Provisional technique using BRS

When to do it?
When not to do it?

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When to do it?

- true or not-true bifurcations suitable for a single stent technique
- discrepancy between distal MB and proximal MB not exceeding 0.5 mm
- MB size 2.5-4.0 mm
How to do it?

Recommendations today:

1. Select the stent according to proximal reference in suitable anatomy (otherwise distal reference);
2. POT 0.5 mm bigger balloon than the reference;
3. If no SB compromise, procedure is finished;
4. If SB compromise, dilate with adequately sized balloon (≤12-14atm) and final POT;
5. Routine Final kissing balloon not recommended, Mini-final kissing balloon inflation if needed, 5atm;
6. If second stent needed: T/TAP; Metallic DES for SB;
7. Recommendations apply to current generation BRS and may need to be revised with new stent designs

XI European Bifurcation Club meeting - Athens, Greece - 25th & 26th September 2015
When to do it? case 1

1, 1, 1 lesion with short lesion on SB, 1-stent strategy

vessel size suitable for BRS
When to do it? case 1

3x28 mm Absorb

POT 3.5mm NCB
When to do it? case 1
53 year-old pt, NSTEMI  

Direct Absorb 3.5x18 mm
When to do it? case 2

Whisper GW on D1
2.5x15 mm balloon D1
3.75 x 8 NC balloon LAD
When to do it? case 3

59-year-old pt
NSTEMI

2 mm balloon
3 mm cutting

3.5x18 mm Absorb
When to do it? case 3

1.25 mm balloon
2 mm balloon
2.5 mm NC balloon
4 mm NCB
When to do it? case 3

2.25 mm DES
(anchoring with 4mm NCB)
When NOT to do it?

• 2 stents likely
• discrepancy between prox MB and dist MB > 0.5 mm
• vessel < 2.5 mm or > 4.0 mm
When NOT to do it? case 1

inverted provisional T -> culotte
When NOT to do it? case 2

prox MB 3.8 mm, distal MB 3 mm  3 mm DES, 3.75 mm NCB
### Hospital del Mar 2013-2015

**n= 129 bifurcations treated with Absorb**

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<table>
<thead>
<tr>
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<tbody>
<tr>
<td><strong>Age</strong></td>
<td>60 +/- 10</td>
</tr>
<tr>
<td><strong>DM</strong></td>
<td>50 %</td>
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<tr>
<td><strong>Multivessel Disease</strong></td>
<td>37 %</td>
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<tr>
<td><strong>ACS</strong></td>
<td>59 %</td>
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<tr>
<td><strong>True Bifurcation</strong></td>
<td>45 %</td>
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<tr>
<td><strong>Predilatation MB</strong></td>
<td>84 %</td>
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<tr>
<td><strong>Scaffolded Length</strong></td>
<td>29 +/- 16</td>
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<tr>
<td><strong>Postdilatation MB</strong></td>
<td>84 %</td>
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<tr>
<td><strong>Sequential Ballooning</strong></td>
<td>15 %</td>
</tr>
<tr>
<td><strong>Kissing</strong></td>
<td>6 %</td>
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<td><strong>SB Stent</strong></td>
<td>0.8 %</td>
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**Follow-up**

*median time 472d*

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<tbody>
<tr>
<td><strong>TLR (clinically driven)</strong></td>
<td>3.9 %</td>
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<tr>
<td><strong>TVR (clinically driven)</strong></td>
<td>4.6 %</td>
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<tr>
<td><strong>Sc Thrombosis (def + prob)</strong></td>
<td>0.8 %</td>
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Conclusions

• The provisional technique with BRS is feasible in most bifurcation lesions

• Technical considerations

• Favorable mid-term outcomes
gràcies
thank you
dank u