Case Summary:
This 72 y/o male suffered from recurrent angina after STEMI s/p stenting at LAD-P. The repeat CAG showed LM (M) 40–50% stenosis, LAD (M–D) diffuse 50–60% stenosis but FFR is 0.75 at LAD-D and 1 at LCX. After IVUS check up, we recognize the culprit lesion in LAD-D. But FFR is still 0.78 after treatment of LAD-D by 3.0 x 30mm BMS. So the culprit lesion should be located in the LMT to LAD and there was 50% stenosis and the CSA 5–6 mm2 by IVUS. We performed PCI by 4.0*24 DES in LMT to LAD, the final FFR is about 0.91 at LAD-D and well apposition is got by IVUS.

Relevant catheterization findings:
CAG: LMCA 100% thrombotic occlusion

[Interventional Management]
Procedural step:
7 Fr XB 3.5 Whisper ES wire Xience 4x23 stent
Initial 12 hours post PCI were uneventful
Around 12 midnight, he had an episode of AV dissociation, HR ~20-30 bpm, necessitating a temporary pacemaker implantation
In view of poor hemodynamics, he was intubated and inotropic support hiked
Check angiogram done, which revealed patent stents with TIMI III flow in LAD, however poor myocardial blush grades

Patient was slowly weaned off the inotropes and ventilatory support and was subsequently discharged on Day 7. He continues to be on a regular OPD follow up
Case Summary:
HD-Extensive anterior wall MI (delayed presentation)Severe LV systolic dysfunction Acute LMCA occlusion Successful PCI to LMCA-LAD and POBA to LCx done.

TCTAP C-045
LM Bifurcation Lesion with CTO of RCA
Paiboon Chotnoparatpat
Vajira Bangkok University, Thailand

[Clinical Information]
Patient initials or identifier number:
Mrs. SK
Relevant clinical history and physical exam:
82 years old female with high risk Unstable angina with heart failure Risk Factors: Hypertension, Diabetic, Dyslipidemia ECG: Extensive anterior wall ischemia Tropinin T: 0.3, LDL-C 125 Echo: Global hypokinesia, EF ¼ 40%

Relevant test results prior to catheterization:
ECG showed ST depression at V2-V6.

Relevant catheterization findings:
95% stenosis of Lm bifurcation with CTO of mid RCA

[Interventional Management]
Procedural step:
CABG: (Distal bifurcation LM, TVD, CTO of RCA) Syntax Score > 33 The patient refuse CABG LM/ LAD/LCx and staged PCI in RCA IABP Critical stenosis of ostial LCx, wide angle, LAD, LCx match diameter Provisional T is impossible (1,1,1)

Crulotte (too short LM, wide angle) / DK / mini crush
@ A 3.0 mm stent (1:1:1 ratio) was advance into LCx 1-2mm protrusion and 3.5mm balloon positioned in LM, LAD
@ After stenting LCX, stent balloon and wire was removed, inflated balloon in LM (first Crush)
@ Re-cross wiring LCx, first kissing using 3.5, 3.0 mm NC balloon 4.0 Stenting LM, LAD (Double Crush)
Recross wiring into LCx FKBI 4.0, 3.0 mm NC balloon inflated pressure 18 ATM for 15 sec (second kissing) IVUS-guided, good apposition

* Take Home Messages
4.0 Stenting LM, LAD (double Crush)
Recross wiring into LCx FKBI 4.0, 3.0 mm NC balloon inflated pressure 18 ATM for 15 sec (second kissing) IVUS-guided, good apposition

* Key Point of DK Crush
DK Crush: Selected bifurcation 1/1/1, wide angle > 70 degree 7F guiding with back up support Stent (1:1:1 ratio) was advance into SB 1-2mm protrusion in MB After stenting SB, stent balloon and wire was removed, inflated balloon in MB (first Crush)
Re-cross wiring into SB (distal strut), first kissing using NC balloon Double Crush (anchoring SB for access MB stenting) NC balloon inflated pressure 18 ATM for 15 sec (second kissing)

Case Summary:
An 82 years old woman (sok Kee) HN 2833/55 presenting with severe prolonged angina pain at rest and CHF. ECG showed diffuse ST depression in V2-V6 echocardiogram showed fair LV function, global hypokinesia, positive troponin T. CAG was done, revealed 90% stenosis of distal LM, heavy calcified, 90% stenosis of proximal LAD, 95% stenosis of orifice LCX. Chronic Total occlusion of mid RCA. PCI was done In LM, LAD, LCX using DK crush techniques.