Case Summary. In hypertrophic cardio myopathy, not only the systolic anterior motion of mitral valve (obstruction at the level of basal septum), but also the bulging myocardium at LV mid-cavity result in the dynamic LVOT obstruction. To achieve a complete resolution of pressure gradient in this situation, a large area of ventricular septum must be ablated, with alcohol injection into multiple septal branches. To avoid complications such atriioventricular block or ventricular tachycardia, a sequential “one at a time” approach is advocated. This method is shown to be safe and effective for eliminating the LVOT obstruction in this case.

INVASIVE CORONARY IMAGING:
IVUS, OCT, SPECTROSCOPY, AND OTHER
(TCTAP C-146 TO TCTAP C-156)

TCTAP C-146
Optical Coherence Tomography and Intravascular Ultrasound Findings of 18 Month After Implanted Everolimus Eluting Stent into the Large Coronary Artery Hematoma
Yuzo Akita
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[CLINICAL INFORMATION]
Patient initials or identifier number. T. M
Relevant clinical history and physical exam. This is 60’s gentleman known history of hypertension and dyslipidemia. He had admitted to our hospital due to NSTEMI on February 2012. His coronary angiogram (CAG) showed that chronic total occlusion (CTO) in distal right coronary artery (RCA) and severe stenosis with TIMI2 flow in proximal circumflex (Cx). He underwent for percutaneous coronary intervention (PCI) to Cx. After that he could discharge from our hospital.
Relevant test results prior to catheterization. His ECG showed small q wave in inferior leads. His myocardial perfusion image showed that his inferior myocardium wall had the viability. His left ventricular gram showed that inferior wall had wall motion.

Relevant catheterization findings. He underwent for restudy CAG on Nov 2012. It showed that no in stent restenosis in Cx, no significant stenosis in LAD, distal RCA was occluded. So we planned for PCI to RCA CTO lesion.

[Interventional Management]
Procedural step. He underwent for PCI to RCA CTO on December 2012. We couldn’t cross the wire from antegrade, and then we started the retrograde approach. We could get the wire externalization. Then we opened the CTO lesion using the 2.5 mm balloon that we had already used as the trapper balloon. This balloon had pin hall rupture. Coronary artery hematoma was expanded because of this ruptured balloon inflation into the subintimal space. After then we implanted 3 Everolimus Eluting Stents (EES) from RCA proximal to #4PD. We could open the CTO lesion and get the good blood flow in the RCA. We performed restudy CAG 3 month after this procedure. It showed that big coronary hematoma was seen at distal RCA and fractured stent was seen at the stent overlapping site. IVUS findings was also seen the huge coronary artery hematoma and fractured stent. We also checked his CAG 18 month after the procedure. It showed that the coronary artery hematoma became smaller than before. We performed IVUS and OCT; they showed that the coronary artery hematoma was regression naturally 18 month period.
Case Summary. We made the coronary artery hematoma by the ruptured balloon inflation into the sub intimal tracking space after the Reverse CART technique. We implanted EES as 2nd generation drug eluting stent into the coronary artery hematoma. IVUS and OCT showed that this huge coronary artery hematoma was regression naturally 18 month period.

[TCTAP C-147]

Attenuated Plaque: A Strong Predictor for Slow Reflow

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[CLINICAL INFORMATION]

Patient initials or identifier number. 25089745

Relevant clinical history and physical exam. A 48-year-old man suffered from NSTEMI one year ago, when coronary angiography showed IRA was RCA. PCI with Promus Element stent for RCA was done. The coronary artery disease risk factor were male, dyslipidemia, hypertension.