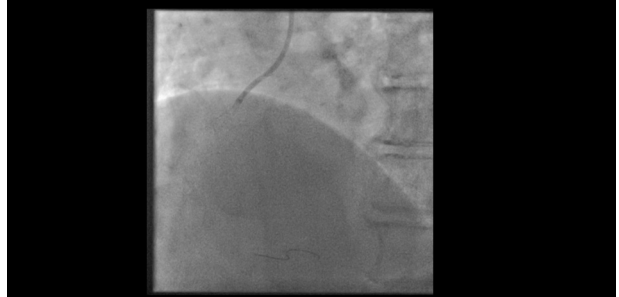


[INTERVENTIONAL MANAGEMENT]

Procedural step. Target: RCA

1. Engage 6Fr. JR4 to RCA
2. Advance Sion wire to distal RCA
3. We could not advance OCT into proper position because the vessel is too tortuous
4. In order to advance wire more distally, we changed JR4 to AL 1 for better support
5. Then we advanced the Sion wire more distally to PLA
6. We still could not advance OCT into proper position
7. Use microcatheter to change Sion into Grand slam for extra-support
8. Pseudo-lesion was noted and the patient started to have chest pain
9. Advance OCT smoothly into proper position
10. Use OCT to check proximal lesion
11. the OCT showed dissection flap. And there is thrombus formation
12. POBA with Sprinter 4x12mm at p-RCA
13. Deploy a Liberte 5x12mm stent to cover the dissection
14. Post dilatation with Quantum Apex 5x8mm, up to 20A
14. Because the patient still had chest pain, we did not perform final OCT study
15. The final flow was good. And the patient's symptom got relieved after we removed the wire and GC

Use MC to advance GW to distal RCA, pseudo-lesions occurred



Case Summary.

1. OCT can provide detailed information regarding to plaque morphology. In our case, the angiography showed that the lesion might be a ruptured plaque or dissection. To have a better resolution and interpretation, we choose OCT rather than IVUS.
2. For adequate OCT positioning in a very tortuous vessel, we used microcatheter and extra-support wire to reach PLA
3. One of the OCT's limitations is the vessel tortuosity. In our case, the lesion is very proximal so we don't have to worry that the OCT may not reach to distal RCA.

To sum up, we demonstrated a successful OCT- guided PCI in a very tortuous vessel.

TCTAP C-149

FFR Is No Substitute for a Brain!

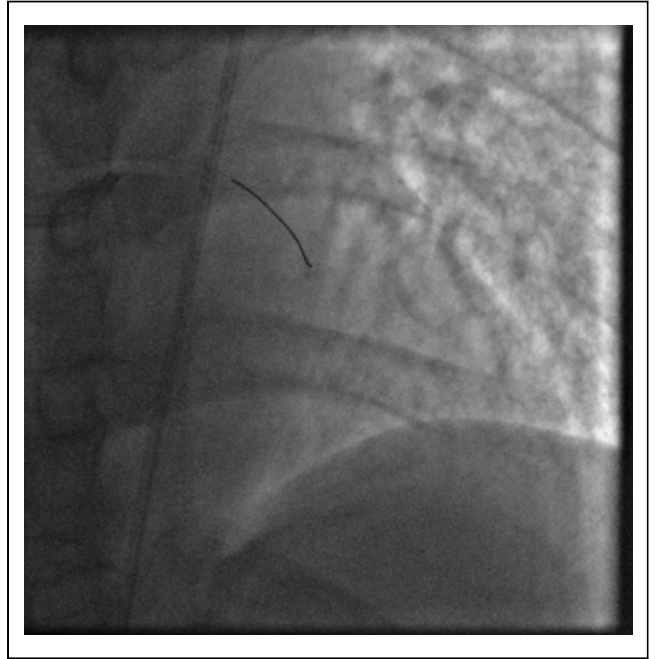
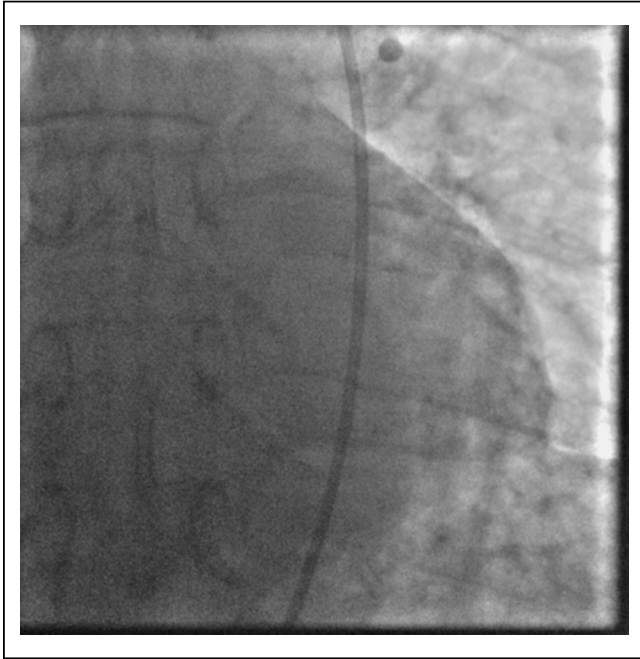
Hany Ragy,¹ Mohamed Ahmed Yehya Abdelrhman Sherif Hegab¹
¹National Heart Institute, Cairo, Egypt

[CLINICAL INFORMATION]

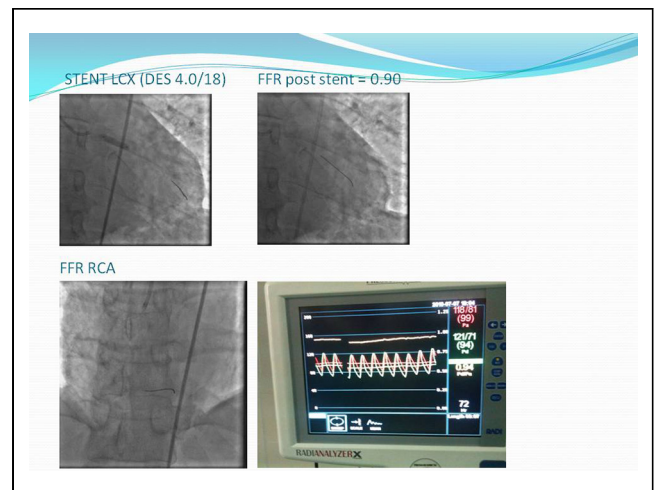
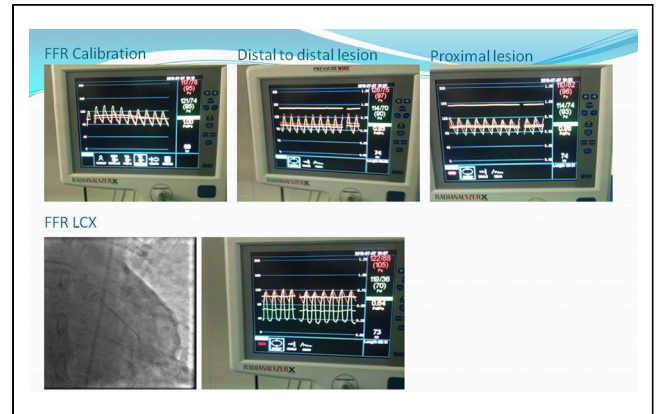
Patient initials or identifier number. GS

Relevant clinical history and physical exam.

- 49 year old patient, severe angina on exertion, (severe stable angina), smoker, not diabetic or hypertensive.
- No noninvasive testing.
- Coronary angiography and FFR done
- July 2010



Relevant test results prior to catheterization. See the images



Relevant catheterization findings. See the images

[INTERVENTIONAL MANAGEMENT]

Procedural step. Same patient exactly 4 years later

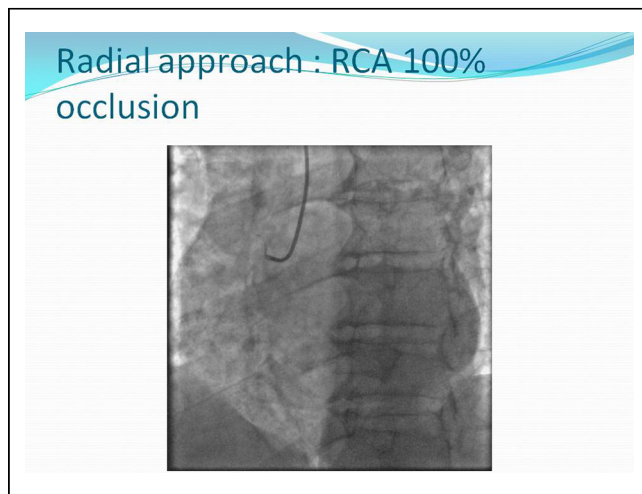
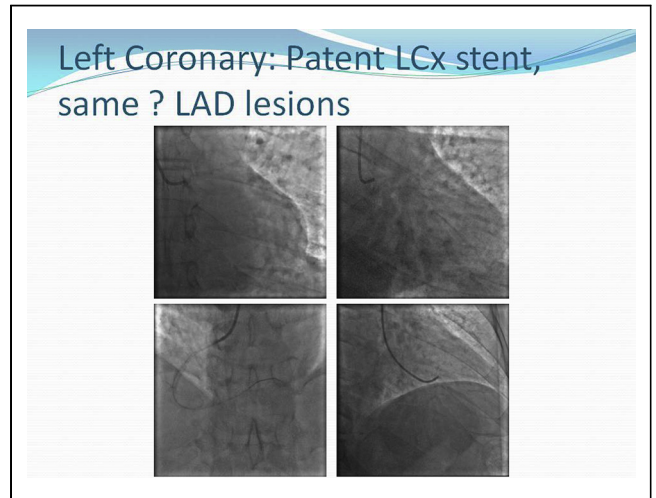
Was asymptomatic for exactly 4 years 7/2010-7/2014
 Was on 80 mg Atorvastatin
 Presented with Troponin +ve NSTEMI with normal LV function.

Conclusion in November 2010

One stent placed in the hemodynamically significant lesion.
 Patient free of angina since 4 months.
 On OMT (including 80 mg LIPITOR).
 Using FFR helped us place one stent instead of 4 even in presence of what seemed significant angiographic stenosis specially of the RCA.

Discussion: We don't have very long follow up data post FFR.
 Should we even FFR severe stenoses in large epicardial arteries without prior MI? or just treat?

Remember FFR recommended for lesions 40-70%
 What would a surgeon who is about to perform CABG do if you gave data showing a significantly stenosed artery has a normal FFR or a normal SPECT, not causing ischemia?



Question: The LAD

1. FFR
2. PCI/Stent
3. Leave alone

Case Summary. Conclusion: Even though FFR is a very valuable tool in the cath lab, it is not a substitute for a human brain.

Individual operator decisions inside the cath lab remain the default strategy, imaging/physiological assessment is very helpful but not compulsory in decision making if it seems to defy visual and logical thinking.

Coronary artery disease progression is unpredictable.

TCTAP C-150

IVUS and FFR Guided PCI for Patient of In-Stent Restenosis

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¹Tangshan Gongren Hospital, China

[CLINICAL INFORMATION]

Patient initials or identifier number. XM

Relevant clinical history and physical exam. The patient was a 45 year-old woman. She was diagnosed unstable angina; hypertension classifications 3.

She underwent PCI 3 years ago,an RESOLUTE stent has been implanted in her LAD.

And she states her chest stuffy worsening for 3 months.

T 36°C, P 77bpm, R 18bpm, Bp 137/79 mmHg.

No obvious signs in body examination.

Relevant test results prior to catheterization.

- TN-I < 0.010 ng/ml
- NT-proBNP 77 ng/l
- PT-SEC 13.9
- PT-INR 1.09
- PT-RATIO 1.07
- APTT 43.0
- APTT-RATIO 1.23
- TT 16.5
- TT-RATIO 1.03
- Fib 3.13
- DDI 0.42