who were referred for conventional invasive coronary angiography. Patients were eligible if they were >18 years of age. Patients with atrial fibrillation, contraindication to iodinated contrast agents, and serum creatinine values >1.4 mg/dl were excluded.

Coronary angiography was performed using standard 6Fr coronary catheters through transfemoral or transradial approach. Coronary angiograms were evaluated by 2 experienced, independent observers. Coronary arteries were segmented according to guidelines of the American Heart Association 18 (modified 16-segment model, with segment 17 being intermediately branch of the left coronary artery).

12 patients were investigated by MSCT (Philips, 64 Slice, Philips, USA). After determination of the contrast agent transit time, a volumetric dataset was acquired (collimation 2640.6 mm, z-flying spot, gantry rotation time ms, tube current 400mA/rotation, tube voltage 120kV) without application additional beta-blocker medication to control heart rate. Contrast agent (60 to 80 ml, iodine 350 mg/ml) was injected at a flow rate of 5 ml/s. All scans were performed using electrocardiographically gated tube current modulation. Maximal tube current was limited to an interval 30% to 70% of cardiac cycle. Trans-axial images were reconstructed with 0.75-mm slice thickness, 0.5-mm increment, and a medium soft convolution kernel (B26f). The position of the reconstruction window within the cardiac cycle was individually selected to minimize motion artifacts. The best dataset was used for subsequent analysis.

RESULTS In total, 16 consecutive patients (75%men, mean ages 55years) with coronary artery diseases who underwent coronary angiography were included in the study. Six cases of single coronary artery (SCA) were found: including three cases of anomalous right coronary artery (RCA) originating from the proximal or mid of left descending coronary artery; left main coronary artery (LMCA) arising from the RCA, reverse orifice RCA originating from the distal of left circumflex (LCX) artery two cases. Ten cases of anomalous RCA were detected: including anomalous RCA arising from anterior wall of ascending aorta six cases and left sinus of Valsalva four cases respectively. Multi-slice computed tomography (MSCT) detected the origin and course of the anomalous coronary artery in 12 of 16 patients (75%).

CONCLUSION Coronary angiography is essential detecting methods to find coronary anomalies and MSCT clearly depict the origin and course of the anomalous coronary artery.

Keywords: MSCT. Coronary artery anomalies. Coronary angiography.

TCTAP A-178
Primary PCI with “Single” Catheter
Sho Torii,1 Yuji Ikari1
Tokai University School of Medicine, Japan

BACKGROUND The benefit of primary percutaneous coronary intervention (PCI) for acute ST segment elevation myocardial infarction (STEMI) is well documented and is closely tied to the door to balloon (DTB) time. To shorten the DTB time, we perform diagnostic angiography with IL-4.0 guiding catheter (Heartrail, Terumo Corporation, Tokyo, Japan) because we can switch to the primary PCI immediately following the full coronary angiogram with a single catheter.

METHODS We studied consecutive 31 STEMI patients who underwent primary PCI at our hospital from November 1st 2013 to November 15th 2014. All patients were radial artery approach and the patients with shock vital were excluded. Eight patients were performed diagnostic angiography with IL-4.0 (IL group), and other 23 patients were performed with JL-4.0, and JR-4.0(stANDARD group). The cath lab to first device time was calculated.

RESULTS The cath lab to first device time was significantly faster in IL group compared with standard group (19.5 min vs. 38.3 min, p=0.0001).

CONCLUSION For STEMI patients, IL-4.0 catheter angiography shortens the DTB time and may improve the patients’ outcome.

TCTAP A-189
Safety and Efficacy of Thrombolysis for Stuck Valve in Rheumatic Heart Disease - A Single Centre Experience
Arup Prasath Palamalai,1 Sujal Nikhil Ramakrishnan,1 Anand Kumar Gopi1
1Mahatma Gandhi Medical College and Research Institute, India

BACKGROUND Rheumatic heart disease causes significant morbidity and mortality in many of Latin and African countries. The resultant corrective surgery for valve necessitates mechanical prosthetic valve implantation at an earlier age to these patients. Prosthetic valve implantation has its inherent problems and needs a proper oral anticoagulation negates the need for redo procedure, if successful. Here we present a series of cases managed with thrombolysis for stuck valve Rheumatic heart disease patients.

METHODS This retrospective study analyzed 16 patients of Rheumatic Heart disease who underwent prosthetic valve implantation in mitral and aortic position and presented with stuck valve in our center since 2012. The age group ranged from 22 to 60 years with 6 males and 10 females. Patients commonly presented with worsening dyspnea of NYHA class III to acute pulmonary edema. After initial stabilization all patients underwent diagnostic catheterography to ascertain valve movement restriction. The last follow-up INR, denied drug history, drug compliance,