Conclusion: In our cohort, selective screening of patients with either an age over 70, a carotid bruit, a history of cerebrovascular disease, a diabetes mellitus or a peripheral vascular disease would have reduced the screening load by 40% with trivial impact on surgical management or neurologic outcomes.

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Detection of the coronary restenosis after coronary angioplasty by myocardial perfusion imaging (spect), a prospective study

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The angioplasty transluminal coronary (ATC), gesture of revascularisation which can be realised at the same time that the coronarography, can be enamelled by complication, the most frequent of which are the restenosis.

The aim of our study is to specify, the contribution of the a myocardial perfusion imaging (SPECT) in the detection of the coronary restenose after a planed ATC.

We report in this prospective study, the contribution of the SPECT imaging in the evaluation of the restenose after ATC. The gold standard being the coronarography. The study of the restenose is made by angiographique quantification at 6 months.

It is about 126 patients, 115 men whose average age is 57.42 ± 8.53 years presenting a coronary monotonroulence lesion. 24 % of the patients are diabetics and 63 % of the men are smoking.

On the coronarographic side, we undertook a dilation on 129 lesion. Sixty seven percent of the lesion sits on the anterior interventriculaire (IVA), 21 % on right coronary and 12 % on circumflex. Sixty two percent lesion are of type ≥ B2. In 19 % of the cases, the diameter is less than 2.5 mm. Its length is > 15 mm in 56 % of the cases. The used stents is in naked metal.

The coronarographique control in 6 months interested 118 patients. The rate of restenosis angiographique was estimated at 12 %. The performance of the SPECT myocardial imaging correlated at the coronarography allowed to detect the restenosis with a 88 % sensibility, a 98 % specificity, a positive predictive value and negative predictive value respectively of 88 % and 98 %.

The TSM is a good mean for the diagnosis of the restenosis after an ATC.

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Coronary spasm : a rare cause of myocardial infarction

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Introduction: Acute myocardial infarction may also occur when the coronary arteries are normal or nearly normal. It affects primarily younger persons. The possible mechanisms underlying myocardial infarction with normal coronary arteries coronary vasospasm, thrombosis, embolisation or minimal atherosclerosis.

Observation: A 36-year-old lacting women was admitted to our center with constructive chest pain lasting for more than 30 minutes. She was a passive smoker and had no other risk factors for CAD, no prior history of chest pain and the family history was negative. Cardiovascular examination revealed no abnormal heart sound, gallop or murmur. The initial electrocardiogram revealed sinus rhythm with negative T waves in anterior leads. The occurence of myocardial infarction was confirmed by elevation of cardiac troponin. She was treated conventionally. The normokinesis of all wall motion has been shown.

The initial electrocardiogram revealed no abnormal heart sound, gallop or murmur. The initial electrocardiogram revealed sinus rhythm with negative T waves in anterior leads. The occurrence of myocardial infarction was confirmed by elevation of cardiac troponin. She was treated conventionally, with normal left ventricular function.

Coronary angiography revealed an occlusion of the left anterior descending artery, avoided by nitrate intracoronary. Coronary spasm was suspected and she was started on calcium blockers. Two weeks after, contro coronary angiography revealed normal coronary arteries.

Conclusion: Coronary artery spasm has been shown to cause myocardial infarction in patients with normal coronary arteries. Vasospasm can cause vascular endothelial injury leading to platelet aggregation and coagulation system activation with resultant thrombosis and myocardial infarction. Multislice computed tomography coronary angiography can be used as an alternative first-line imaging modality for the diagnosis of acute myocardial infarction in young patients thought to normal coronary arteries.

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Final kissing with non compliant balloons improves immediate results in bifurcation angioplasty

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Background: Provisional side-branch T stenting (PTS) has emerged as a gold standard in the treatment of bifurcation lesions. Final kissing balloon inflation (Kiss) allows optimisation of main branch (MB) stent deployment and SB ostium scaffolding with the MB stent. By improving proximal MB stent deployment and avoiding overstretch of the SB, non compliant balloons (NC) may improve these results.

Objectives and design: to assess in a pilot study, the angiographic results and clinical outcome after bifurcation lesion stenting using NC balloons (Hiryu, Terumo) for Kiss. The default strategy was systematic use of 2 wires in 6 Fr guiding catheters, no SB predilatation, MB stenting using Sirolimus, Everolimus or Paclitaxel drug eluting stents followed by provisional SB stenting using 6 Fr. Pts with Medina 0,0,1 lesions, in-stent restenosis or left main disease were excluded.

Results: 100 bifurcation lesions were treated in 98 Pts. They were 67±11 y-o, 78% male, 22% diabetics. Indication for PCI was silent ischemia in 23%, stable angina 47% and acute coronary syndrome 30%. Transradial approach was used in 87% of cases. Lesions were mainly located in LAD-diagonal bifurcation (50%). Reference MB diameter was 3.18±0.53 mm and SB 2.28±0.40 mm. MB lesion length was 16.3±6.6 mm and SB 2.34±2.18 mm. The MB was predilated in 49% of cases. The predilated MB stent length was 22.7±6.9 mm and diameter 3.10±0.36 mm. Kiss was performed in all cases but in 3 SB dilatation through the MB stent with a small balloon was needed before Kiss. Optimal SB scaffolding by the MB stent was observed by “stent boost” in 89% of cases. In the remaining, SB dissection or residual lesion > 70% was observed and a SB stent was needed in 7 cases (7%). In hospital outcome was uneventful.

Conclusion: Treatment of bifurcation lesions with PTS approach using NC balloons is feasible with excellent immediate results and a low need for SB stenting. Six-month clinical outcome will be presented at the meeting.