7. Stent the SB with a 2.0*20mm stent.
8. The final kissing balloon dilatation was performed.
9. The final angiography and IVUS show optimal stent expansion.

**Case Summary.** Questions/Discussion

1. What’s your recommended strategy for the SB wire protect?
2. What’s your recommended strategy for the SB total Occlusion after stent?

**TCTAP C-046**
Left Main Occlusion Presenting as ST Elevation Myocardial Infarction: From Chaos to Stability
Thomas George
Caritas Hospital, India

**[CLINICAL INFORMATION]**
Patient initials or identifier number. J T
Relevant clinical history and physical exam. 57 year old male hypertensive and smoker was admitted with 7 hours history of rest angina. He was not a diabetic and there was no past history of limb claudication, stroke or effort angina. At admission he was restless tachypnoeic and had diaphoresis. Peripheries were cold and clammy. Pulse was thready with tachycardia and systolic bp at right upper limb was 70 mm hg. There were extensive rales in chest. ECG at admission showed rbbb with st elevation in anterior leads. He was taken up for emergency.
Relevant test results prior to catheterization. Echocardiogram showed severe LV dysfunction with regional wall motion abnormality in LAD territory.

Relevant catheterization findings. The right coronary artery was dominant and normal. The distal Lt main coronary artery was totally occluded.

[Interventional Management]

Procedural step. Methods: Patient was taken up for emergency primary PCI. Through a left femoral access an IABP was put in. Through right femoral vein a temporary pacemaker was kept in RV. A check angiogram of right coronary artery was normal. The left coronary artery was occluded at left main. With a 6F EBU 3.5 guide the Lt coronary was cannulated and a 0.014 fielder FC wire was passed into distal LAD. The proximal lesion was predilated with a 2.0x12 compliant balloon. Thrombosuction was done next with an export catheter. A 3.0 x 33 DES was deployed at 12 atm. The Left circumflex artery was recrossed through the stent struts and with a 1.5x12 compliant balloon. TIMI 3 flow was achieved.

Results: Patient was shifted to cardiac ICU on IAB and inotropes. he was gradually weaned off all supports. he had no episodes of LV failure in recovery. an echocardiogram done 6 months post procedure showed moderate LV dysfunction and he has NYHA class 2 dyspnea. Primary PCI in patients with cardiogenic shock & LVF

Effective revascularization improves survival even with relative late presentation.

Time duration between onset of shock & revascularization also determines outcome. Whatever may be the duration of shock PCI is superior to pharmacological therapy-shock trial

Even though IABP is given class2a recommendation and the negative impact of IABP in shock 2 trial-still plays an imp role in real world scenarios.
Case Summary. Primary PCI in patients with cardiogenic shock & LVF
Effective revascularization improves survival even with relative late
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impact of IABP in shock 2 trial-still plays an imp role in real world
scenarios.

TCTAP C-047
LAD/D1 Bifurcation Stenting
Ankur Gupta
1Post Graduate Institute of Medical Education & Research, India

[CLINICAL INFORMATION]
Patient initials or identifier number. BS
Relevant clinical history and physical exam.
- BS 55 yrs old M, Smoker
- Lateral wall MI 2 days back, thrombolysed with STK
- Now presented with post infarct angina
- ECG showed ST elevation in I, aVL, V5 and V6.
- Echo showed lateral wall hypokinesia and LVEF 45%

Relevant catheterization findings. Coronary angiography shows lad/d1
bifurcation lesion.