Case Summary:
A 28 year old young man presented with acute inferior myocardial infarction of 3 and half an hour duration.
He was rushed to the cathlab from ED and angiography revealed spiral dissection with thrombus load in LAD extending from the ostia to the mid portion.
RCA was the culprit vessel, has had 100% occlusion from the proximal part with full of thrombus.
Collaterals from the conus branch to LAD seen.
RCA was cannulated with AL 1 guide catheter having PP.
Floppy Runthrough wire taken and crossed the lesion.
Thrombectomy was done by aspiration catheter on repeated succession.
After establishing TIMI III flow a 4/24, DES deployed at 14 ATM.
Flow well established but the conus branch were jailed.
Now, felt into a dilemma where to intervene LAD or not at the same setting.
We decided to proceed considering patients age, vessel condition and evidences in favor from the recently published PRAMI study (N Engl J Med. 2013 Sep 19;369(12):1115-23).
We engaged an EBU 3.5 guide catheter, wired with some difficulty and deployed a DES 3.5/26 at 16 ATM.
IVUS showed mal-apposition at the region of LAD ostia and post-dilated by NC balloon.

TCTAP C-167
OCT Follow-up of Absorb BVS Implanted in Saphenous Vein Graft
Wojciech Wojakowski
Medical University of Silesia, Poland

[Clinical Information]
Patient initials or identifier number:
H.W. 11253/2013

Relevant clinical history and physical exam:
54 years old male with stable angina, hypertension and dyslipidemia, as well as history of coronary artery bypass grafting (CABG) with implantation of 2 saphenous vein grafts (VG) to LAD (Ao-LAD) and diagonal branch (Ao-D1) 23 years ago.

Relevant test results prior to catheterization:
None.

Relevant catheterization findings:
Coronary angiography done because of recurrent angina revealed a chronic total occlusion of right coronary artery, occlusion of Ao-LAD and significant stenosis of Ao-D1. Quantitative coronary angiography (QCA) showed 92% stenosis of Ao-D1 with its reference lumen diameter of 3.7mm, minimal lumen diameter (MLD) of 0.3mm, and lesion length of 11mm.

[Interventional Management]
Procedural steps:
After predilatation with semi-compliant balloon 2.5x8mm an everolimus eluting biodegradable vascular scaffold (BVS) ABSORB 3.5x12mm (Abbott, Santa Clara, CA) had been implanted with good angiographic results. Acute angiographic results and QCA post implantation showed MLD of 3.1mm and 15% residual stenosis of SVG.
Afterwards, the patient had been scheduled for an intravascular optical coherence (OCT) imaging 3 months after the intervention to monitor Ao-D1 healing. OCT revealed complete apposition, no edge dissection or an excessive neointimal hyperplasia in the BVS. The minimal lumen area was 6.2mm2 and the minimal BVS area was 6.7mm2. Moreover, 136 BVS struts were analyzed and 71 (52%) of them had been already covered by the neointima. No signs of BVS absorption were detected.
Case Summary:
This report presents favorable vessel healing after ABSORB implantation to VG in short-term follow-up. However, further observations are required to monitor the influence of BVS absorption on the VG morphology in long-term follow-up.

TCTAP C-168
Fractional Flow Reserve = 0.8 - Stent or Not Stent?
Yiu Tung Anthony Wong, Arthur Yung, Kelvin Chan, Stephen Lee
Queen Mary Hospital, Hong Kong, China

[Clinical Information]
Patient initials or identifier number:
CYS
Relevant clinical history and physical exam:
CYS had history of hypertension and diabetes mellitus. He suffered from non-ST elevation myocardial infarction in September 2011, with percutaneous coronary intervention (PCI) using drug-eluting stent (DES) to proximal left anterior descending artery (LAD).
He developed recurrence of angina since November 2012. Physical examination was unremarkable.
Relevant test results prior to catheterization:
Chest X-ray, electrocardiogram, and blood tests were normal.
Relevant catheterization findings:
Restudy coronary angiogram in December 2012 showed ostial LAD moderate disease, patent proximal LAD stent, ostial left circumflex artery (LCX) minor disease and minor RCA disease.
[Interventional Management]
Procedural step:
Right femoral puncture
6Fr sheath was inserted into the right femoral artery
5Fr sheath was inserted into the right femoral vein
Ostial LM engaged with Cordis JL4 ST guiding catheter
St. Jude Medical PressureWire was advanced to distal LAD
Fractional flow reserve (FFR) measured at distal LAD was 0.80
0.014 inch Abott Whisper guidewire was advanced to distal LCX
Another 0.014 inch Abott Whisper guidewire was advanced to distal LAD
St. Jude Medical Optical Coherence Tomography (OCT) was performed at LAD, showing ostial LAD stenosis
Ostial and proximal LAD was pre-dilated with Boston Scientific Flexilome cutting balloon 3.0/10mm
Plaque was shift to the ostial LCX
Ostial LCX was dilated with Abbott Trek balloon 3.0/12mm
LM to proximal LAD was stented with Biosensor Biomatrix 3.0/24mm, overlapped with the previous proximal LAD stent
Plaque was shifted to LCX
Ostial LCX was stented with Biosensor Biomatrix 3.0/11mm
Distal LM and ostial LAD was post-dilated with OrbusNeich Sapphire balloon 4.0/10mm
Post-procedural OCT was performed at LM to LAD stent
Post-procedural FFR measurement at distal LAD was 0.94
Procedure completed