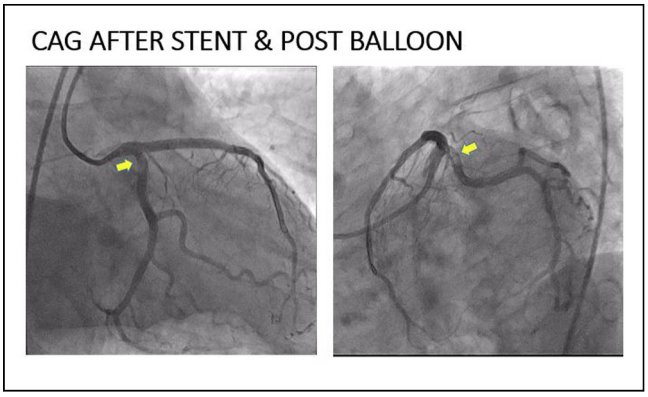
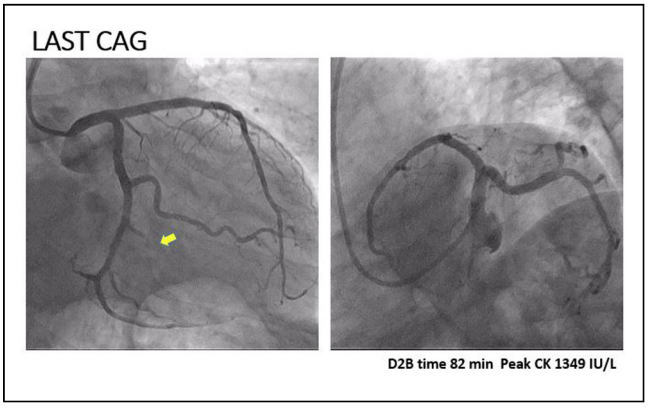




Case Summary. We would like to report a case of longitudinal stent elongation during repetitive post-dilation with semi-compliant balloon resulted in the complication with residual thrombus shifting to LCx when performing emergent PCI.

TCTAP C-263

Management of Long Complex CTO in LCX by Indigenous Biomime Morph Tapering Stents from Meril

Manotosh Panja[1]
[1]BelleVue Clinic, India

[CLINICAL INFORMATION]

Patient initials or identifier number. Mr S S

Relevant clinical history and physical exam.

- A 56 years old male patient has admitted with the features of unstable angina with a past history of Inferior wall Myocardial Infarction 2 years back.
- He was diabetic for 4 years
- He is hypertensive
- EF- 53%

Relevant test results prior to catheterization.

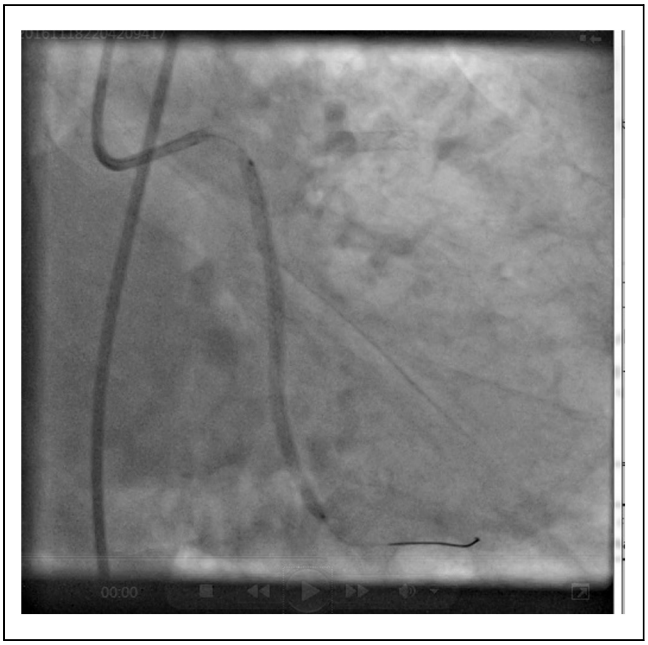
- EF- 53%

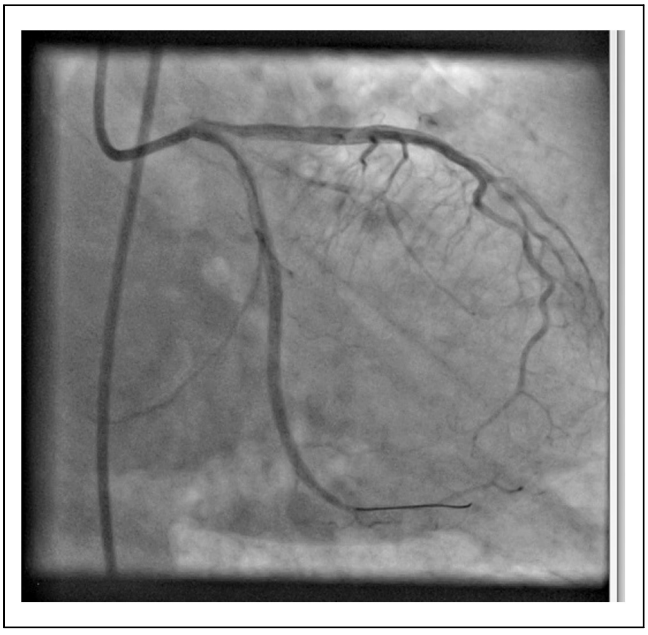
Relevant catheterization findings. A coronary angiography shows double vessel disease involving LAD (85% narrowing with diagonal ostial lesion with a small caliber) and Left Circumflex with proximal CTO with retrograde co lateral from LAD. RCA has minor disease.

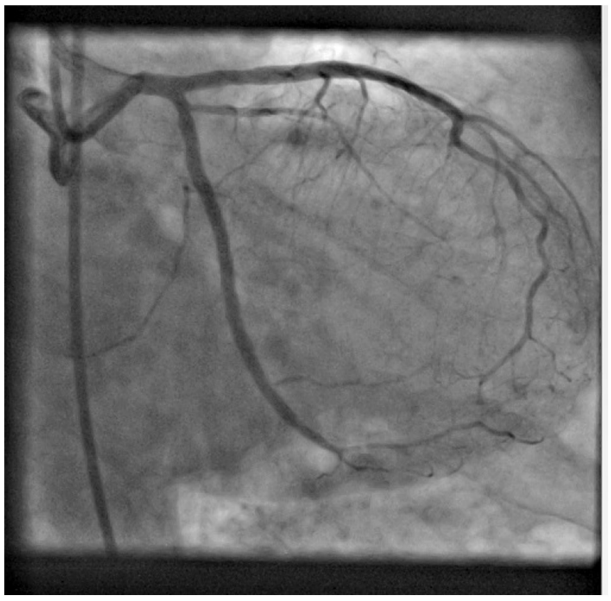
[INTERVENTIONAL MANAGEMENT]

Procedural step.

- The conventional approach of CTO with multivessel disease is to treat the CTOfirst followed by the PCI of othe vessels.
- This patient's LCX CTO had good co-laterals from LAD.
- UnconventionallyI opened the LAD first so that the retrograde to the co-laterals feeding the distal CTO LCX gets a further improvement of flow.
- LAD had 85% lesion crossed with a Floppy wire and jailing od D1 was prevented with another wire
- DirectSENTING of LAD was done with Endeavor Resolute DES.
- ExcellentLAD flow and improvement of collaterals feeding the CTO LCx
- Could able to cross with a Whisper wire and balloon support with great difficulty
- Repeatedly the guide wire was going to the side branch
- After the use of Intra coronary nicorandil, finally, could cross the CTO.
- Sequential balloon dilatation was performed in the whole CTO segment.
- Result after repeated sequential Sprinter balloon dilatation
- It was extremely difficult to tract the 60 mm tapered DES (Proximal 2.75 mm and distal 2.25 mm)
- The guide catheter was dislodged for better co axial alignment to the 90 degrees angulated LCX to tract the long DES while it was half delivered in the LCX
- After post dilation had an excellent result with a long tapered DES







Case Summary. The Biomime Morph from Meryl is a more anatomically acceptable and cost-effective option in diffuse or tandem coronary lesions. There is no question of overlapping stents. It requires less procedural time and provides good clinical outcomes. Ultimately large scale multicentric study with long term follow-up is needed regarding its future.

- 100% proximal CTO of LCX with nearly 90% acute angle with LMCA
- The LCx is a small vessel with a long lesion (60 mm)
- Proximal and distal diameter of the vessel had a gross difference which required 2stents or a long tapered stent (proximal 2.75 mm and distal 2.25 mm)
- LCx had some bending with some minor calcification.

TCTAP C-264

Successful PTCA Using Single Long 48 mm Stent in Complex Lesions Including Long-in Stent CTO

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[1]Cumballa Hill Hospital, India

[CLINICAL INFORMATION]

Patient initials or identifier number. CASE 1 - VC CASE 2 - SS CASE 3- TT CASE 4 - JJ

Relevant clinical history and physical exam.

Case 1 A 53 years old diabetic lady with history of PTCA to mid-RCA 5 years ago, presented with exertional angina of few months duration

Case 2 A 62 years old lady with HT and dyslipidemia presented with recent onset angina

Case 3 A 49 years old man presented with acute coronary syndrome

Case 4 A 55 years old lady with HT presented with the exertional breathless ness of one month duration

Relevant test results prior to catheterization.

Case 1 ECG showed old inferior Mi pattern with ST-T changes

Case 2 Treadmill stress test was strongly positive

Case 3 2D echo revealed LV ejection fraction of 40% with distal septal and apicolateral hypokinesia

Case 4 Angiography showed severe 80-90 % mid RCA lesion with irregular plaques form proximal to mid RCA.

Relevant catheterization findings.

Case 1 Angiography showed in stent CTO in rightcoronary artery

Case 2 Angiography showed 3 significant lesions from proximal to mid RCA

Case 3 Angiography showed severe focal 95% LAD lesion in mid segment and longirregular plaque in proximal LAD

Case 4 Angiography showed severe 80-90% mid RCA lesion with irregular plaques form proximal to mid RCA

[INTERVENTIONAL MANAGEMENT]

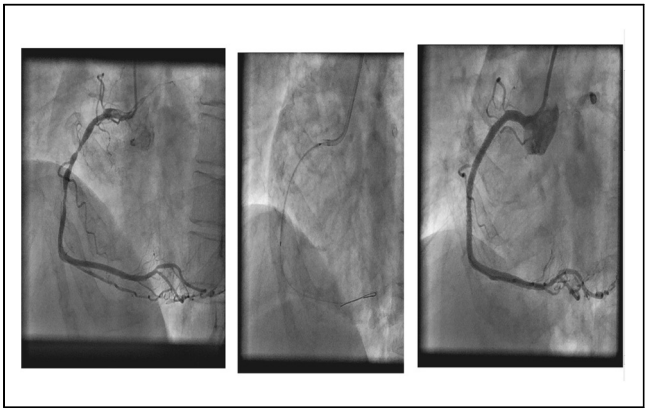
Procedural step.

Case 1 Crossing the in stent CTO was attempted with BMW and fielder FC wires which could not cross. The CTO was finally crossed with Feilder XT-A wire and predilatation was done using 1.25 and 2 mm balloons. A microcatheter was used to exchange the fielder wire with BMWwire. There was long instent and persistent disease both before and after the previous stent. The entire diseased segment was stented using 2.5 x 48 mm Xience expedition stent with good result

Case 2 Predilatation was done of all lesions using 2.5 x 10 mm balloon. 3 x 48 mm Xience expedition stent was deployed covering all the lesions with good result

Case 3 After predilating the point of severe stenosis a 2.75 x 48 mm Xience expedition stent deployed It was post dilated using 3 x 12 mm Balloon proximally with good result

Case 4 After predilatation of the mid RCA lesion the entire diseased area was stented using 3 x 48 mm Xience expedition stent. The proximal and mid part of the stent was post dilated using 3.5 x 10 mm balloon with excellent result



Case Summary. These cases illustrate that complex long lesions or multiple lesions in one vessel can be successfully treated with a 48 mm single stent. Exact measurement of the total length of the lesion and the diameter of the vessel is important . A diameter difference of 5 mm can be easily accepted. The stent size should be selected as per the diameter of the vessel towards the distal part of the lesion. The advantage of using single long 48 mm medicated stent, besides saving in cost and procedure time, the absence of any overlap area (which is unavoidable with multiple stents)and this reduces the chances of re stenosis.

TCTAP C-265

2-link Stent Fracture at the Time of Post Balloon Dilation

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[1]Tokyo Medical University Hachioji Medical Center, Japan

[CLINICAL INFORMATION]

Patient initials or identifier number. 00762466

Relevant clinical history and physical exam. A 77 year-old man admitted to our emergency department due to persisting chest oppression and diagnosed with acute anterior myocardial infarction.

Coronary risk factors were hypertention and dyslipidemia.

Relevant test results prior to catheterization. ECG : ST elevation in $V_{1\text{-}4}$

Echo cardiogram : LVEF : 40%, Anterior area mid ~ apex akinesis

Relevant catheterization findings. CAG revealed total occlusion in middle segment of LAD.

Others did not admit stenosis.