Procedural step. First step was direct stenting middle part of LcX with DES 3.5 x 9. Then direct stenting LCA to LcX with DES 3.5 x 22 was performed. The next stage was debulking with kissing bifurcation of the left main. At the end we performed LAD proximal stenting.

Second stage was transcatheter aortic valve implantation (TAVI) with Edwards Sapien XT 23 mm. First of all valvuloplasty with high rate pacing was created. Then Edwards valve was implanted. All procedures was performed by trans femoral access. Total Rg time was 24 min, total media value 350 ml.

Case Summary. Bifurcation stenting of the left main coronary artery and transcatheter aortic valve implantation in patients with a combination of the obtaining defect of the aortic valve and coronary heart disease is a safe and feasible procedure. Simultaneous carrying out these procedures allows you to get good results and reduce the negative impact of additional manipulation.

TCTAP C-224
Mitral Clip After Surgical Repair of a Mitral Valve Prolapse After Endocarditis
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[CLINICAL INFORMATION]
Patient initials or identifier number. D.C.
Relevant clinical history and physical exam. 58 year male, Chinese 2009 presented with severe mitral regurgitation due to mitral valve prolapse
Echo: severe posterior leaflet prolapse, dilated LA, normal LV size and function
Advice for surgical repair in future once symptom developed
Relevant test results prior to catheterization. 06/2010 Infective endocarditis
  - Complicated with brain abscess
  - Prolong antibiotic
  - Fine for nearly 18 months
  - Symptoms of shortness of breath get worse
  - Echo showed ruptured chordae
  - Surgical repair in 06/2012 with annuloplasty and artificial chordae

[INTERVENTIONAL MANAGEMENT]

Procedural step. Patient was under complete GA, with intubation, arterial line, CVP line.
TEE was inserted and confirm the degree of mitral regurgitation
Right femoral puncture performed.
Under TEE guide, trans-septal puncture of the right atrial septum was performed under TEE guide.
Puncture site tended to be high and posterior in order to gain enough height for manipulation.
Once trans-septal was performed, the patient was fully anti-coagulated.
The 18F steerable sheath was inserted after the trans-septal sheath was taken out.
The sheath crossed the atrial septum.
The steerable mitral clip system was inserted into the LA, then slowly towards the LV orifice.
Position was checked by the TEE.
Once the plane was corrected, the device dived into the LV with the clip arms at 180 degree
Once inside the LV, the clip closed at 120 degree and pull back towards LA.
Once the mitral leaflets fell into the clip, and checked the position were correct. (Further assess on the clip the clip was access by position and the residual amount of MR.
If the position id correct, the clip is closed and detached. The long sheath and alnd all procedure related tools are out.
TEE checked the final results. Sheath is closed by figure of 8 stitches.
Case Summary. Mitral clip was not suitable for the beginning because of the patient’s choice.
After the operation, the post opt was very stormy
Patient refused for further operation
One clip managed to do the track and can reduced the MR

TCTAP C-225
Pre-Existing Mitral Prosthesis Is an Enemy of TAVI?
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[CLINICAL INFORMATION]
Patient initials or identifier number. KSY
Relevant clinical history and physical exam. KSY was a 74-year-old woman with history of mitral valve replacement done 24 years ago for her chronic rheumatic heart disease. The mitral valve prosthesis was a 29mm single tilting disc mechanical heart valve from Sorin. She also has history of atrial fibrillation and cerebellar hemorrhage.
She was admitted for heart failure symptoms lately, and was found to have symptomatic aortic stenosis from subsequent investigations. Transfemoral transcatheter aortic valve implantation (TAVI) was planned.

Relevant test results prior to catheterization. Transthoracic echocardiogram (TTE) showed severe aortic stenosis with peak and mean transaortic gradient to be 68 mmHg and 38 mmHg respectively. The aortic valve area was 0.67 sq cm by continuity equation. The mitral prosthesis was functionally well.
Preprocedural screening Computed tomography (CT) of aorta was done for aortic and peripheral vessels sizing. Aortic annulus dimensions were 26.5mm x 20.0mm, area was 445.8 sq mm, and perimeter was 76.39mm.