ASIAN INTERVENTIONAL CARDIOVASCULAR THERAPEUTICS
THE OFFICIAL CONGRESS OF APSIC

Chain reaction---Endless nightmares!

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Conflicts of Interest

Speaker's name: Dr. Dhiman Banik

☑ **I do not have any potential conflict of interest**

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Initial Diagnosis:

- Mr. X-29 years old, Physician by profession
- Hypertensive, Strong family history of IHD
- NSTMI
- ECG shows T↓ in V1-V6.
- Echo reveals no regional wall motion abnormality with LVEF -60%.
- CAG was done three weeks after the NSTMI.

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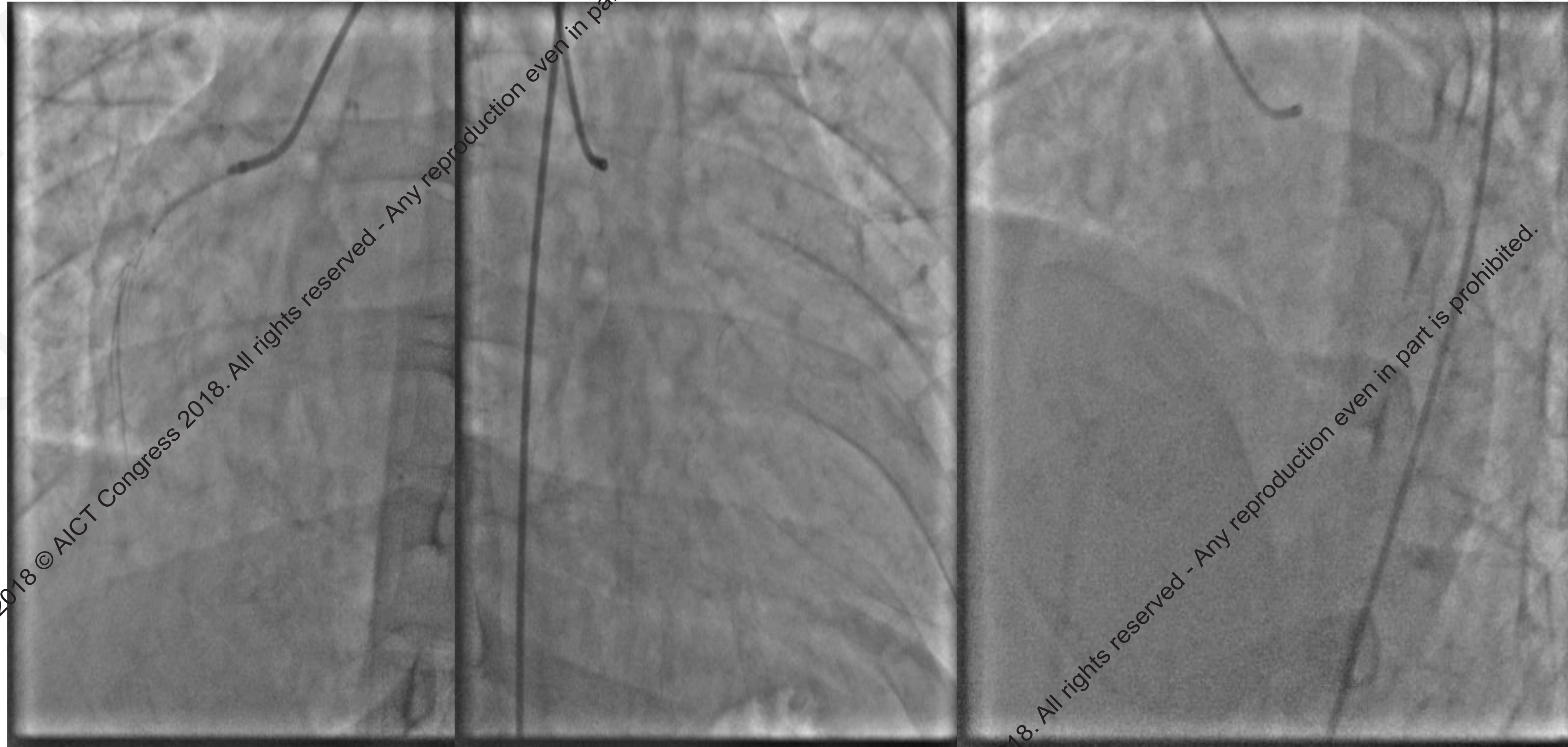
RCA : Non dominant and normal.



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LMCA : ??

LAD : ????.

LCX : Dominant & no significant stenosis.

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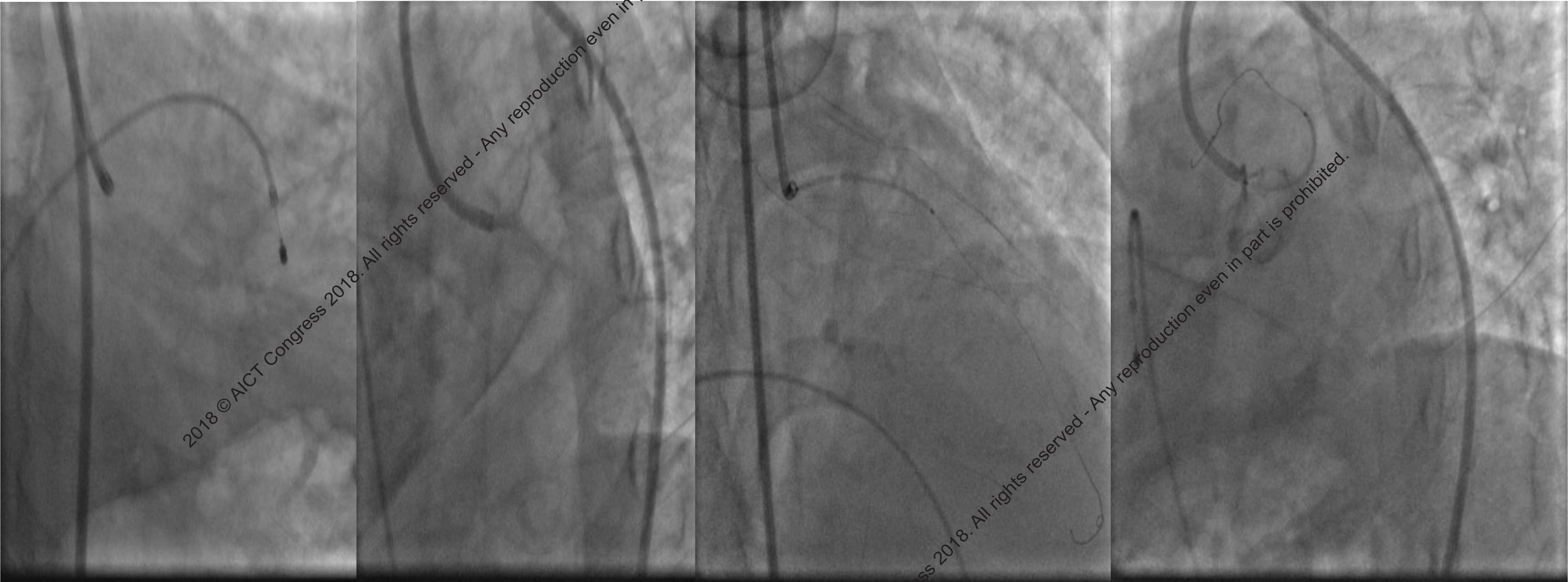
Three days later PCI was done in an another center--------



Patient developed cardiac arrest during PCI and revert by CPR

3.0 mm x 36 mm DES was deployed .

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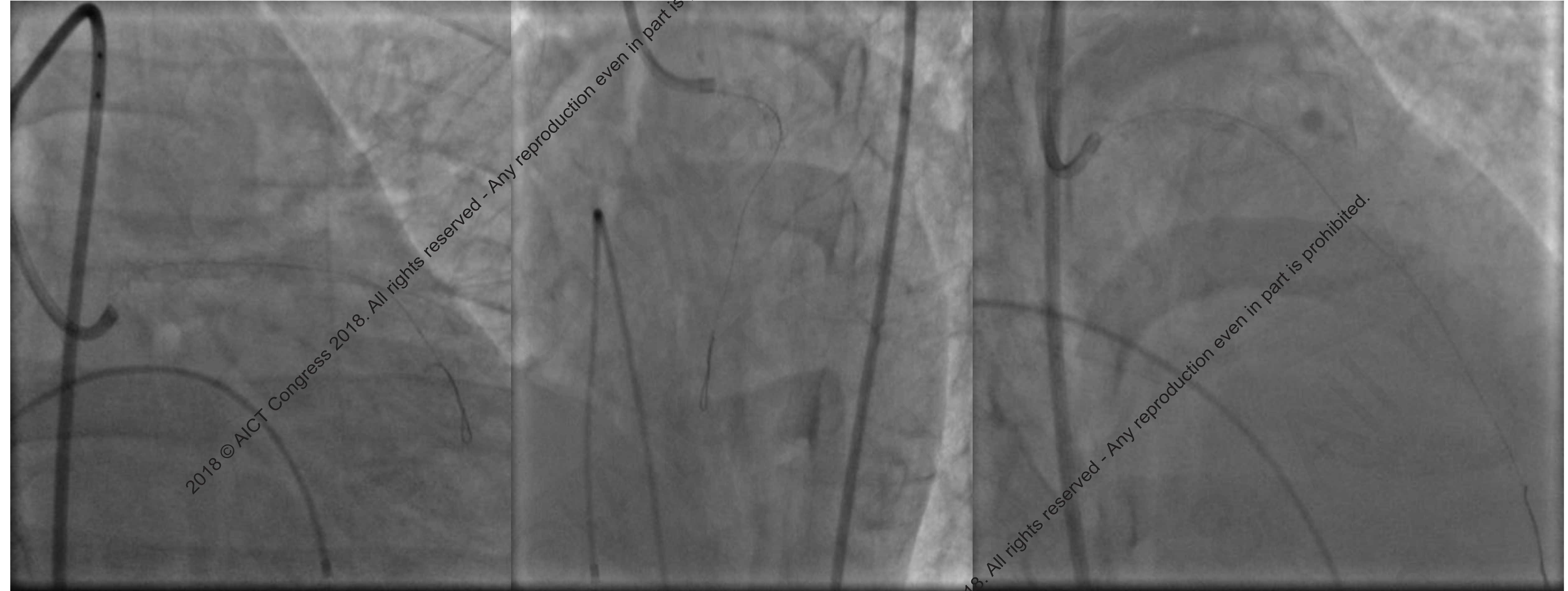

After stenting : Failed to engaged the left main due to stent over hanging in the Aorta.

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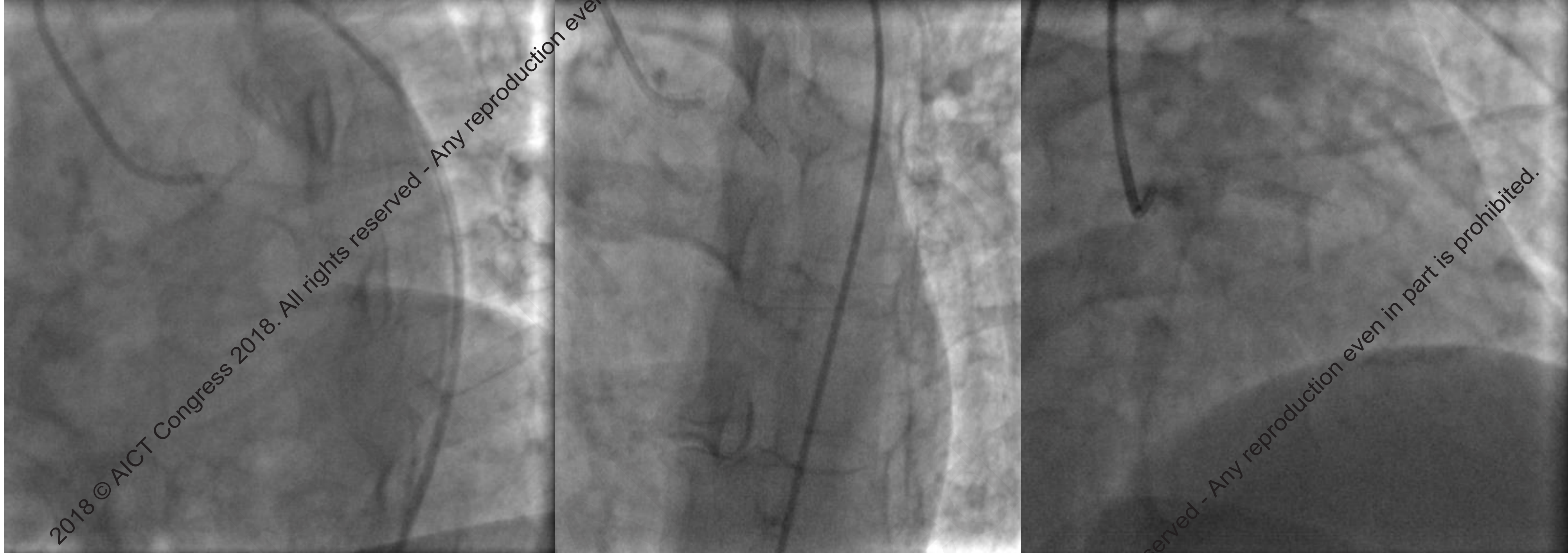
- After 6 months patient developed effort angina (CCS-III).
- Check CAG was done….



Severe ISR in LMCA, Significant stenosis in LCX origin, Stent over-hang in Aorta

CABG was done 10 days later.

- Grafts were-
  - LIMA to LAD.
  - Sequential SVG to diagonal and OM branch.

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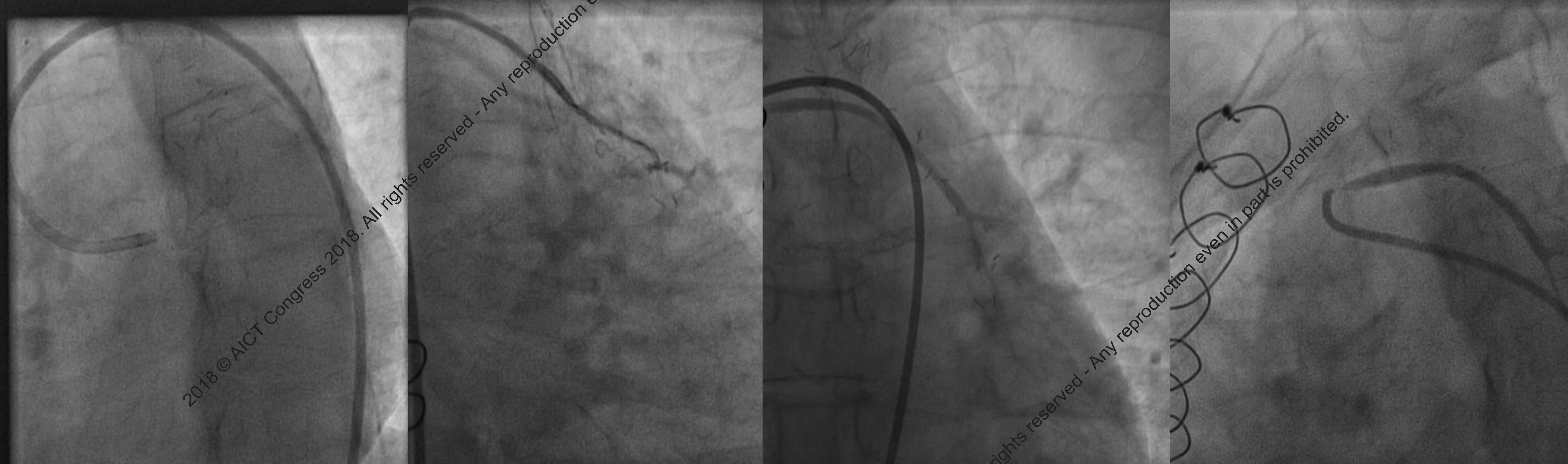
After 14 months-

- Patient again developed chest pain and diagnosed as NSTMI with LVF.
- Patient was hospitalized and LVF was controlled.
- Again check CAG was done:



- LMCA (significant ISR) & LAD (100% ISR).
- Dominant LCX with 90% ostial stenosis.

- LIMA to LAD severe stenosis at the distal anastomotic site.
- SVG to OM & Diagonal: Severe stenosis in proximal as well as distal also.

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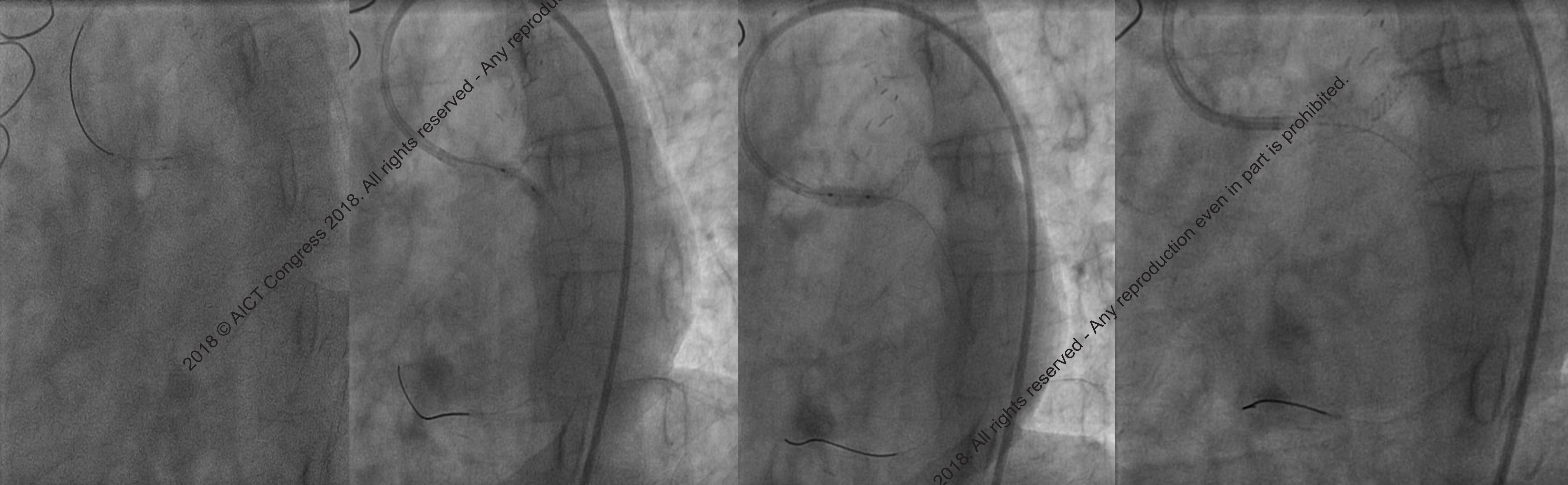
So, planned for Re-PCI :

- Plan –
  - Fixing the LMCA & ostial LCX
  - Opening up of the LAD CTO.



Wiring of the LCX.

Pre-dilatation of LMCA with ostial LCX: 3.5 x 09 mm NC balloon at 20 ATM.
Pre-dilatation of LMCA: 4.0 x 09 mm NC balloon at 18 ATM.

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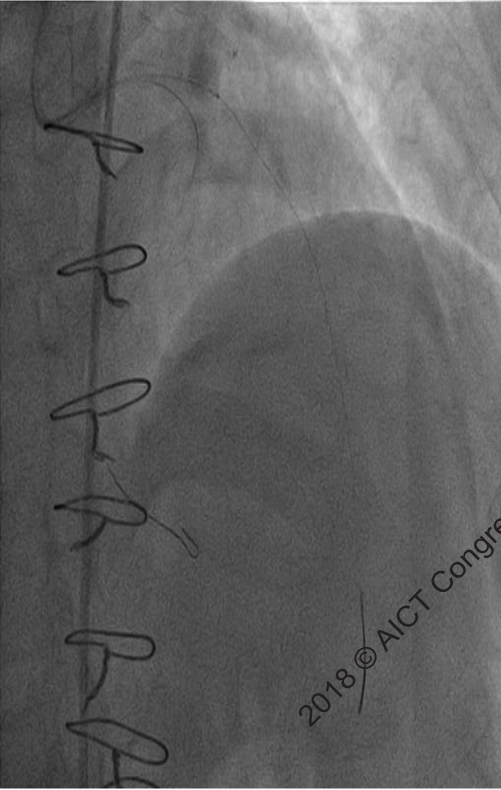
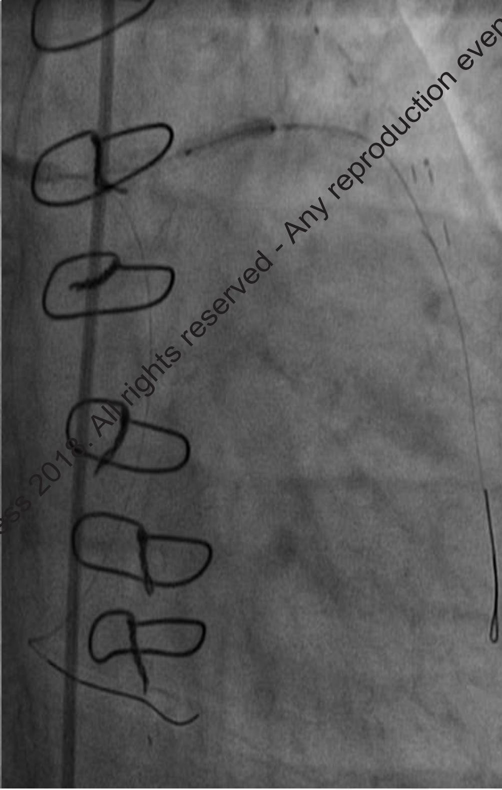
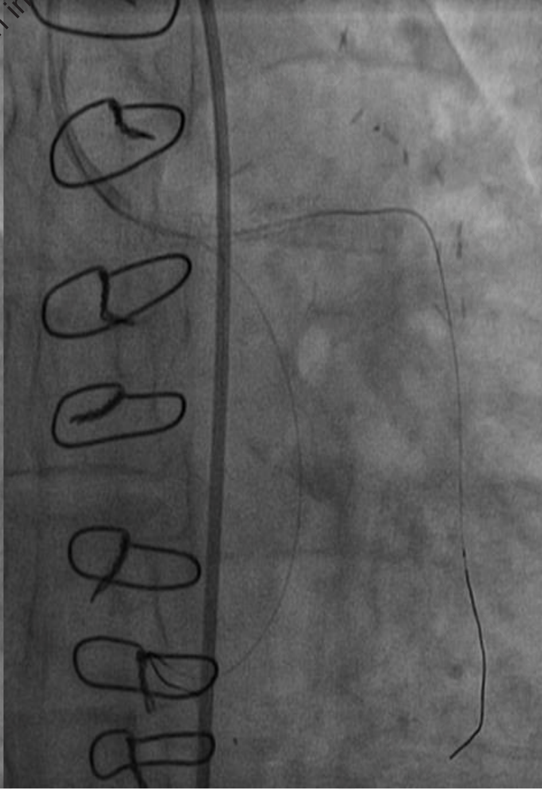
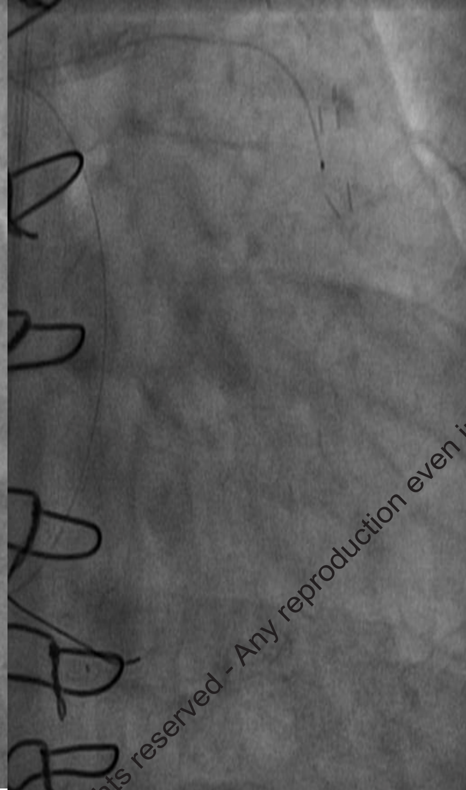
LAD was wired with CTO wire (Pilot 50) supported by micro catheter.

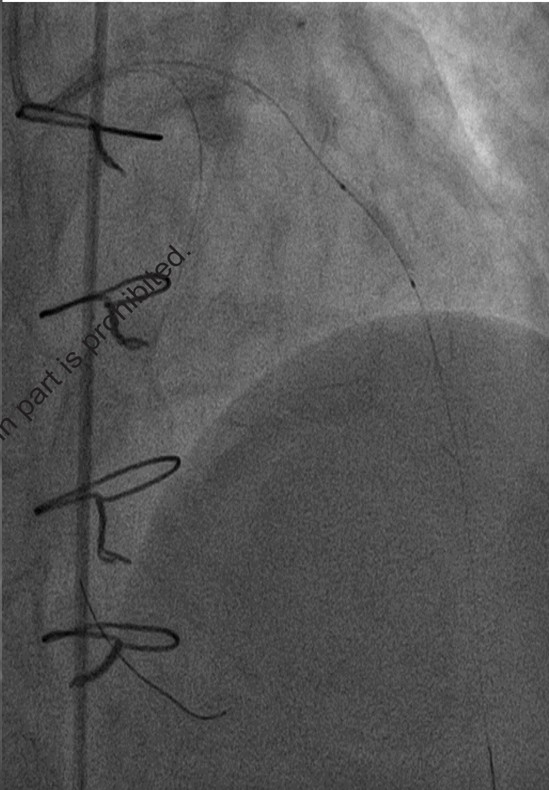
Pre-dilatation in ISR with 3.0 x 12 mm NC balloon.



After pre-dilatation Check angiography



Contrast given through micro catheter- Distal LAD well visualized.



Mid LAD dilatation with small size balloon at low pressure.

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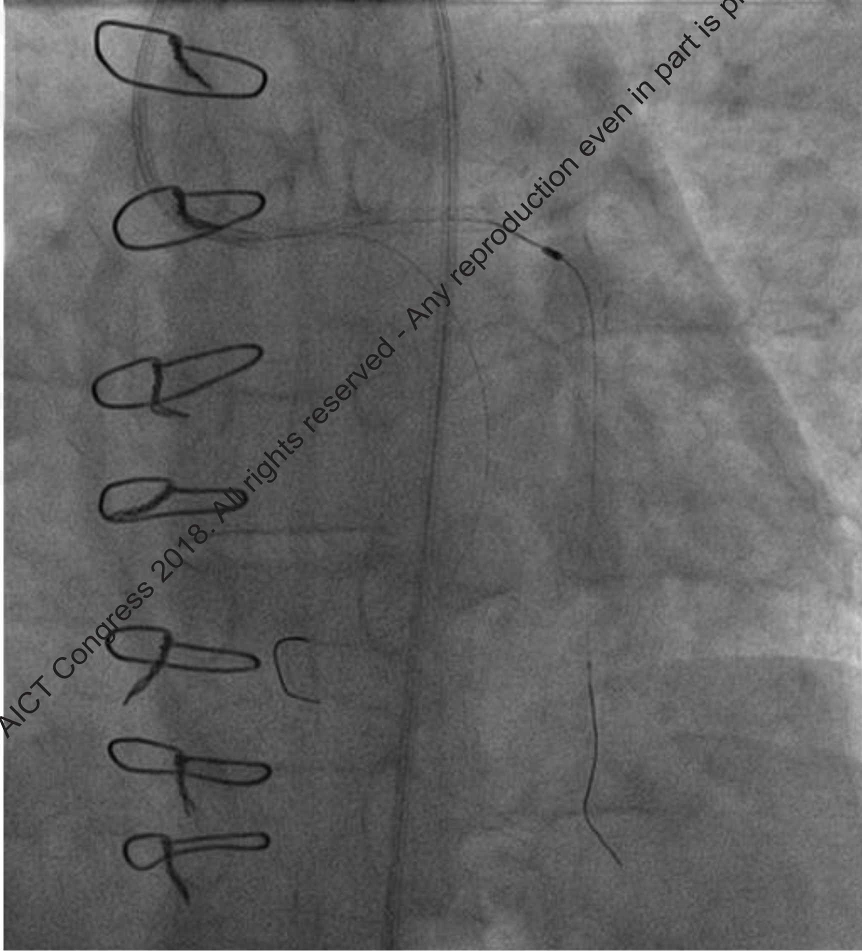

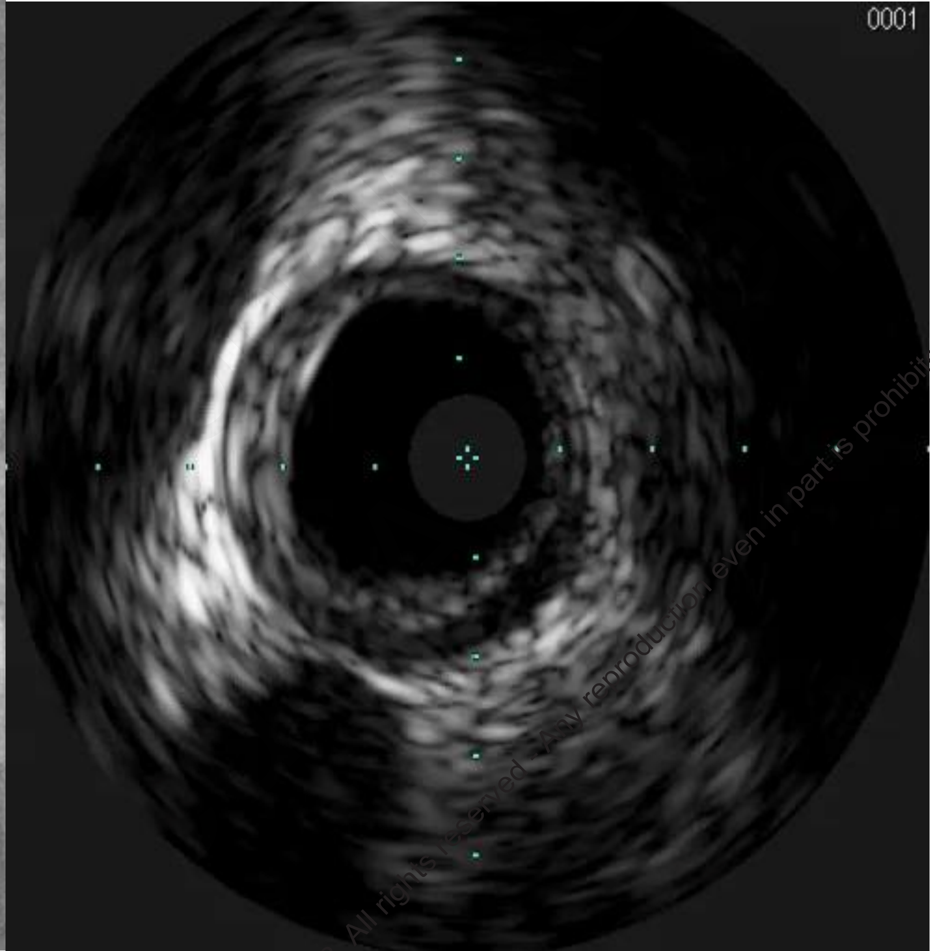

IVUS done

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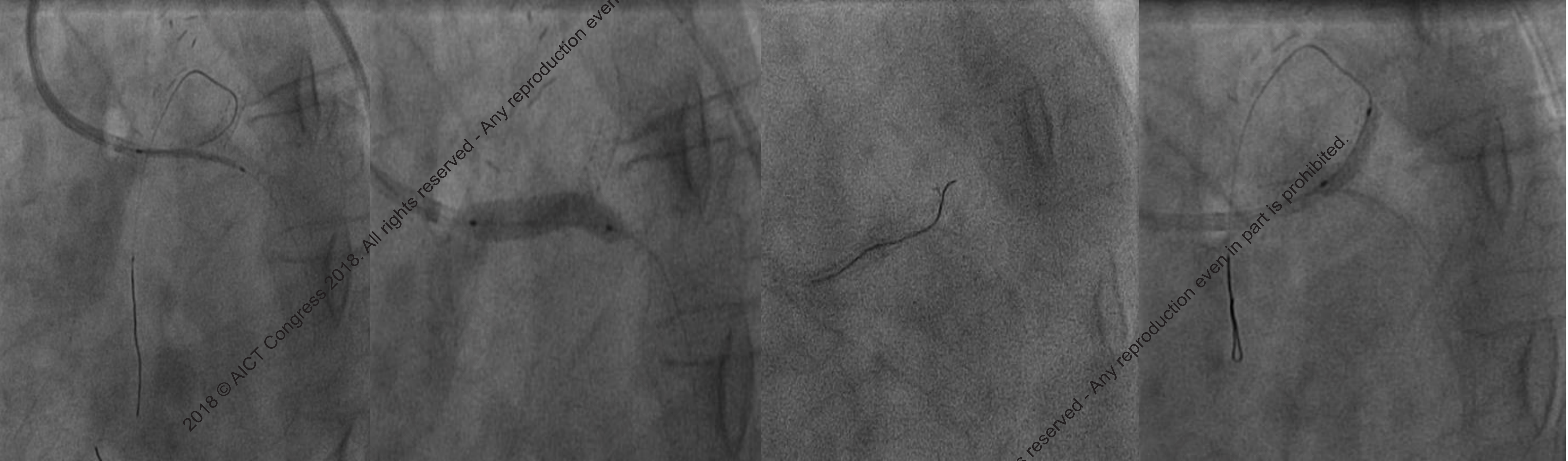

Stenting of LMCA to LCX with 4.5mm x 22 mm DES

LAD was re-wired

Aggressive instent balloon dilatation done with NC balloon

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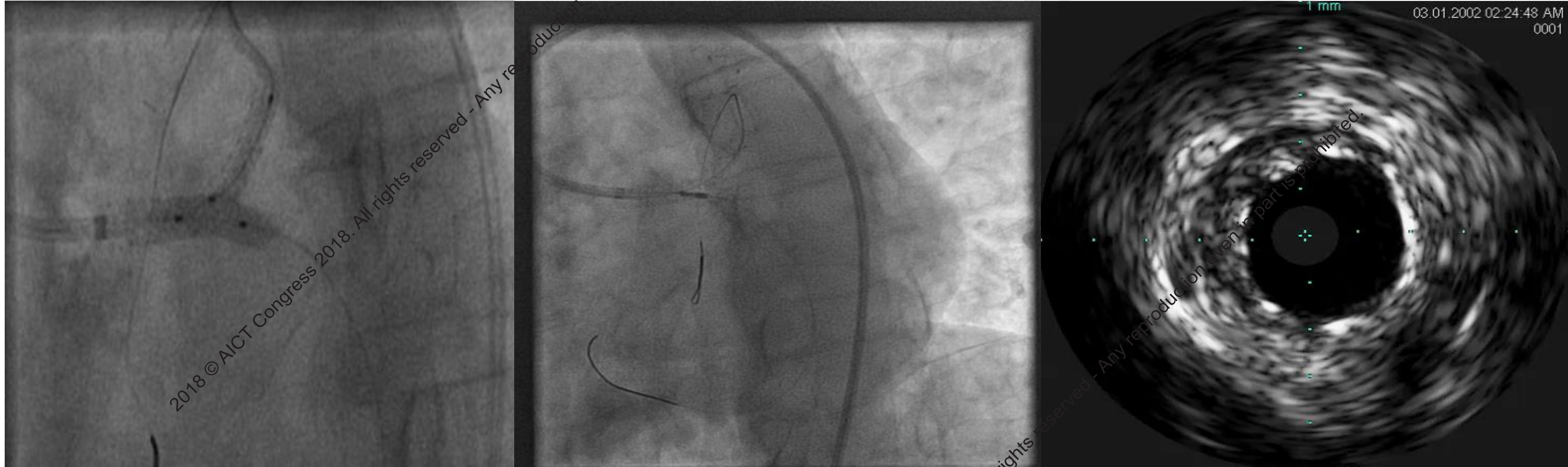

Final kissing done with 3.5 x 25 mm DEB in LAD & 4.5 x 08 mm in LMCA to LCX

IVUS done from Left main to LCX.

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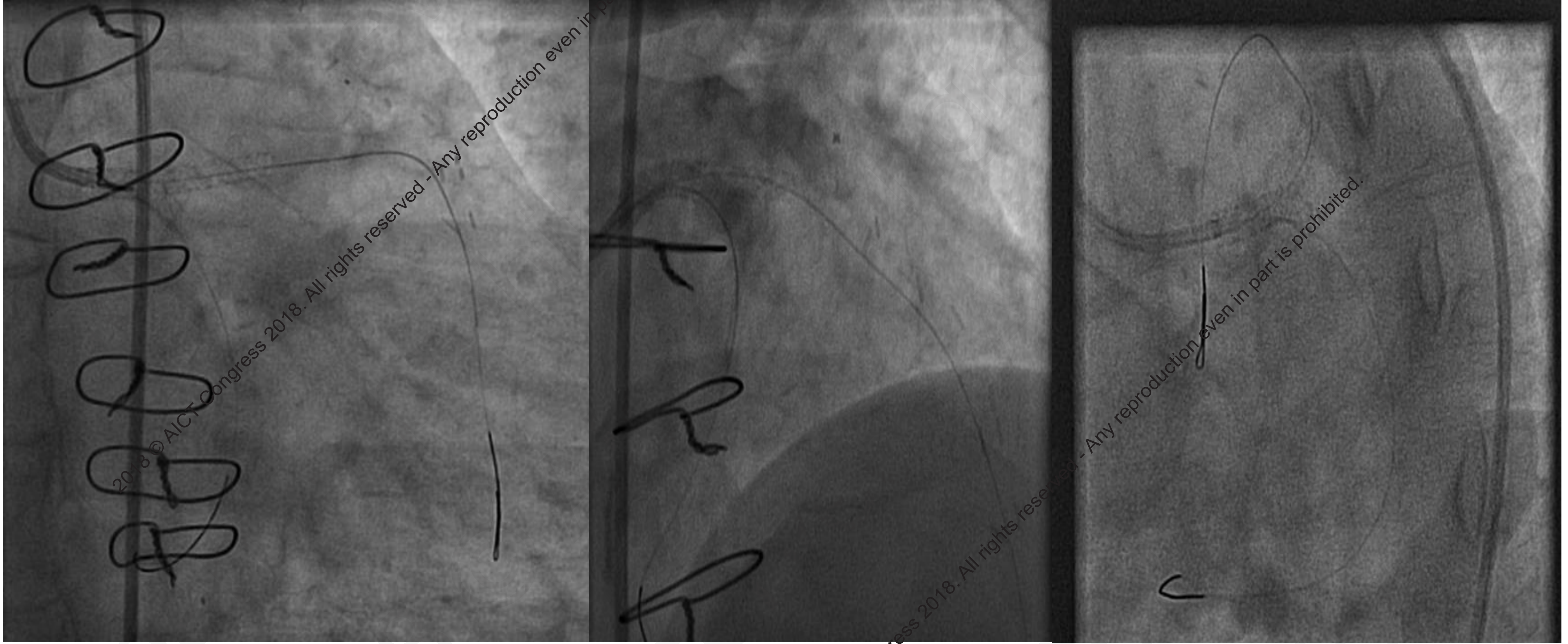
Final result



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Take home message:

- Any PCI or CABG is not free from life threatening complications.
- Before doing an ostial LMCA & proximal LAD in a left dominant case the pros and cons should be carefully assessed.
- For the proper assessment of lesion severity in ostial Left main & proximal LAD, -----------IVUS & FFR can be of immense value.
- Proper sizing of stent is mandatory.
- Stent should be properly placed to avoid over hanging in the aorta.
- Infact overhanging led to great difficulty in catheter engagement during check CAG & redo PCI.

A chain reaction of coronary events -----Endless nightmares!

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NHFH Cathlab team

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Thank You

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