Case Summary. The reason of stent lost for the patient is very clear, the remnant metal filament wound stents caused the stent to take off from balloon. If, after the first LAD - D1 stents deployed, we put third wire through stent mesh into LAD, and then take out BMW wire before pre-dilate LAD, guiding wire would be more easy to withdraw, and probably can avoid wire broken and left in LAD-LM-Ao. Second, when we pull back the wire pressed by stent and meet high pulling back resistance, we should gradually and kindly pull back, or pull back the wire with help of small diameter balloon. Third if stent forward resistance is high, we need to analyze reasons, don’t push too hard. Fourth, if facing some complicated complications or problems, we should consult with experienced colleagues, it may avoid second complications or malignant complications.

TCTAP C-114
A Hybrid Approach for Giant Coronary Artery Saccular Aneurysm with Stent Migration

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[CLINICAL INFORMATION]
Patient initials or identifier number. 46 years female
Relevant clinical history and physical exam. A 46 yrs old female who is a known case of T2 DM, old Anterior wall Myocardial Infarction, S/P PTCA to LAD in 2012 had presented with unstable angina. She had Anterior wall MI in 2012, Single vessel disease, underwent Primary Angioplasty to Proximal LAD with 3.5x 23 mm DES with no adverse events, perforations or dissection
Relevant test results prior to catheterization. In the year 2013, she had presented with multiple episodes of heart failure and was hospitalized 5 times, managed conservatively, now she go treadmilled with unstable angina
Relevant catheterization findings. Her coronary Angiogram revealed critical stenosis of LMCA, giant saccular aneurysm of Proximal LAD with stent migration and total occlusion of Mid LAD. Surgical option was planned and she underwent CABG, but LIMA could not be harvested due to poor quality and underwent SVG to LAD. Irregular thick and hard aneurysm was firmly adherent to epicardium, hence could not be ligated, OMs were also unable to graft.

[INTERVENTIONAL MANAGEMENT]
Procedural step. So she was planned for covered stent to LMCA to OM, she was taken after one week post CABG, her ECG, ECHO parameters were also re-evaluated, her coronary angiogram showed LAD aneurysm in proximal LAD with distal stent, graft (LIMA) to LAD was patent with good flow to distal LAD. OM and LCX were separately wired with 0.014 wire. A 4.0x15 covered stent: Jostentgraft master(Abbott) was deployed obliterating the aneurysm, post PTCA was uneventful. CT CAG following it confirmed patent LMCA stent and graft to LAD.
Case Summary. Coronary aneurysms after coronary intervention are rare, and most “aneurysms” are in fact pseudo-aneurysms. Interventional or surgical treatment is recommended to avoid potential life threatening complications. Covered stent graft is effective and safe option in selected patients. Our case highlights unique hybrid approach to treat such rare challenging scenario.

TCTAP C-115
Successful PTCA of Complex Anomalous Left and Right Coronary Artery Using Amplatz Guiding Catheter
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[CLINICAL INFORMATION]
Patient initials or identifier number. AS
Relevant clinical history and physical exam. 53 year old male, non-hypertensive, non-diabetic presented with recent onset angina. He had no past history of ischemic heart disease
On examination Pulse-70/min, BP-124/80, CVS-normal RS-normal
Relevant test results prior to catheterization. Treadmill stress test was positive for inducible ischemia and he was advised coronary angiography.
Relevant catheterization findings. Coronary angiography was performed from femoral access. The left coronary artery could not be selectively engaged and non selective injection revealed anomalous high origins of left and right coronary artery from left cusp. Selective engagement of left coronary artery with Al 1 catheter showed severe discrete mid LAD lesion, LCX was unremarkable. The right coronary artery revealed a 90 % discrete proximal stenosis.