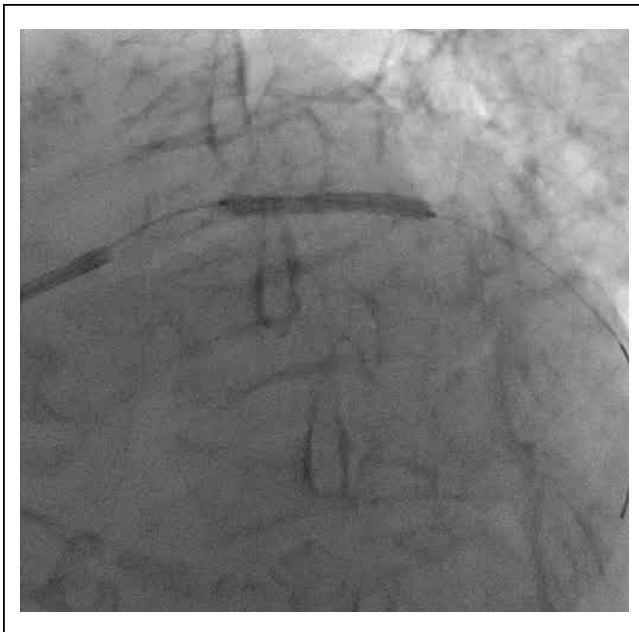
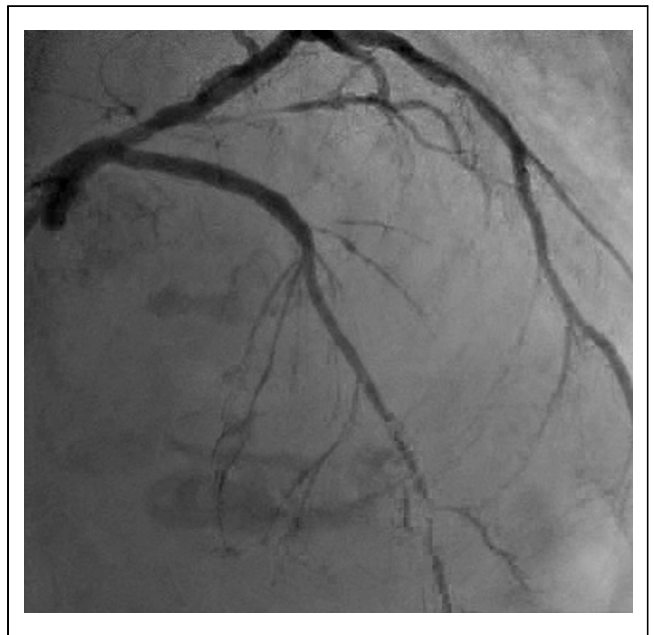


[INTERVENTIONAL MANAGEMENT]

Procedural step. We could not insert intra-aortic balloon pumping (IABP) because of severe tortuosity of aorta. 6 Fr sheath was inserted to right radial artery and we engaged guiding catheter; CLS 3 Mach1 6Fr (Boston Scientific, Natick, USA) to left coronary artery (LCA). At first we crossed a Runthrough froppy guide wire (Terumo, Tokyo, Japan) to LCX and deployed paclitaxel eluting stent (PES), 2.75 x 24mm. Next, we treated the chronic total occlusion (CTO) site of LAD. The CTO lesion was successfully penetrated using a Finecross microcatheter (Terumo, Tokyo, Japan) and a 0.010-inch guide-wire; eel intermediate (Japan Lifeline, Tokyo, Japan). We deployed PES 2.75 x 24mm at proximal site of LAD, resulting in TIMI 3 flow of LAD and LCX. After the procedure, the heart failure improved and she discharged without complication.



Case Summary. We experienced the case of the old patient of severe ischemic heart failure including chronic total occlusion. The aggressive revascularization in one session could help to improve heart failure without mechanical support.

TCTAP C-143

Late Presentation ST-Elevation Myocardial Infarction Complicated by Post-MI Angina and Heart Failure with Unusual High Risk Coronary Anatomy

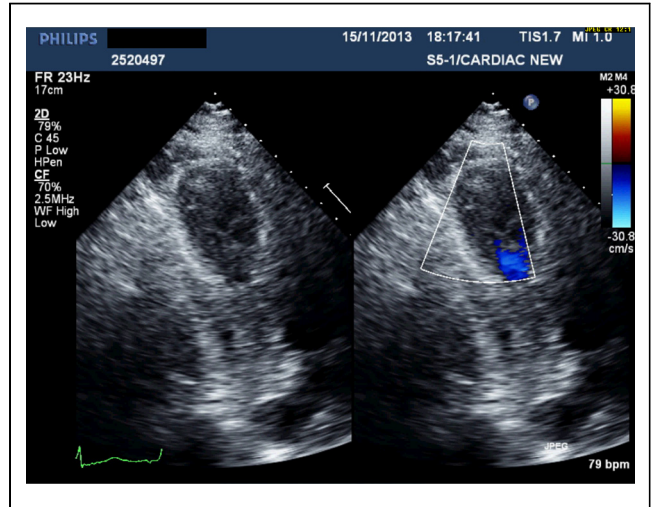
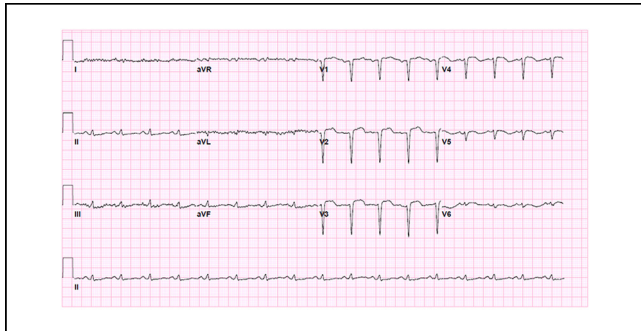
Basil Thanoon Saeed,¹ Ali M. ALGhamdi,² Ameer Al-Ajab,³ Ahmed Alsaileek,² Waqas M. Khan,¹ Ahmad S. Omran⁴
¹King AbdulAziz Medical City, United Kingdom; ²King AbdulAziz Medical City, Saudi Arabia; ³King AbdulAziz Medical City, Sudan; ⁴King AbdulAziz Medical City, Canada

[CLINICAL INFORMATION]

Patient initials or identifier number. A.J

Relevant clinical history and physical exam. A 43 yrs old male presented with angina and breathlessness 7 days after being treated medically

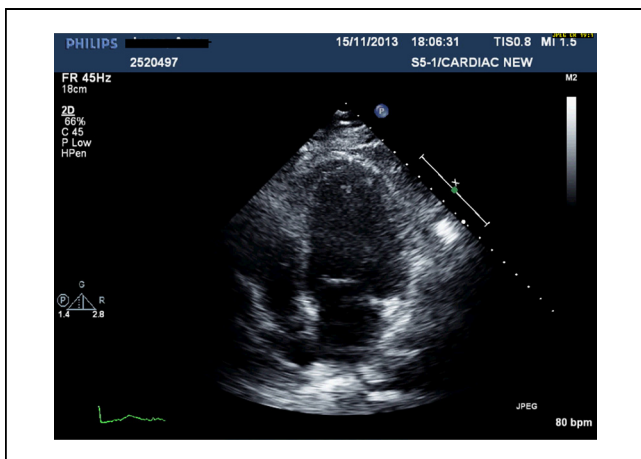
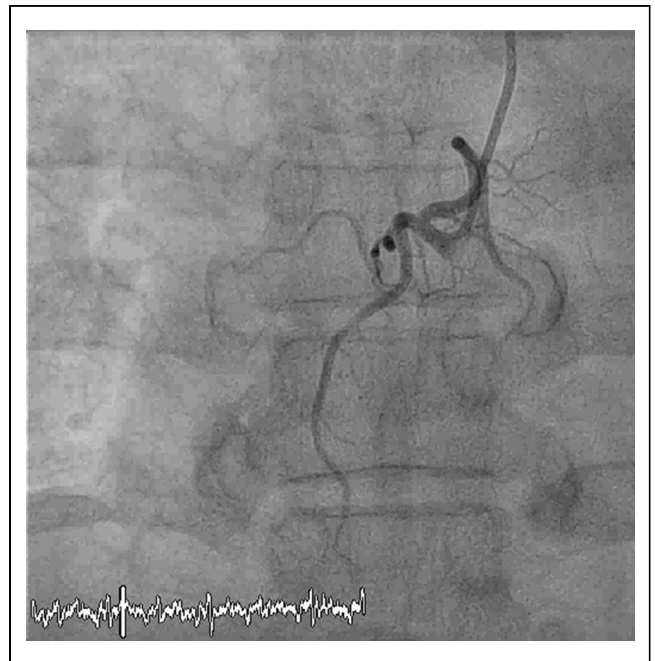
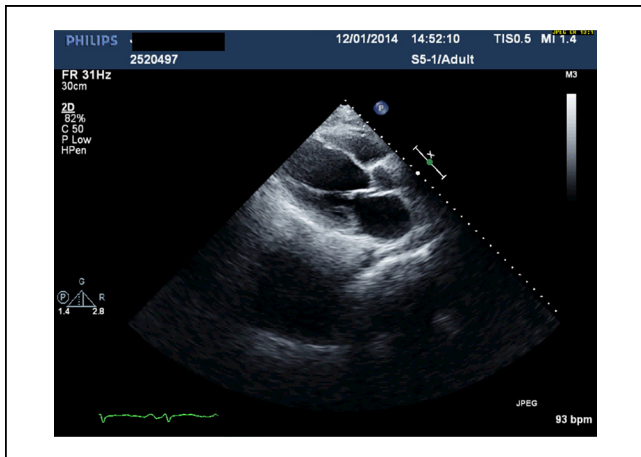
for an anterior STEMI in another hospital. He was in left ventricular failure (LVF) and treated for this and ACS with IV diuretics, DAPT and IV heparin followed by Warfarin after the finding of LV thrombus on Echo. Became stable and discharged home without invasive testing as felt unsafe with LV thrombus. Readmitted 2 weeks later with ACS and LVF and investigations with cardiac cath ultimately done.

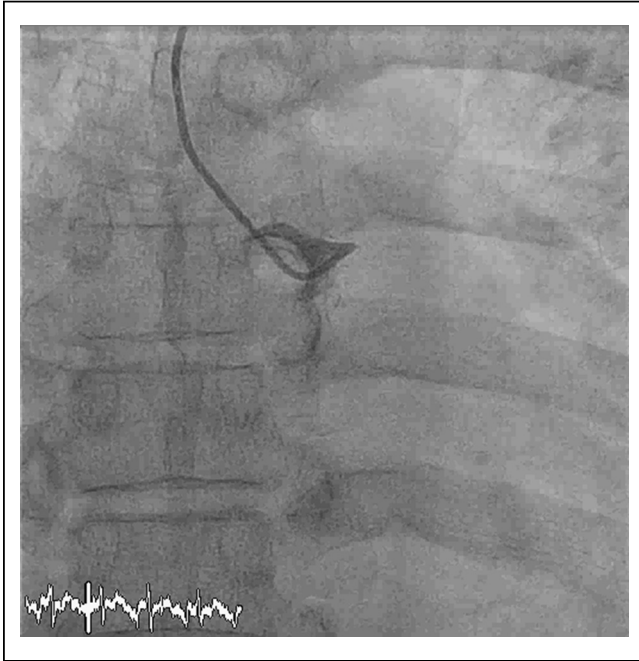


Relevant test results prior to catheterization. His BNP was raised after the first admission to 359 ng/ml and Troponin was 14 mcg/L came down to 1.5mcg/L on the 2nd admission. His EKG showed no further changes the 2nd admission. Echo-cardiogram showed extensive anterior wall akinesia with poor ejection fraction of about 30%. To justify invasive management, a Cardiac MRI was also performed which showed no significant viability in the LAD territory.

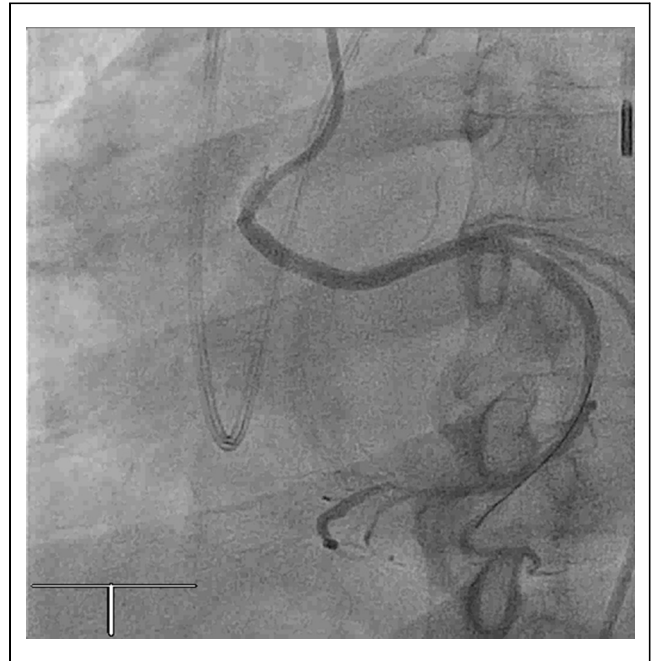
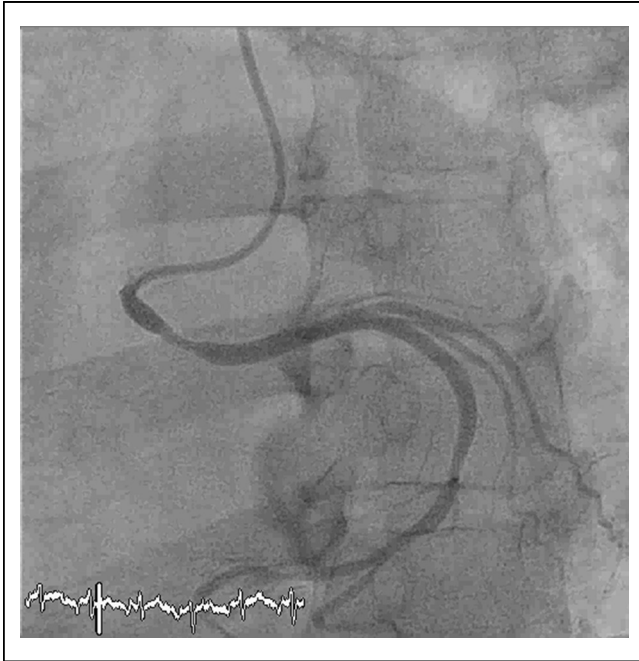
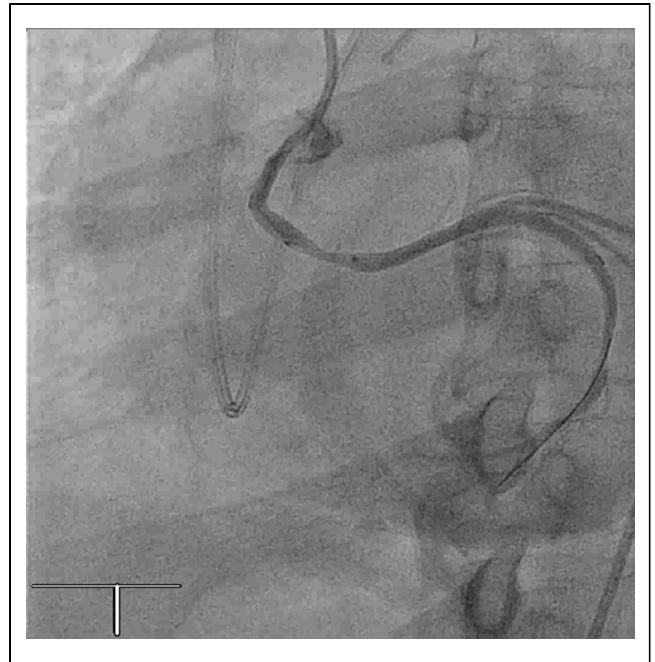
Relevant catheterization findings. As he continued to be unstable clinically and haemodynamically, invasive investigations were contemplated with view to intervention.

The cardiac cath was done through the right radial access. His right coronary artery was small and non-dominant. His left coronary artery was occluded near the ostium. His left circumflex was found to be ectopic from the right coronary sinus and was large and dominant with significant proximal 80% stenosis.





over the next 3 days and ultimately was off IV Inotropes and discharged home on day 5 after the interventional procedure in a stable condition. Two months later, he traveled to his home country and was in a stable health.



[INTERVENTIONAL MANAGEMENT]

Procedural step. It was felt that the patient was a high risk for all kind of intervention and therefore the case was discussed in our multi-disciplinary meeting. The consensus was that his risk of intervention was high whether PCI or surgical intervention was to be performed. We therefore proceeded with PCI to the proximal stenosis of his ectopic circumflex artery with Intra-Aortic Balloon pump support. Right femoral access was chosen and the guiding catheter was right Amplatz which was engaged after some difficulty. A BMW wire was passed into the ectopic Cx artery and the lesion was treated with direct stenting with good result and no complications. He improved

Case Summary. This is a case of late presentation STEMI in which the patients was unfortunate not to receive timely primary PCI which would have probably avoided his high risk presentations with heart failure due to significant LV dysfunction and ongoing ACS. The case highlight few management issues in relation to the timing of invasive/ interventional procedures in patients with complicated STEMI specially those who miss out on primary PCI and which need to be as early as possible according to published guidelines. It also highlight

the incidental finding of the unusual and relatively high risk coronary anatomy in a clinically high risk situation patient.

We would like to discuss these interesting learning points.

TCTAP C-144

PCI Without Using Any Contrast Media for Patient Who Has Allergy to It

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[CLINICAL INFORMATION]

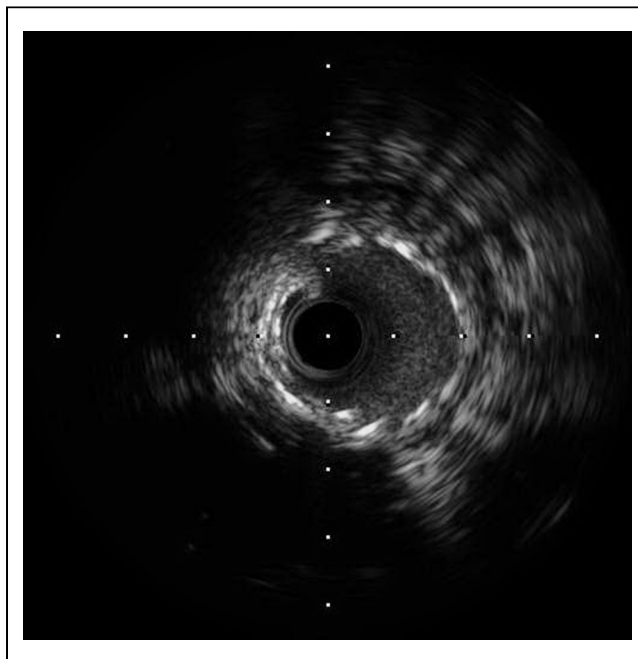
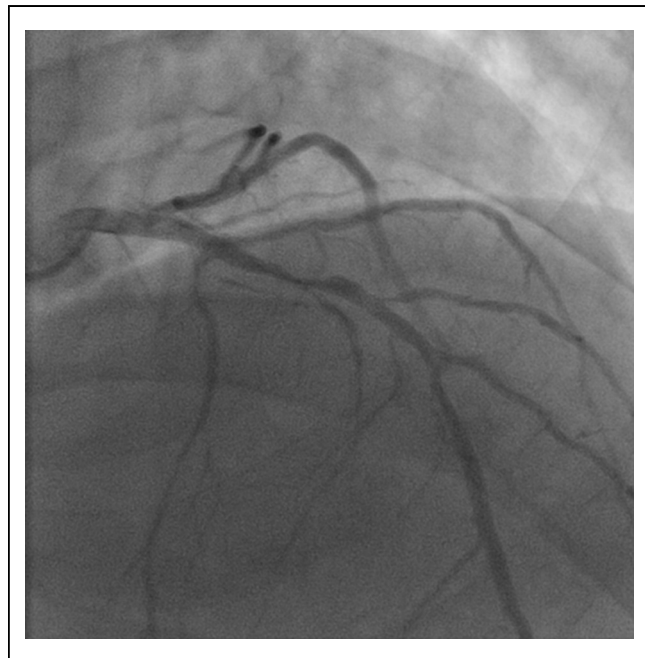
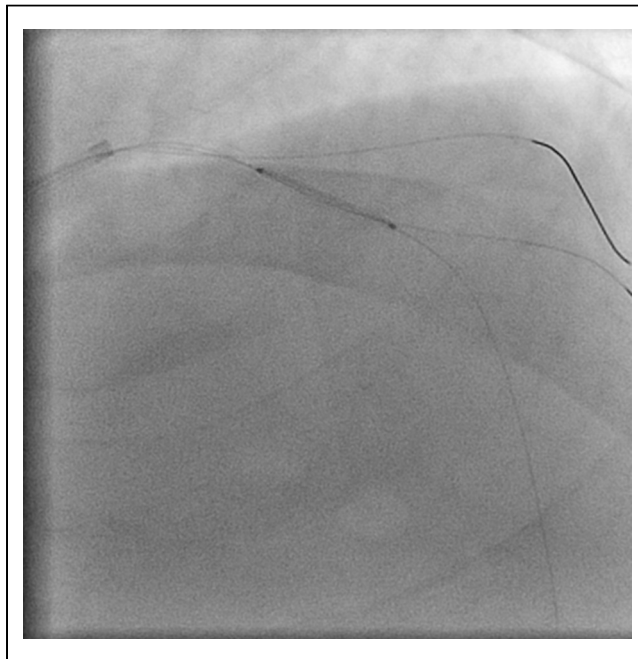
Patient initials or identifier number. N.H.

Relevant clinical history and physical exam. A 54 years old male was admitted to our hospital, complaining about chest discomfort at effort on August 8th, in 2012. He has been suffering from the symptom for about 2 months. He started hemodialysis due to diabetes mellitus about a year before hospitalization.

Relevant test results prior to catheterization.

Relevant catheterization findings

We performed CAG and he had a tight stenosis lesion in his LAD. After CAG, he started have rash all over his body and we thought that he had allergy to contrast media. After CAG, because of allergy, we recommended him to have CABG but he refused to have it. So we tried to perform PCI without using any contrast media. We gave him steroid for pre medication just in case.



[INTERVENTIONAL MANAGEMENT]

Procedural step. We crossed 3 guide wires to LAD, D1, and D2 for merkmal, because the lesion was located between D1 and D2. We used IVUS for measuring the length, the vessel diameter, and also did IVUS marking for the proximal edge and the distal edge. We put stent (Promus 3X18), and added post dilatation using non-compliant balloon (Powered Lacross 2TM 3.25X10). After stenting, we used IVUS for checking that the stent expansion was enough, there was no edge dissection occurred. ECG showed no change between before and after PCI. UCG showed no pericardial effusion. PCI was successfully finished without using any contrast media.

Case Summary. We performed successful PCI for a patient who had allergy to contrast media without using any of it. Using IVUS and wire marking were very useful. We could use this procedure technique mainly for a patient with allergy to contrast media but also for a patient with CKD.