseased and calcified from mid segment 100% occluded in distal part. Thrombus containing lesion RCA gives large collaterals to LAD and LCx.

[INTERVENTIONAL MANAGEMENT]
Procedural step.
Options: 1. Emergency surgery. 2. Urgent PCI of Culprit vessel with staged PCI of other vessels later on. 3. Multi vessel PCI.
Family refused for surgery as elderly. Surgeons refused because high risk patient with uncontrolled DM 2, severe LV dysfunction and markedly elevated Trop I. RCA Angioplasty through right radial route. 6F Sheath. Loading with 600 Clopidogrel, Aspirin 300 mg, UF Heparin 5000 Units. Epitibafide bolus and infusion. JR 3.5 6F Guiding catheter. BMW 0.014 Coranory Guidewire. Shinobi Wire 0.014 (Cordis), 2.5x15 mm Sprinter balloon. Multiple tandem dilatations 2.5x15mm balloon. 3x38 mm XIence Prime stent (Abbot Vascular). Second Xience Prime 3x38 mm stent. Post Stent Dilatation at high pressure. Voyager NC balloon(Abbot Vascular)3x15 mm at 20 Atm. View final angiogram in LAO cranial view with TIMI III Flow, No residual Stenosis, No dissection, Normal tissue perfusion. Even after successful RCA-plasty, Patient still hemodynamically unstable BP 90/60 mm on high inotropes Dopamine,Epinephrine. Saturation 88% at high flow oxygen. Decided to do LAD plasty as well. LAD-plasty: JL 4.6F Guide Catheter. BMW wire
0.014" (AbbottVascular). 2.5x20 mm Sprinter balloon (Medtronic). Multiple dilatations at 12-14 atm, Tandem dilatations proximal to mid LAD. Balloon dilatation at ostium of LAD. 3x38 mm Xience Prime stent in proximal LAD. Voyeger NC Balloon 3x15 mm at 20 atm. Final Angiogram RAO Cranial View - TIMI III flow, no dissection, no dissection.

Case Summary. Conclusion: Post-procedural - Inotropes tapered off over 48 hrs. Pre discharge Echo showed EF 40 %, Mild Mitral regurgitation. Discharged on 5th day on aspirin 150 mg od, clopidogrel 75 mg twice a day, atorvastatin 80 mg od, ramipril 2.5 mg od, metoprolol succinate 50 mg od.

The ACS stellar points: Diffuse long segment disease with severe calcification common particularly in elderly making stent delivery difficult. May be more than one culprit lesions necessitating multivessel stenting to stabilize patient. Rota should be avoided to prevent distal embolization. High pressure dilatation with non compliant balloon should always be done to optimize stent results.

TCTAP C-111
Crusade Micro-Catheter Assisted Antegrade Wiring of a Chronic Total Occlusion Lesion Located at Proximal Bifurcation of the Left Anterior Descending Artery
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[CLINICAL INFORMATION]
Patient initials or identifier number. LDC
Relevant clinical history and physical exam. 80-year-old male presented with acute infero-lateral myocardial infarction on 2014/7/16. Killip-1. Emergency percutaneous coronary intervention (PCI) was performed and the left circumflex artery (LCX) was stented by a bare-metal stent after aspiration thrombectomy. Chronic total occlusion (CTO) of the left anterior descending artery (LAD) was also noted. The recovery was uneventful and he was discharged home 3 days later. He was re-admitted on 2014/9/8 for elective PCI to the CTO of LAD.