**[INTERVENTIONAL MANAGEMENT]**

**Procedural step.**

1. **Possible Causes:**
   - Very late stent thrombosis
   - Stent Malapposition or Under expansion
   - Inadequate or Resistant Antiplatelet Tx
   - Delay healing
2. **Gycoprotein IIb/IIIa inhibitors infusion**
3. **Check Previous PCI report**
   - LMT-LAD stenting
   - m-LAD with Biomatrix 3x28mm
   - LMT-LAD with Biomatrix 3.5x23mm
   - Final Kissing with 3.5 and 2.75 balloon
   - RCA stenting
   - m-RCA with Resolute 2.75x24mm 12 atm
   - p-RCA with Resolute 3.0 x24mm 14atm
   - According to report
   - No IVS check
   - No Post-dilatation
4. **Check IVUS and OCT later in 2nd Look**
   - a under expansion stent shown
   - we arrange a 4.0 mm balloon inflation in the m-RCA and a 4.5 mm balloon inflation in the orifice of RCA

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**Case Summary.** Angiographic guided PCI is feasible but not always adequate. Application of Image modalities like IVUS or OCT will facilitate and intensify our PCI strategies, especially in the DES era. Safety is of the highest priority.

**TCTAP C-007**

Unprotected Left Main Trifurcation Treated with VV Four Stent Technic During Anterior STEMI Complicated with Cardiogenic Shock

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**[CLINICAL INFORMATION]**

**Patient initials or identifier number.** SFVV

**Relevant clinical history and physical exam.** A 55 y male was brought to our emergency ward for severe dyspnoea and orthopnoea and intensive chest pain. The onset of symptoms was sudden and the beginning was some hours before admission. In his past history is to mention important chronic pulmonary obstruction. As risk factors is to mention: hypertension, and smoking.

At physical examination there were signs of pulmonary oedema and cool extremities

**Relevant test results prior to catheterization.** At ECG with RBB block there were signs of anterior STEMI but also with significant ST elevation in aVR. Thoracic X-ray demonstrated presence of pulmonary oedema and the laboratory data evidenced high levels of myocardial enzymes (CKMB 124, TnT 7,89) with acute respiratory and metabolic acidosis (pH 7,23; pCO2 54). At echocardiography there were akinesia of the apex and hypokinesis of the basal-mid segments of anterior and lateral wall con EF about 30%
Relevant catheterization findings. The angiography was performed by right femoral approach. The RCA was dominant and free of significant lesions. LM ended with a trifurcation where there was sub-occlusive lesion involving the ostium of LAD and RI. At this moment the patient became unstable so he was intubated, IABP was placed and intracoronary bolus of agrastat and bivalirudin was done.

**INTERVENTIONAL MANAGEMENT**

**Procedural step.** Coronary wires were placed in LAD (BMW Elite), and in RI (Luge). For difficulties to negotiate the CX, we did kissing POBA of LAD and RI (Maverick 2,0x20 at 10 Atm). Whisper ES was placed in CX and a POBA (Maverick 2,0 x 20 mm at 10 Atm) of LM/CX was performed, then a triple balloon inflation was performed (all Maverick 2,0 x 20 mm) on LM/LAD/RI/CX. Achieving a good lumen we place separately three stents at the ostiums of all three (LAD, RI and CX) vessels - VV technic. First we delivered a DES (Biomatrix 3,0x18 mm at 20 Atm) on LAD. Keeping the balloon of the same stent in LAD at 10 ATM we positioned second DES (Biomatrix 3,0x18 mm at 20 Atm) at the ostium of RI. A third DES (Biomatrix 3,0x18 mm at 20 Atm) was delivered at the ostium of CX while the balloon from the stent in the RI was maintained at 10 Atm in RI. Again triple balloon inflation (NC Sprinter 3,0x20 mm at 24 Atm) on the axis LM/LAD/RI/CX was done (Fig. 2). On the LAD wire fourth DES (Biomatrix 4,0x24 mm at 20 Atm) was delivered from the LM ostium to its trifurcation. Good final result (Fig. 4) was achieved after final triple kissing-balloon on LM/LAD/RI/CX (3 NC balloons at NC Sprinter 3,0 x 20 mm at 20 Atm) and final post-dilatation of LM (NC Quantum Apex 4,0 x 20 mm at 20 Atm) fig 3.
**Case Summary.** LM trifurcation is rare anatomic finding and if affected with critical stenosis is difficult for treatment, particularly in the setting of STEMI. Another important issue is the stenting technique. In our case we decided to adopt a separate stenting of all branches and then of the LM with good final result as the patient was discharged in good clinical conditions with EF of 40% and only apex akinesia.

**TCTAP C-008**

Anterior Acute Myocardial Infarction Associated with Trousseau's Syndrome, Successfully Treated with Thrombectomy

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[CLINICAL INFORMATION]

**Patient initials or identifier number.** O.M.

**Relevant clinical history and physical exam.** Clinical History

She transferred to our hospital because of anterior acute myocardial infarction from a neurosurgical hospital. She had been treated in previous hospital because of multiple repetitive cerebral infarctions.

Physical Exam

- Blood Pressure: 140/84mmHg, Heart Rate: 75bpm, regular
- O2 Saturation: 100% (room air)
- Body Temperature: 37.1°C
- Lung: clear, no rale
- Heart: S1 --, S2 --, S3 -, S4-, no murmur
- Left hemiplegia

**Relevant test results prior to catheterization.** 12 Leads electrocardiogram

- Heart Rate: 76bpm, Sinus Rhythm
- Q with ST elevation in II III aVF V1-4
- Chest Roentgenogram
- Cardio-thoracic Rate: 57%
- Congestion: -
- Effusion: -
- Echocardiogram
- Left ventricular apical asynergy

**Relevant catheterization findings.**

- Coronary Angiogram (CAG)
  - Right Coronary Artery (RCA): no significant stenosis
  - Left Anterior Descending Artery (LAD) #8: 100%
  - Left Circumflex Artery (LCX): no significant stenosis