At this point an additional stent was placed from the ostium to the mid left main and instantaneously all balloon passage became completely easy with absolutely no resistance. The stents were post-dilated at high pressure with 4.0 mm balloon and FKB was done in the LAD and diagonal. Final IVUS results were good.

Case Summary:
This is a case of an extensively diseased LAD that was far worse on IVUS with plaque extending to the left stent. Stenting of the left stent, LAD and diagonal was performed with ease. Care was not taken to keep the guide away from the mid left main stent and in the middle of the case when everything seemed to be going fine, balloon passage became impossible from the left main onwards due to longitudinal compression. Eventually the situation was rectified but the lesson to take home was that it is vital to PREVENT the guider from interacting with a stent once deployed, particularly in the left main. Perhaps an anchor wire in the aorta as soon as the left main stent was deployed would have been wise.

TCTAP C-054
Bailout Left Main Stenting for LMCA Dissection During Elective PTCA Stent to LAD
Sudam Jare
Kims Superspeciality Hospital, India

Clinical Information
Patient initials or identifier number: GS
Relevant clinical history and physical exam:
52 Yrs/ Female/GS
Unstable Angina – Duration 15 days
Diabetic – Type 2
HTN

Test results prior to catheterization:
ECG
Sinus Rhythm,
QS in V1-V5,
T Inversion in V1-V5.

Relevant catheterization findings:
LM: Normal
LAD: Mid & Distal long segment 80% Stenosis.
Diagonals: Normal
LCX: Distally 50% Stenosis.
OM’s: Normal
RCA: Normal

Interventional Management
Procedural step:
Lesion was accessed through Radial Approach 6Fr JL 3.
Lesion crossed with 0.014” BMW
Direct Stenting done for Distal LAD with 2.5x36mm DES at 8 atm.
Overlap stent done with 2.75x36mm DES at 12 atm.
Overlap and Proximal stent post dilated with 2.75x15mm NC Balloon at 18 atm
Distal Stent Postdilated with 2.5x15mm NC Balloon at 18 atm.
At the end of LAD stenting there was Left main dissection with no flow with cardiac arrest.
CPR done and Inotropes started.
IABP inserted through Right Femoral Artery.
Bailout LMCA to LAD Stenting done with 3.5x24mm DES at 12 atm.
Subsequently after 24 Hrs IABP removed and Inotropes Weaned off.
Patient Discharged after 3 and 1 month clinical follow-up patient is Asymptomatic and doing her daily activities.

Case Summary:
During PTCA stent guiding cath should be coaxial to the artery.
While enjecting contrast, make sure it should be at low pressure & continuous.

TCTAP C-055
Stenting for a Lesion of Chronic Total Occlusion and Trifurcation Stenosis
Seung Mo Kang, Young-Hak Kim, Seung-Whan Lee
Asan Medical Center, Korea (Republic of)

Clinical Information
Patient initials or identifier number: HDJ, 46670830
Relevant clinical history and physical exam:
A 52 years old man was referred to your hospital after failed CTO intervention of LAD lesion. He complained of effort related chest pain for 3 months. His coronary risk factors were current smoking of 60 pack-years and hyperlipidemia.

Test results prior to catheterization:
Initial EKG showed normal sinus rhythm. The echocardiography showed normal LV systolic function without regional wall motion abnormality.

Catheterization findings:
The left coronary angiogram showed total occlusion in proximal LAD, and tight stenosis in proximal LAD trifurcation site. The right coronary angiogram showed total occlusion of distal RCA with bridging collateral flow. Collateral flow to LAD from distal RCA was seen.

Procedural step:
Right coronary artery was cannulated with a 7 Fr AL1 SH guiding catheter and left coronary artery was positioned with a 8 Fr XB 3.5 SH guiding catheter through the bifemoral approach. Initially, we tried antegrade approach at PLAD by using a 0.014 inch Fielder FC wire with Finecross 0.014 inch 1.8 Fr 130cm microcatheter. After negotiation, we succeeded in the engagement of wire into dLAD with Fielder XT 0.014 inch - 190 cm wire, and predilation was performed with Maverick 1.2 x 20mm balloon at plAD. And then 0.014 inch BMW and Sion wires were inserted into the 1st and 2nd diagonal branches, respectively. We decided to treat diagonal bifurcation with crush technique first and then LAD bifurcation with culotte stenting. First, balloon angioplasty for LAD, 1st and 2nd diagonal branch was done using a Ryujin balloon 2.0 x 20mm. Xience prime 2.75 x 28mm stent was deployed at the 2nd diagonal branch. Then we performed balloon crush with 3.0 x 20mm Quantum at plAD to 1st diagonal branch. After rewiring into 2nd diagonal branch balloon inflation was performed at 2nd diagonal branch ostium. Then 3.5 x 33mm Xience Prime stent was deployed from LM to 1st diagonal branch. After rewiring we performed kissing balloon inflation with Quantum 3.5 x 20mm and Maverick 2.5 x 20mm. Then 3.0 x 38mm Xience Prime stent was deployed at pmlAD. After rewiring into 1st diagonal branch, we performed balloon inflation at diagonal ostium with Pantera LEO 3.5 x 20mm. And finally we performed kissing balloon inflation with Pantera LEO 3.5 x 20mm and Quantum 3.5 x 20mm. We checked angiogram but small dissection was seen at distal edge of LAD stent. So we deployed 2.75 x 28 mm Xience Prime stent at mLAD. Final angiogram showed the procedure was successful.