Case Summary. Complex coronary anatomy and multiple lesions make us interpret with difficulty regarding which lesions are culprits in patients presenting worsening angina. Based on this case, we can address that since the poor collateral flow to the chronic ischemic area is a strong clue that antegrade flow via bypass graft is still alive and acutely deteriorated, every effort to visualize all the channel going to ischemic area should be done.

TCTAP C-119
PCPS Supported Successful PCI for Complex Coronary Artery Disease with High Surgical Risk: Poor LVEF, Severe Aortic Valvular Stenosis, Tight Left Main Stenosis with Triple Vessel Disease
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[CLINICAL INFORMATION]
Patient initials or identifier number. SSG

Relevant clinical history and physical exam. 60 years old male presented with sudden dyspnea, chest pain and syncope since 1 day ago. He was on hemodialysis since 1999 years, and on medication due to chest pain with suspicious RCA territory infarction on echocardiography (on February 2013), however, coronary angiography could not be done because of gross hematuria.

- Risk factors: HTN, DM ESRD on HD, current smoker
- Physical exam: blood pressure 96/53 mmHg-heart rate 94 /min, rales on whole lung field

Relevant test results prior to catheterization.
1. Chest X-ray: pulmonary edema
2. ECG: ST depression at V4-6, II, III, aVF
3. Lab: CK 76 U/L, CK-MB 1.7 ng/mL, Troponin-I 0.21 ng/mL, Pro-BNP 32,002 pg/mL, pH 7.445, pCO2 38.7 mmHg, pO2 49.5 mmHg, O2 saturation 83.2 %, HCO3 26.0 mEq/L, BUN/Cr 38/5.89 mg/dL
4. Echocardiography: EF 32 %, global hypokinesia, dilated LV cavity, low pressure gradient severe AS (Vmax 3.06 m/sec, mean pressure gradient 37 mmHg), severe pulmonary hypertension (pulmonary artery pressure 75 mmHg)
Relevant catheterization findings. Heavily calcified coronary tree.

- LM: Os 99 % stenosis
- LAD: pLAD tubular 80 % stenosis
  Di Os focal 90 % stenosis
- LCx: Os 90 % stenosis
- RCA: mRCA focal 90 % stenosis
  dRCA diffuse near total occlusion
collateral from LAD to dRCA (gradeII)

Optimal treatment strategy is CABG plus AVR. However, it is considered as high risky, considering patient’s multiple comorbidities; ESRD, low LVEF. The surgeons declined to proceed with CABG plus AVR.

[INTERVENTIONAL MANAGEMENT]
Procedural step. We decided PCI under PCPS support rather than CABG with expect to improved LV systolic function, than planned AVR 6 months later.

Before PCI, mechanical ventilator support was done, PCPS and temporary pacemaker were inserted via left femoral artery and vein, respectively, because emergency situation such as cardiac arrest or intractable hypoxemia or serious cardiogenic shock, were highly probable during PCI. Via right femoral artery, 7 Fr Amplatz Left (AL) 0.75 guiding catheter with side hole was engaged into RCA and Fielder XT wire was put in. After predilatation with 2.5 mm Angiosculp balloon, Osio 3.0 x 15 mm was deployed in mid RCA. Next, predilatating with 2.0 mm balloon in distal RCA, Resolute-integrity 2.25 x 30 mm, 2.75 x 22 mm were deployed in distal RCA and mid to distal RCA, respectively. Since catheter induced RCA ostium intimal...
dissection occurred during these procedures, Osiro 3.0 x 26 mm was deployed in RCA ostium. Left coronary artery was engaged with 7 Fr AL 1 with side hole and wired with Fielder XT. After predilatation with 2.5 mm from left main to proximal LAD, Osiro 3.5 x 26 mm was deployed in left main to proximal LAD. Immediate after left main stenting, LCx flow was decreased. Predilatation with 1.3 mm balloon in LCx ostium, and subsequent kissing balloon were done in both LAD with 3.5 mm balloon and LCx with 1.3 mm balloon. Finally Osiro 2.5 x 18mm was deployed in proximal LAD partially overlapped with previous left main to proximal LAD stent.

Case Summary. This is a successful PCI under PCPS support for tight left main stenosis with triple vessel disease combined with multiple comorbidities and severe aortic valvular stenosis, which is a poor surgical candidate. PCPS weaning and extubation were done at POD 7 and 8, respectively. However, he died from septic shock by multi-drug resistance Acinetobactor baumanii bacteremia at POD13, unfortunately.

TCTAP C-120
Several Attempts of a Stent Dislodgement During LCX PCI
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[CLINICAL INFORMATION]
Patient initials or identifier number. LJS
Relevant clinical history and physical exam. A 70-year-old female was admitted with chest pain for 2 days. Since last month, he has suffered from crescendo chest pain.
The ECG showed ST elevation on inferior lead and biomarker was elevated.
Relevant test results prior to catheterization. The echo cardiography showed RCA territory RWMA with near normal LV systolic function (LVEF=53%).
Relevant catheterization findings. Baseline coronary angiogram showed nearly total occlusion of mid RCA and significant stenosis at LAD and LCA.(fig 1, 2)