surgery. However, with newer DES and better adjunctive imaging techniques (IVUS, OCT), ULMCA angioplasty & stenting has become an attractive alternative in certain situations. Here, we present our single-unit experience in LMCA stenting over the last 7 years.

**Methods:** We performed 12 cases of ULMCA stenting over the last 7 years. There were 8 male and 4 female in the age group of 34 – 82 years. The etiology was atherosclerosis in 11 and aortoarteritis in one. 7 cases were emergency procedures (primary PCI in acute MI), of which 5 were in cardiogenic shock. LAD occlusion involving distal LMCA bifurcation was seen in 4, LAD occlusion with mid- shaft independent stenosis in 2 and spontaneous dissection of LMCA involving LAD & LCX was seen in 1 postpartum lady. Scases were elective PCIs: all were approved by heart-team with high surgical risk in 3 and patient choice in 2. Two had ostial stenosis, 2 had mid- shaft stenosis and 1 had diffuse LMCA stenosis. IABP insertion was done in all emergency cases and in 2 elective cases with severe LV dysfunction.

**Results:** Transfemoral access was used in 11. Transradial access was done in 1 with additional transfemoral access during the procedure for SKS stenting using a novel simultaneous kissing guide technique for LMCA bifurcation stenting with large LMCA and equal sized smaller LAD & LCX. 6 & 7F guide catheters were used in all. Adjunctive techniques included catheter thrombus aspiration in 5 emergency cases, Flex tome cutting balloon in 1 elective case. Adjunctive IVUS imaging was used in 2 elective cases and OCT in 1, and in none of the emergency cases. Single stent strategy was used in 10 (including crossover stenting), 1 SKS and 1 TAP. DES were used in all but 4 cases. Pharmacology was dual (8) or triple (4) antiplatelet therapy. The procedural success was 100%. In-hospital mortality occurred in 1 emergency case with cardiogenic shock; no mortality at 30-days in the rest. LV function had improved in all primary cases.

On follow up, routine coronary angiography was done in 4 patients, CT coronary angiography in 4, while 2 patients who were clinically stable opted out of repeat coronary angiography.

**Conclusion:** Unprotected LMCA stenting is increasingly being undertaken both in emergency situations and in selected elective cases. The results are encouraging but challenging problems are encountered in emergency cases (will be discussed).