Multivessel coronary spasm can cause life-threatening cardiac events and identifying possible mechanism of vasospasm underlying various manifestations of coronary artery disease should be highlighted.

**TCTAP C-009**

**Too Much Water Will Cost a Patient’s Life After AMI**

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Fuwai Hospital CAMS&PUMC, China

**[Clinical Information]**

**Patient initials or identifier number:**
WCD

**Relevant clinical history and physical exam:**
Male 72 y/o
Chest discomfort for 1 day
Risk Factors: Hypertension, hyperlipidemia, smoking.

**Relevant test results prior to catheterization:**
ECG Show: II III avF ST elevated with dynamic change
UCG Show: LV: 57mm, EF: 55%, segmental wall motion abnormalities in inferior wall and posterior wall
cTnI: Elevated

**Relevant catheterization findings:**
Three-vessel disease and the culprit artery was RCA.

**[Interventional Management]**

**Procedural step:**
1. Perform RCA angiography;
2. Perform LCA angiography;
3. Perform RCA-PCI with Guiding (6F JR 3.5) and Guide wire (Runthrough).
4. Implant Stent (Partner 4.0*29mm and 3.5*36mm)
5. Post-dilation: Voyage NC 4.0*15mm

**Case Summary:**
Too much water will cost a patient’s life after AMI.

**TCTAP C-010**

**A Case of Acute Coronary Syndrome with Critical Mid LAD and D1 Bifurcation Lesion Successfully Treated by Mini-crush Technique**

Hou Tee Lu
Sultanah Aminah Hospital, Malaysia

**[Clinical Information]**

**Patient initials or identifier number:**
TYC

**Relevant clinical history and physical exam:**
A 74 years old man was admitted with recurrent chest pain for 2 weeks.
Coronary Risk Factors: hypertension and cigarette smoking.
He was hemodynamically stable (heart rate: 80/min, BP 140/90 mmHg) at presentation.

**Relevant test results prior to catheterization:**
His baseline ECG showed ‘reversible’ ST elevation at anterior precordial leads.
Troponin T level was mildly elevated.

**Relevant catheterization findings**
1. Left coronary angiogram showed critical stenosis at mid left anterior descending (LAD) artery and severe stenosis at ostial diagonal (D1) artery with Medina Classification (1,1,1).
2. Left main and left circumflex arteries were normal.
3. Right coronary artery was normal.

**[Interventional Management]**

**Procedural step:**
A 7F sheath was inserted through right femoral artery. The left coronary ostium was engaged with a 7F XB catheter with 3.0cm curve. Two 0.014inch BMW and Run-through floppy guidewires were inserted into the LAD and D1 respectively. Two Sprinter Legend (1.25x10 mm, 2.25x10 mm) balloons were used to predilate D1 (side branch) and LAD (main branch) sequentially. After balloon dilation of both LAD and D1, the first stent (XIENCE V 3.0x15 mm) was advanced into D1 while another balloon (Sprinter Legend 2.25x10 mm) was positioned into LAD simultaneously. The D1 stent was inflated first. Then the balloon in LAD was inflated after removal of D1 stent balloon. First kissing balloon angioplasty was performed after successful rewiring and re-balloon of the D1 using Sprinter 2.25x10 mm with NC Sprinter 2.75x12 mm balloon at LAD. D1 balloon was then removed. Subsequently, the second stent (XIENCE V 3.5x18 mm) in the LAD was inflated to further crush the D1 stent. Second kissing angioplasty (final) was repeated after sequential balloononing of the D1 using NC Sprinter 3.0x12mm and of the LAD using NC Sprinter 3.5x12mm at nominal pressure. Final result was good with TIMI 3 flow. Symptom of chest pain was completely resolved after PCI. Patient remained asymptomatic during the latest follow-up (one and half year later) at outpatient clinic.
**Case Summary:**
We encountered a challenging bifurcation lesion in an emergency situation when the ECG showing ‘impending myocardial infarction. The approach of treating this lesion required safe, quick and reliable techniques with promising long term outcomes.

**TCTAP C-011**

**Bleeding and Primary PCI: Difficult Choice for Interventionist**

Januar Wibawa Martha
Hasan Sadikin Hospital, Indonesia

[Clinical Information]

Patient initials or identifier number: Mr. R
Relevant clinical history and physical exam:
A 60 years old male referred from other hospital for acute inferior MCI of 7 hours duration, presenting with acute upper GI bleeding with gross melena.

Relevant test results prior to catheterization:
ECG ST Elevation in inferior leads
Hb 8.4 from 13.2 (at another hospital)

Relevant catheterization findings:
RCA totally occluded at prox
LCX thrombus at bifurcation with OM2
LAD significant (90% stenosis at mid, 70% at prox)
LM normal

[Interventional Management]

Procedural step:
Due to active GI bleeding at presentation, we load the patient with Clopidogrel 300 mg only, and we gave Pantoprazole 40 mg IV.
Femoral approach. JL 3,5 to for left coronary angiography, JR 3,5 6F for guiding to RCA. Intermediate wire then change to Fielder XT for RCA lesion couldn’t pass the lesion (probably CTO). Guiding change to EBU 3.5 6F, 2 Intermediate wire to LCX and OM2. 2x thrombosuction with Zeek, predilatation with Jive 2.0-15, and stenting with Coroflex Blue 2.5-25, Integrity 3.0-26. TIMI flow 3. Final angiography showed loss of distal LAD. Patient felt recurrent chest pain, ECG showed ST elevation in anterior leads. We give Enoxaparine 0.6mg IV, NTG up to 50 ug/min. Commencing with PCI to LAD. Intermediate wire passed the lesion, predilatation with Jive 2.0-15, stenting with Multilink 2.5-33 mid LAD and Integrity 3.0-18 prox LAD. TIMI 3 flow. Consultation with Gastroenterologist, and endoscopy at day 4 showed active mucosal bleeding at mid part of antrum. We gave 5 packs of PRC, Hb stabilized at 11.2. Patient discharged on day 7 with Th/Clopidogrel 1x75mg, Cilostazol 2x50mg, Pantoprazole 2x40 mg.