EBC meeting, 2017, Porta

October 13, 2017 (1350-1500)

How would you treat?

BIFURCATION CASE 3

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Clinical presentation

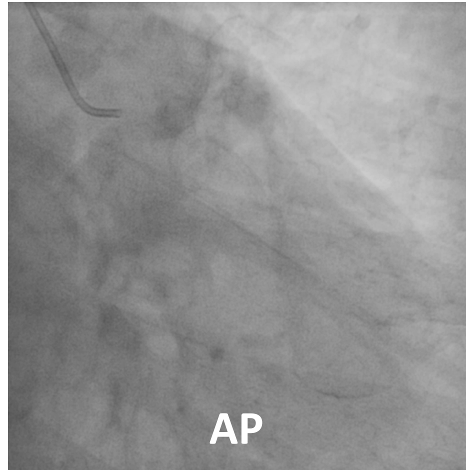
History physical

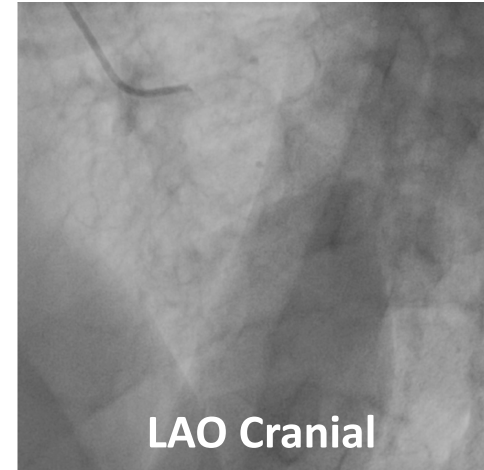
- 58 year old gentleman, (Mr. NL), had exertional chest discomfort for last 15 days
- Non diabetic, normotensive
- Hemodynamically stable
- He was evaluted at another facility

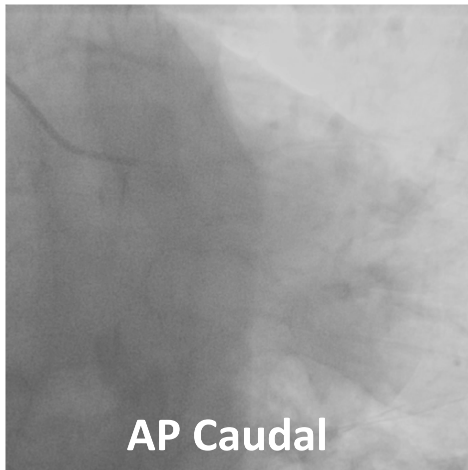
Investigations

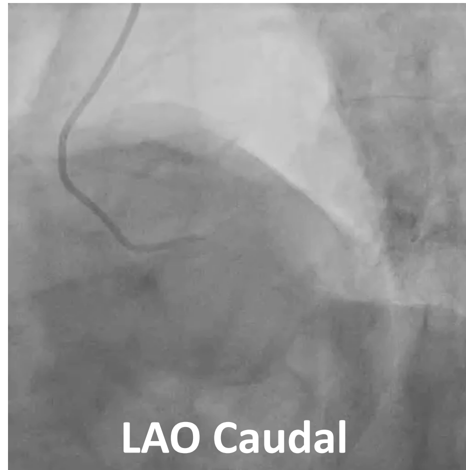
- ECG: Normal sinus rhythm, no ST changes
- Echo: Normal ventricular function (EF 60%) with no RWMA. Normal valves.
- TMT on 25/7/2017 positive for inducible ischemia
- Blood biochemistry and cell counts were normal

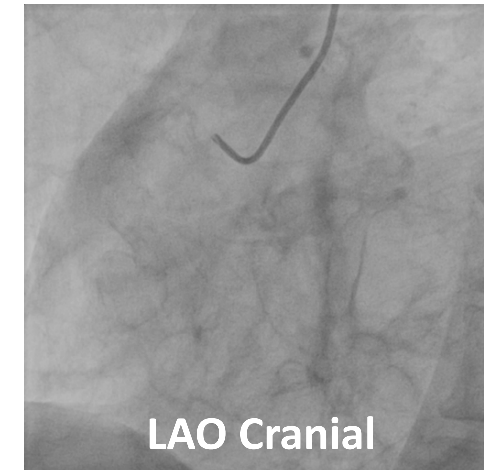
Coronary angiogram





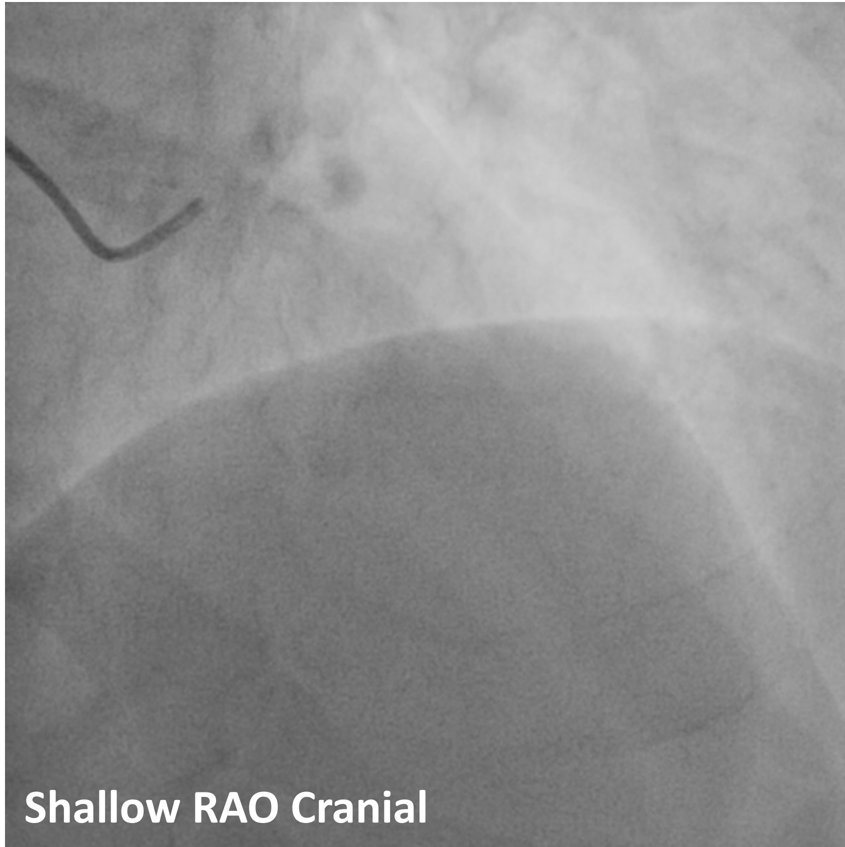


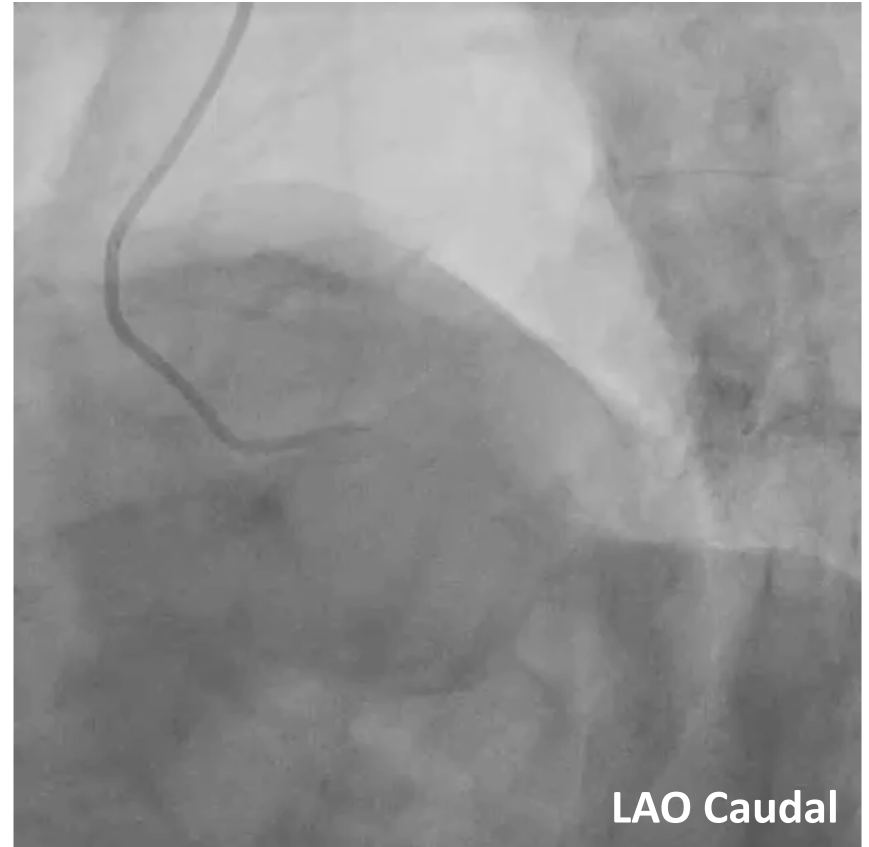




His coronary angiogram showed 80% stenosis of distal LMCA, tight lesion in LAD and moderate stenosis of LCX and R.

How should this be treated?





Open for discussion…

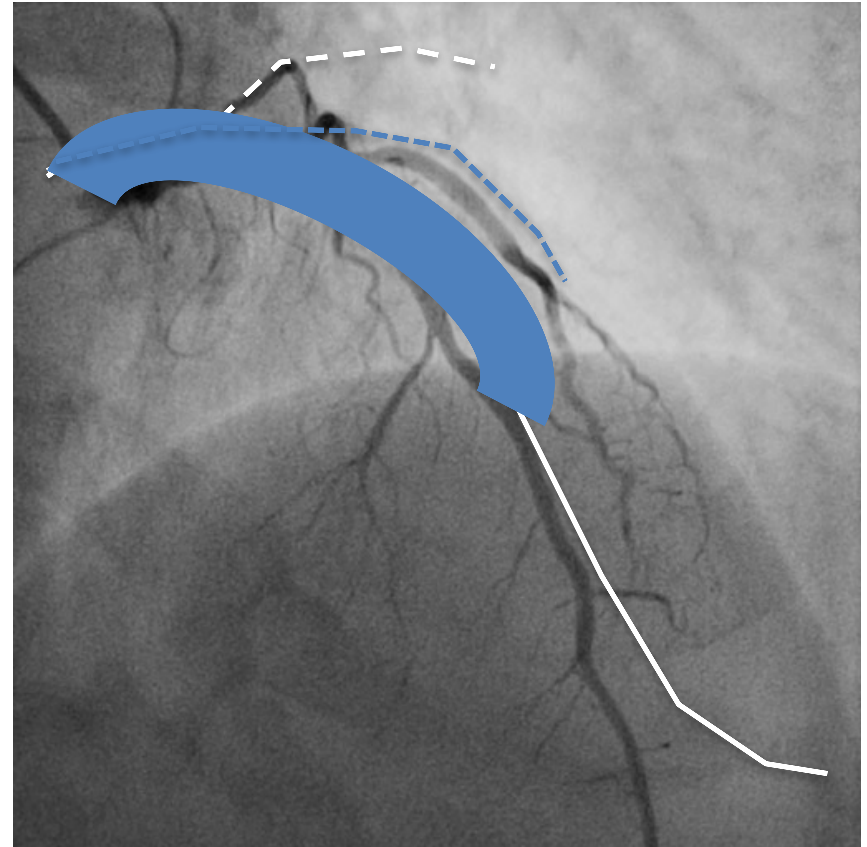
How did I treat

Cardiac Team approach

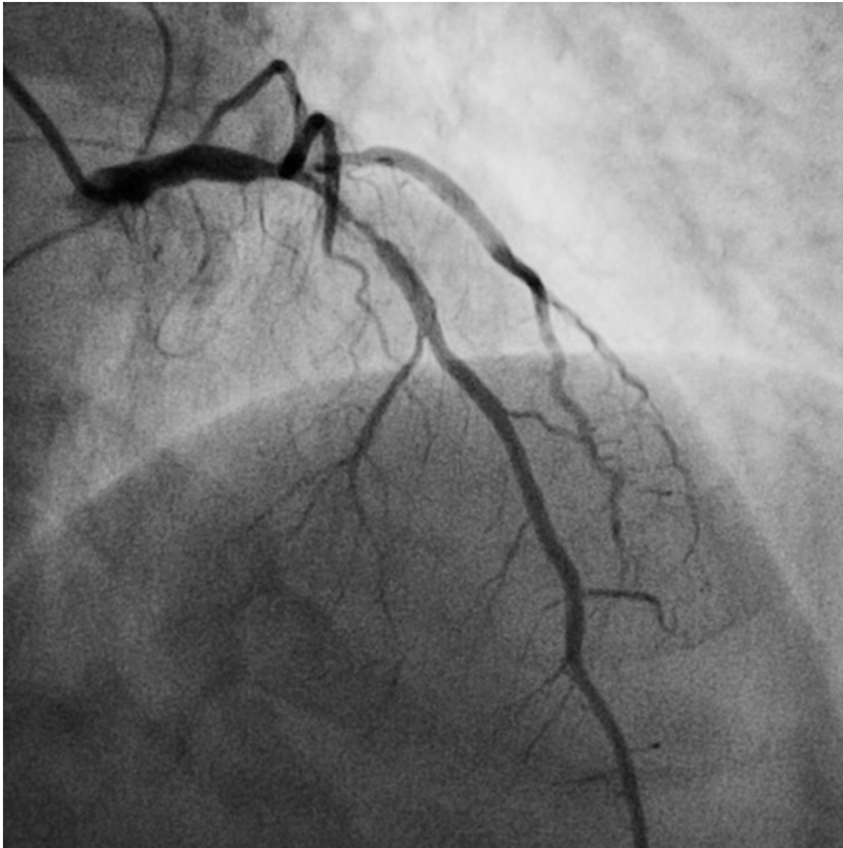
- He was advised for CABG.
- Despite multiple counseling sessions by cardiac team, he was not ready for CABG and came back exploring for feasibility of PTCA.
- He was explained the risks and failure rates, but wanted to go for PCI

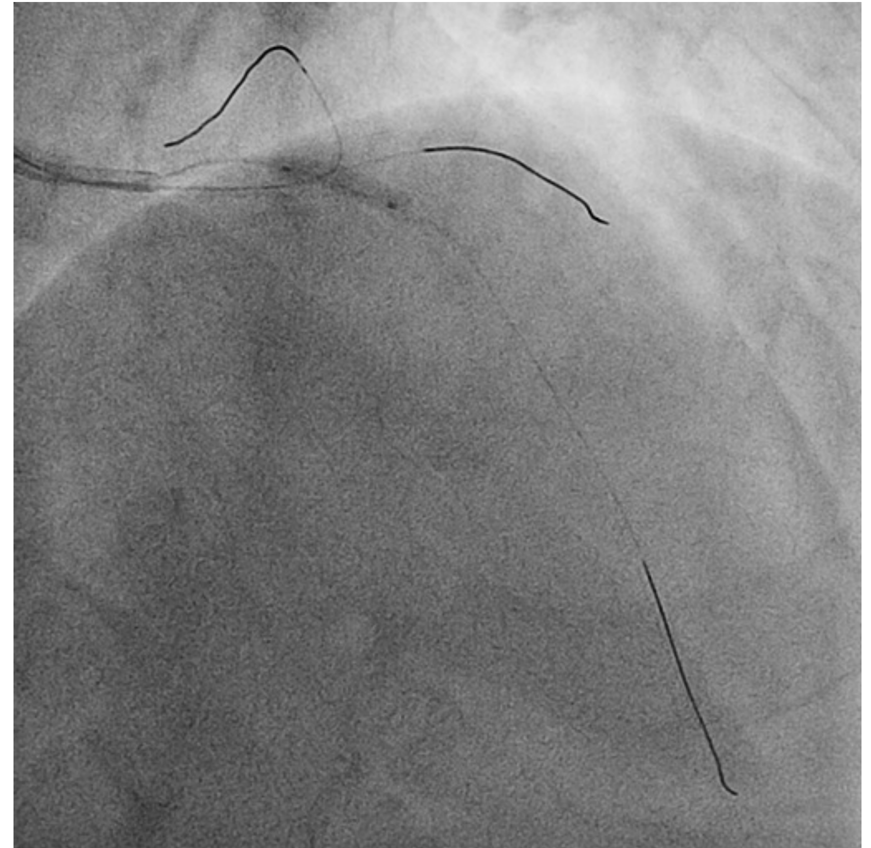
PCI strategy

- LMCA distal trifurcation
  - Wire LAD/LCX/R
  - Provisional single stent strategy

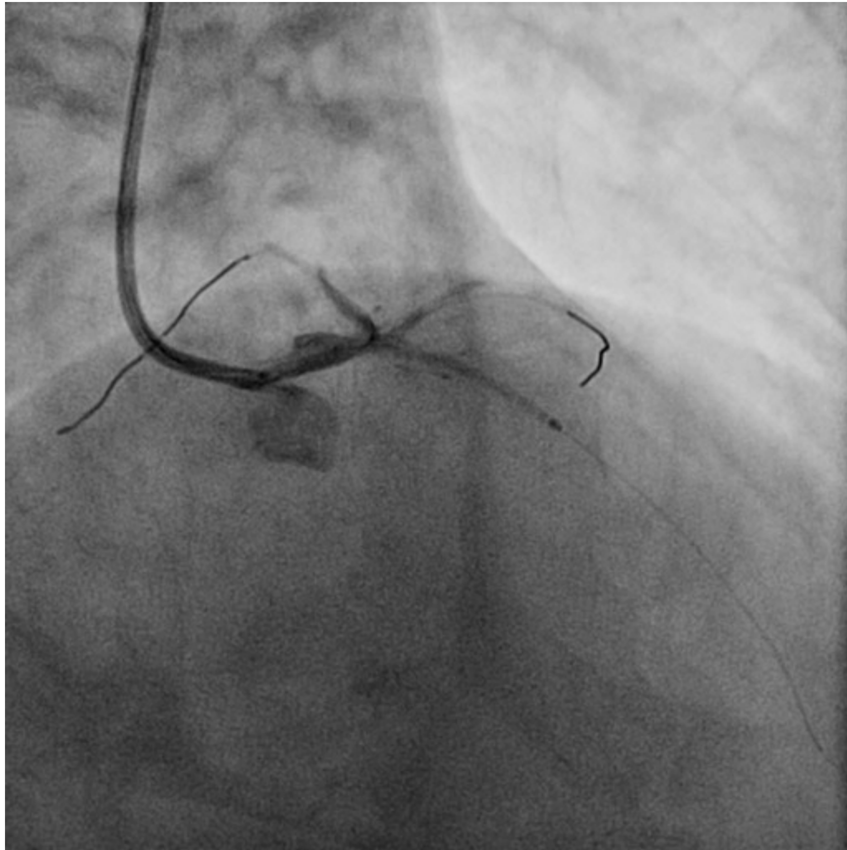


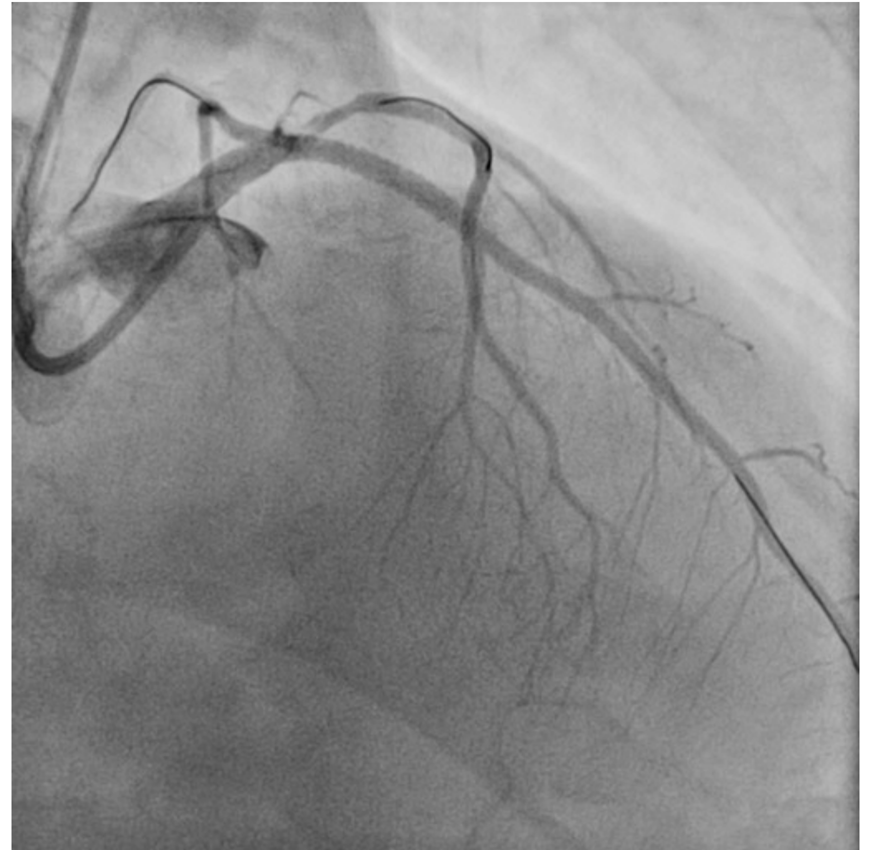
PCI to LMCA trifurcation: Provisional approach



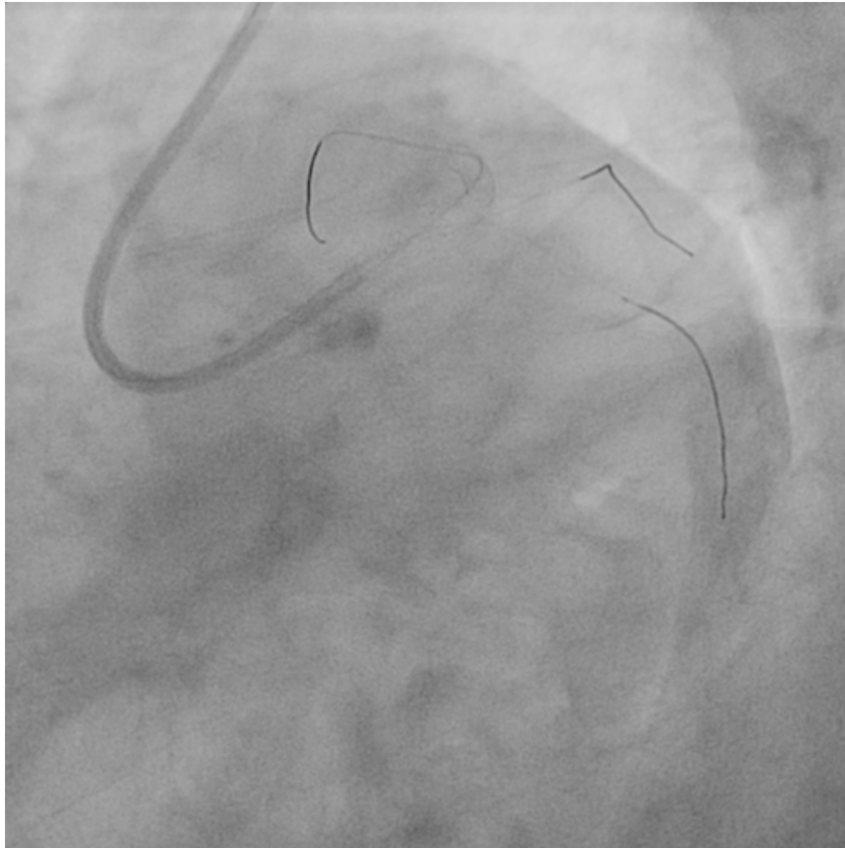


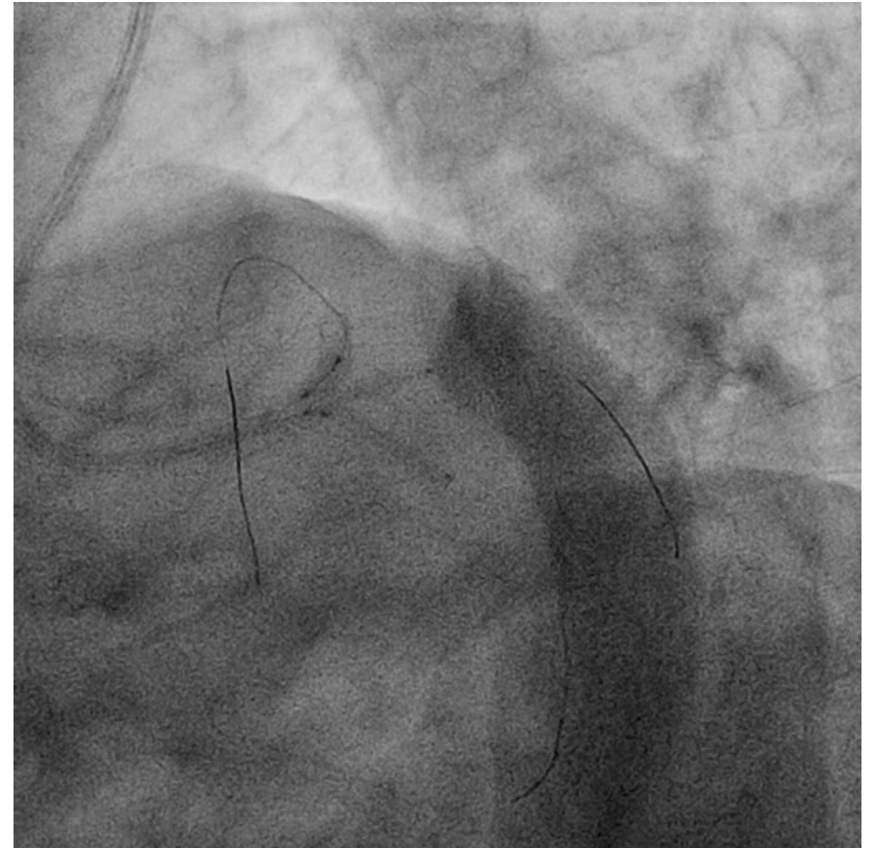
Access: Radial Guide: Left 7Fr XB 3.0; Wire LAD – BMW, R – BMW, LCx – Sion
Balloon 3.25 x 15 NC





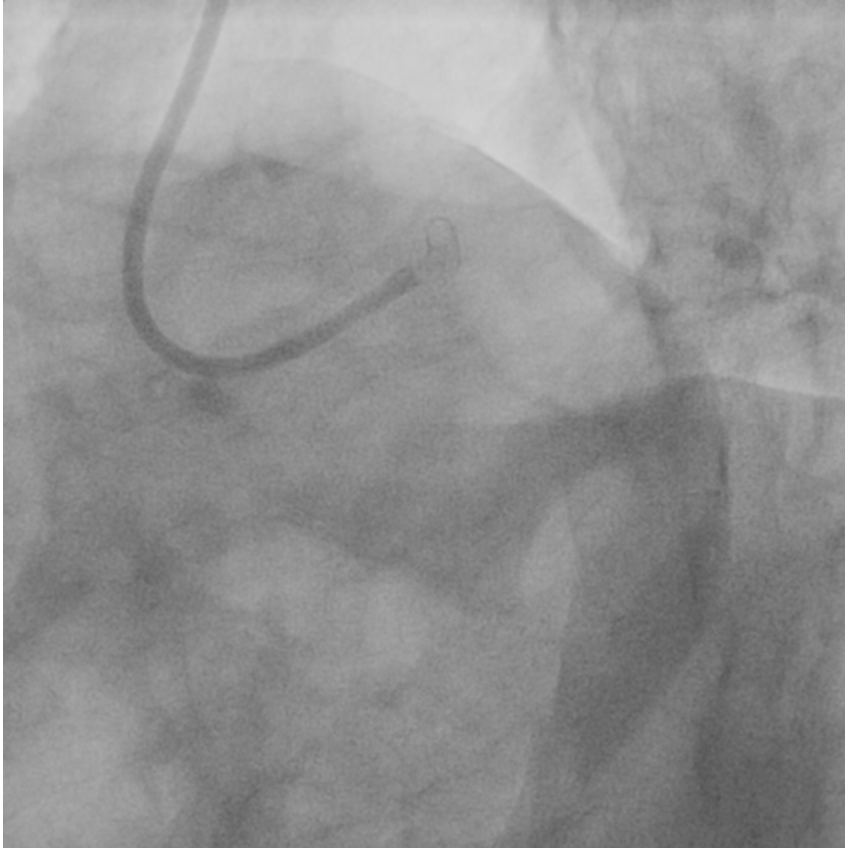
Stent; LMCA – LAD 3.5 x 38 Xience Alpine

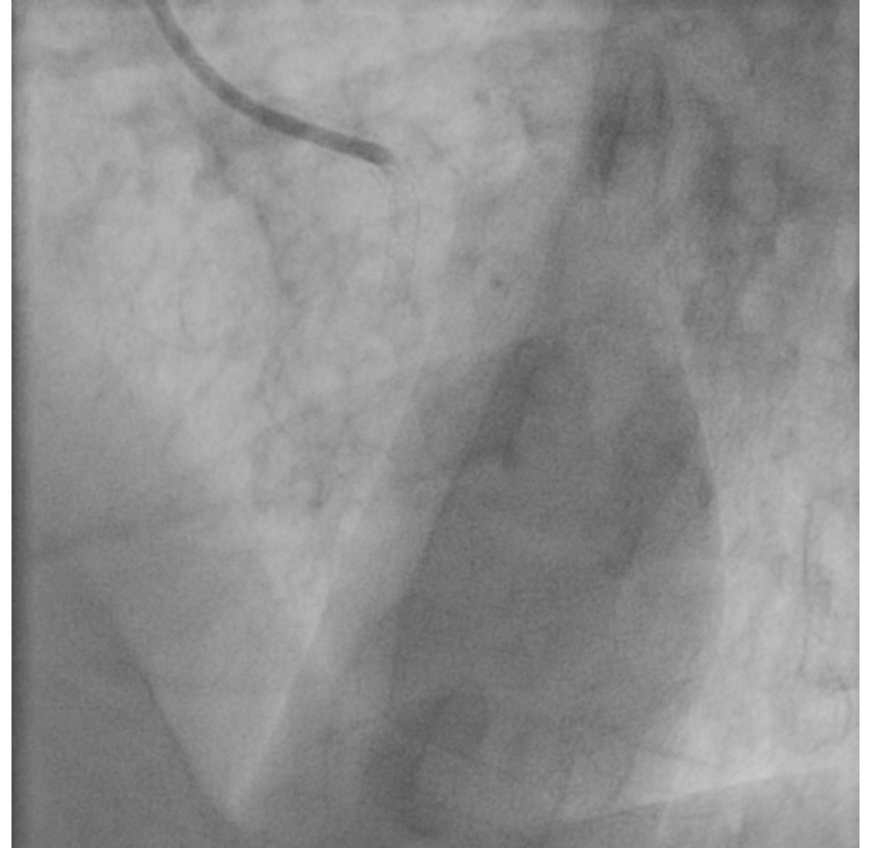




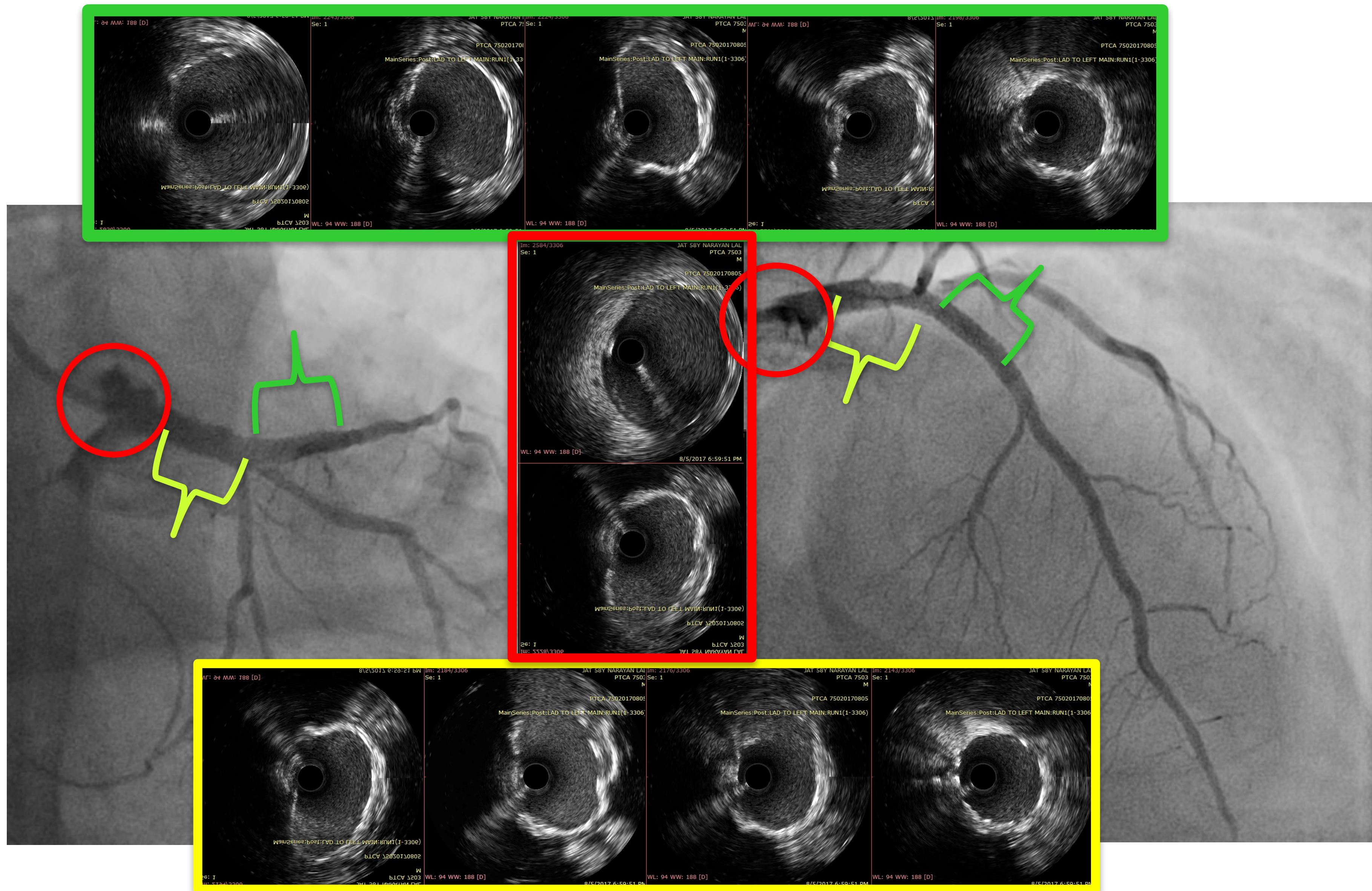
POT : 4.5 x 8 NC Kissing balloon LMCA - LAD; 3.0 x 8 and LMCA – R 2.5 x 15; LMCA- LCx 2.5 x 15 NC, rePOT : 4.5 x 8 NC

Final result





Final result and IVUS



Summary

- This case is of symptomatic middle aged gentleman with unstable angina, found to have distal left main and LAD disease with moderate disease in LCX and Ramus, intending to have PCI.
- Strategy in such trifurcation disease, needs to be decided according coronary anatomy, clinical substrate and hemodynamics:
  - In this case, “Provisional single stent strategy," made it simple
- Imaging and FFR are helpful in deciding the strategy and optimizing final result

Thank you!!!