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 main. Stenting of the left main, 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 guidewire 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
Relevant test results prior to catheterization:
ECG: Sinus Rhythm,
QS in V1-V5,
T Inversion in V1-V5,
* 2D ECHO - RWMA in LAD territory
Moderate LV Dysfunction
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 days 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 injecting contrast, make sure it should be at low pressure & continuous.

TCTAP C-055
Stenting for a Lesion of Chronic Total Occlusion and Trifurcution 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.

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

Relevant catheterization findings:
The left coronary angiogram showed total occlusion of distal RCA with bridging collateral flow. Collateral flow to LAD from distal RCA was seen.

[Interventional Management]
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 microcathether. After negotiation, we succeeded in the engagement of wire into dLAD with Fielder XT 0.014 inch - 190 cm wire, and predilatation 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 Riyujin 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 pLAD. After rewiring into 1st diagonal branch, we performed balloon inflation at diagonal ostium with Panthera 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.
Case Summary:

This case became complicated as it had 2 problems, those were CTO and severe trifurcation stenosis. First, in CTO intervention we had no more option other than antegrade approach because RCA was totally occluded and we didn’t want to treat distal RCA CTO. Fortunately we were able to negotiate microchannel successfully. Secondly, in treating LAD trifurcation stenosis we couldn’t neglect any diagonal branches as they were not small ones. So we decided to stent both diagonal branches. In treating bifurcation lesion in diagonal branch we chose crush technique, and in LAD we chose culotte stenting for complete lesion coverage. Prolonged procedural time and large amount of contrast use were another considerations. Total procedural time was about 2 hours, and we used 500cc of contrast. The patient was discharged without any complication 2 days after procedure.

TCTAP C-056

Two Stent Strategy with DES and BVS for Distal Left Main Treatment

Indulis Kumsars
Pauls Stradiņš University Hospital, Latvia

[Clinical Information]

Patient initials or identifier number: VO
Relevant clinical history and physical exam:
Male
69 y/o
Stable angina CSS II-III
Old Q-MI anterior wall
EF: 50%
PCI with DES LAD 2011

[Relevant catheterization findings:]

Distal LM stenosis 70%

[Interventional Management]

Procedural step:
Guiding catheter- 7F EBU 3.75
IVUS in LCX and LAD
Predilatation LCX- cutting balloon 3.5-10 mm
Absorb 3.5-12 mm in LCX ostium
Predilatation LM- LAD 3.5-15mm
Stenting LM-LAD with DES 4.0-20mm
Kissing 4.0-15 mm 3.3-12 mm
POT 4.5-8 mm LM
Final IVUS and OCT in LAD and LCX

Conclusions:

Strategy with DES+ BVS could be effective treatment option in selected distal LM cases
IVUS and OCT are helpful additional tools in complex LM treatment

TCTAP C-057

Reverse Wire in a Bifurcation Lesion with 7.5 Fr EauCath in the Presence of Radial Artery Spasm/Perforation

Michael Mau-Chen Liang
Wellington Hospital, New Zealand

[Clinical Information]

Patient initials or identifier number: AO
Relevant clinical history and physical exam:
A 62 year-old man who presented to peripheral hospital (150km away) with anterior STEMI underwent underwent thrombolysis with Tenecteplase. Clopidogrel (600mg) and Aspirin (300mg) loading dose was given. Due to ongoing symptom, the patient was transferred to our hospital for coronary angiography.

Relevant test results prior to catheterization:
Peak hs-TnT 1061 ug/L (0-14ug/L). Baseline haemogloblin and Creatinine level was normal. Initial ECG showed ST elevation in anterolateral lead.

[Relevant catheterization findings:]

LM normal
LAD: bifurcation 90% diagonal/LAD (Medina 1,1,1).
LCx mid 60% moderate lesion.
RCA: Dominant, no signifcicant disease.

[Interventional Management]

Procedural step:
Diagnostic performed with a 5 Fr TIG. Initially tried to advance a 6 Fr EBU 3.5 guiding catheter over exchange length 260 cm 0.035”J wire but had strong resistance in forearm. Therefore a 7.5 Fr Sheathless EauCath was used to overcome the problem (spasm/perforation)
1. 7.5 Fr Sheathless EauCath PB3.5 was used to engage the LM ostium
2. Runthrough NS ExtraFloppy wire was used to cross the proximal LAD lesion.
3. Difficulty to access diagonal side branch with Sion or Whisper Wire.
4. Via Crusade microcatheter, a Fielder FC wire, delivered as reverse wire system was able to cross the ostial Diagonal.
5. Via the Crusade microcatheter, the Fielder FC was exchanged for Sion wire.
6. Pre-Dilatation of LAD and diagonal lesions with 2x15 mm MiniTrek balloon.
7. A 2.5x12 mm Promus Premier DES was implanted to cover the ostial diagonal artery.
8. The Diagonal stent struts were crushed with 2.75x15 NC balloon.
9. The diagonal wire was retrieved
10. The LAD lesion was stented with an 2.75x24 mm Promus Premier DES.
11. Proximal optimization was performed with 3.0x15 mm NC balloon.
12. Whisper MS wire was sent to the diagonal branch with the aid of Crusade microcatheter.
13. Kissing balloon inflation performed with 2.75x15 mm NC (Diag), 3x15 mmNC (LAD)
14. Good final results.
15. Radial angiography did not show persistent contrast leak

Case Summary:

Successful intervention to a mid LAD/diagonal bifurcation lesions with reverse wiring technique using a 7.5 Fr Sheathless EauCath from radial artery approach.