



# The emergency patient - STEMI high bleeding risk patient with polymer-free BA9-coated stent

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**Speaker's name: Feng Yu Kuo**

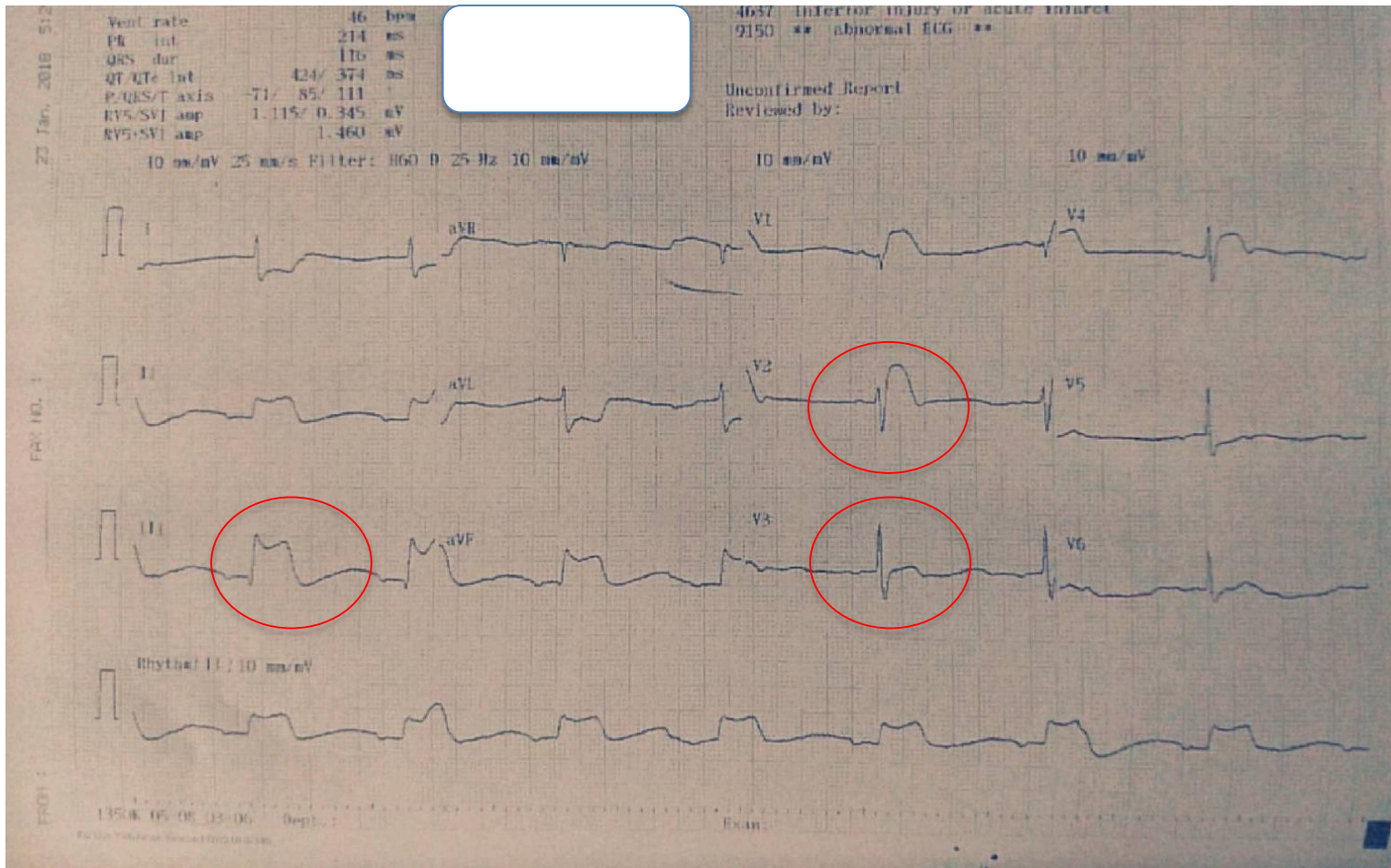
**I do not have any potential conflict of interest**

**I have the following potential conflicts of interest to report:**

# Basic Data

- 46 y/o M, 170cm, 96 Kg.
- 2012 Aug: Hypertensive ICH, R't basal ganglion, s/p medical treatment with L't hemiplegia, type 2 DM with DM nephropathy (poor control) in CKD, stage 4, HTN.
- C.C:
  - Chest pain with cold sweating 1 day prior to admission
- Failed primary PCI at local H.

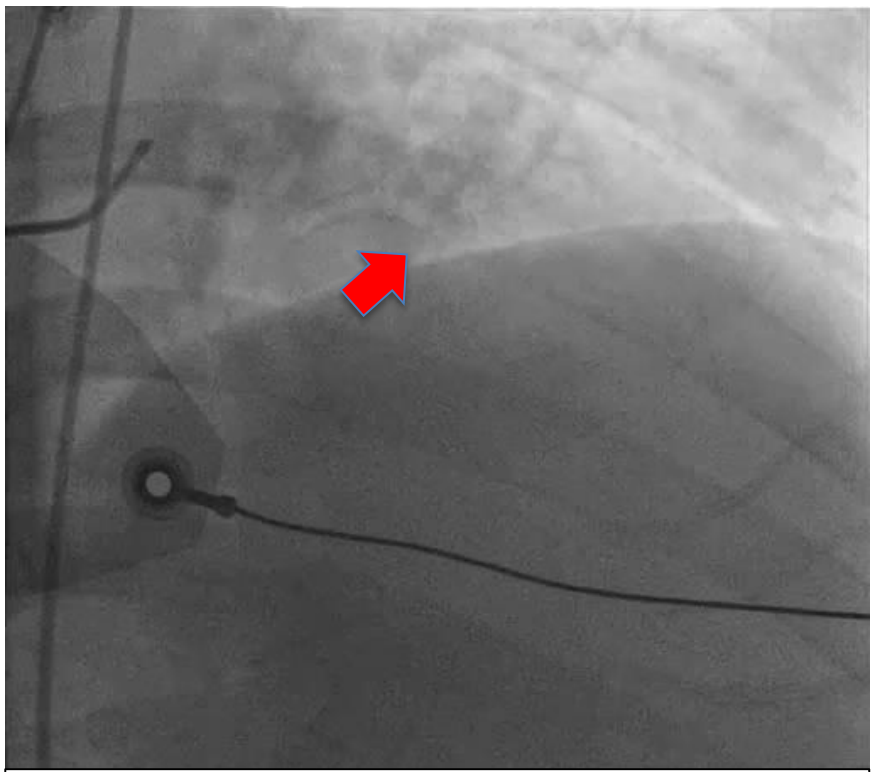
# ECG



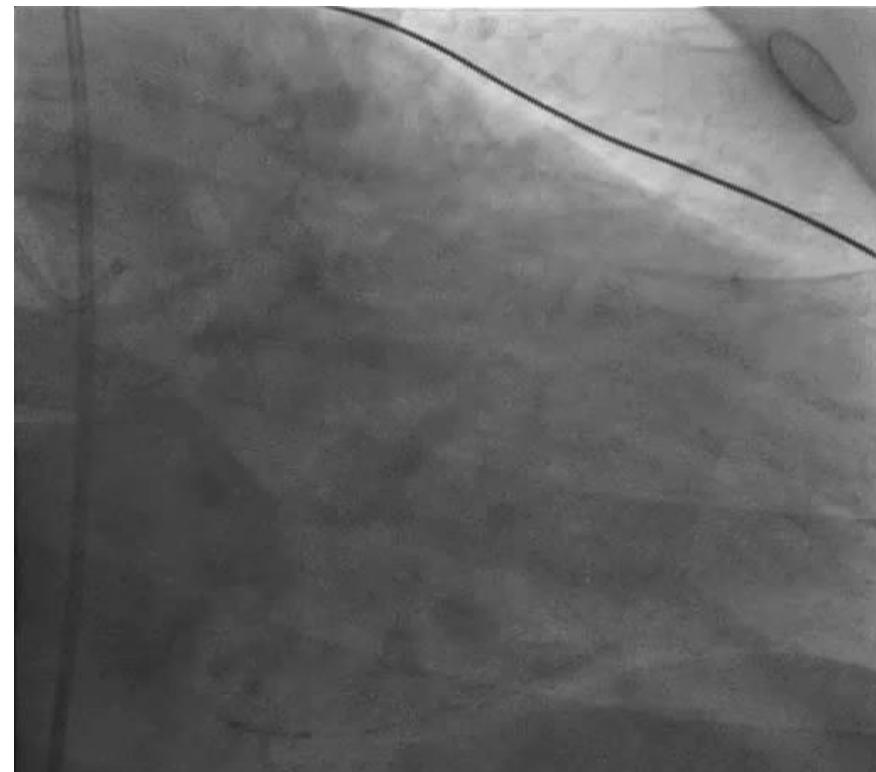
# Vital Signs at our ER

- BP: 96/62 mmHg, H.R: 42/min
- Crt: 3.9 mg/dL, eGFR: 32.1 ml/min
- ECG: ST elevation of II,III, aVF, V2, V3
- Chest pain persisted after medical Tx => PCI suggested.

# CAG

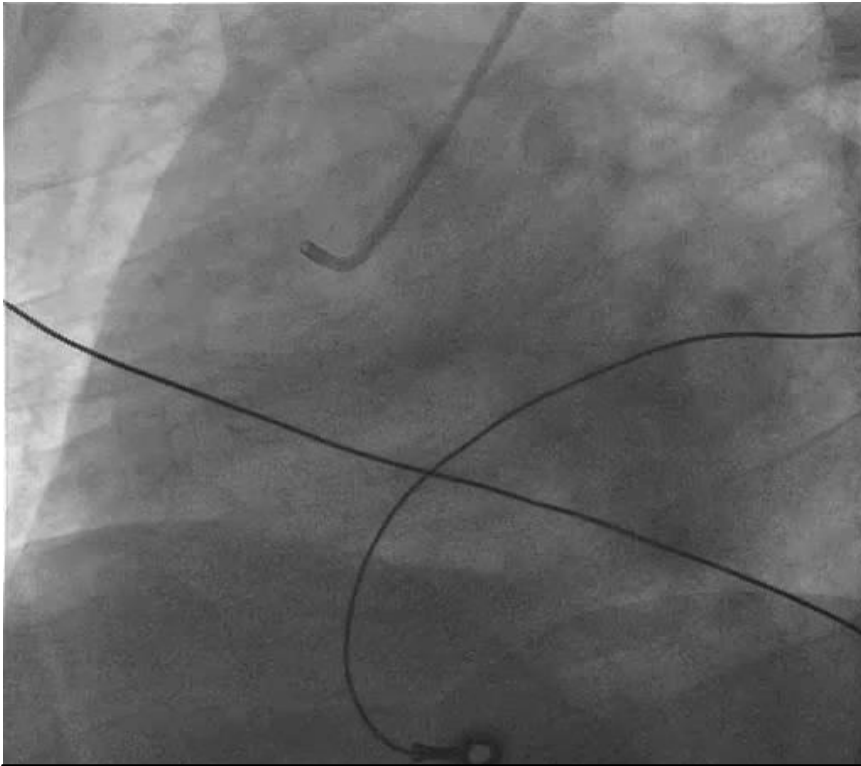


Thrombus in LAD



Non-Dominant Lcx

# RCA



Thrombus in RCA, totally occluded

- CAD with DVD (LAD-m: thrombus formation, RCA-P: total occlusion, dissection ???)

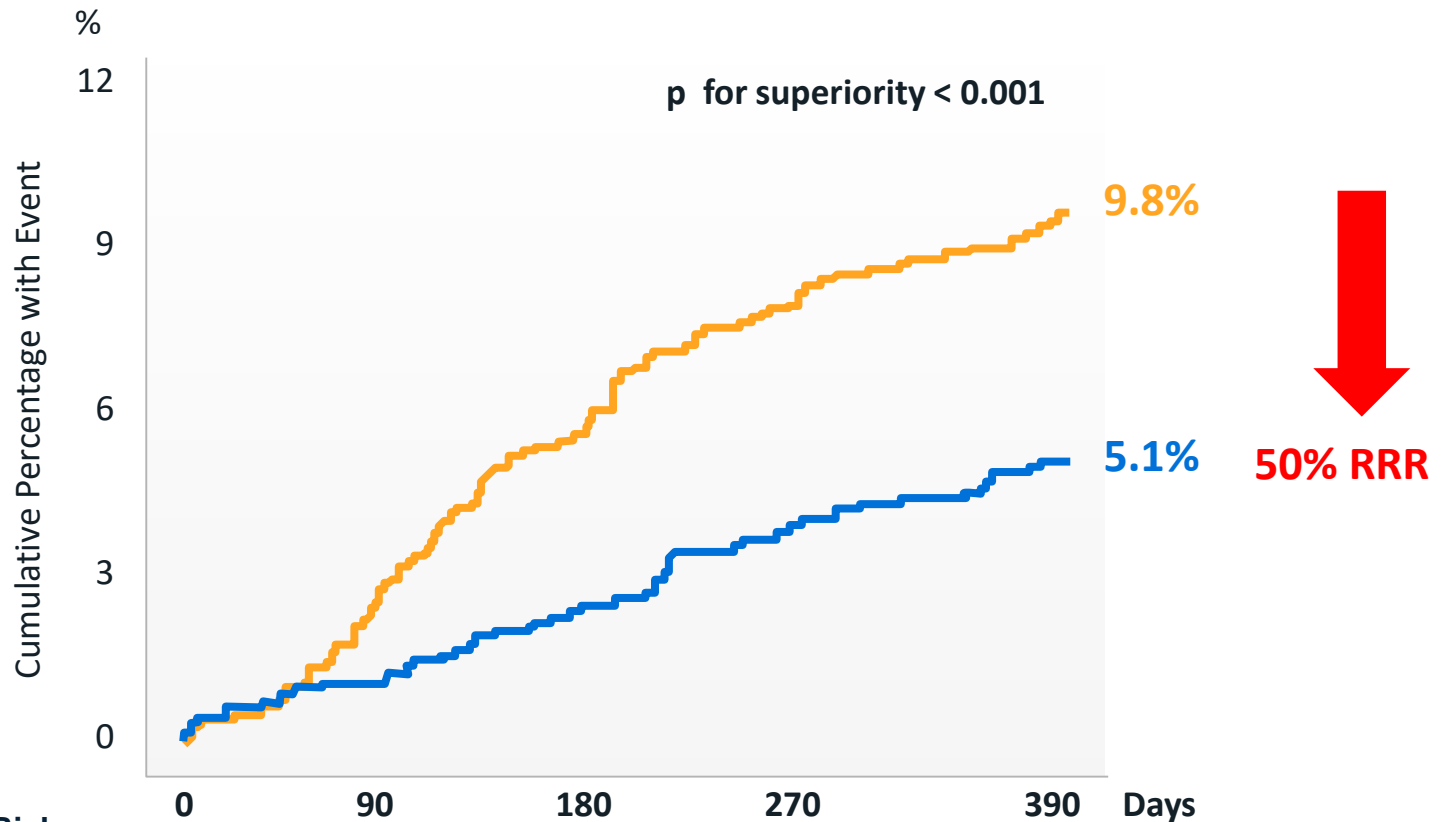
# Inclusion Criteria (One or More)

= Exclusion Criteria for Most DES Studies

- Age  $\geq$  75 years
- OAC planned after PCI
- Baseline Hb  $<$  11g / dl or transfusion during prior 4 weeks
- Planned major surgery (within next year)
- Cancer diagnosed or treated  $\leq$  3 years
- Creatinine clearance  $<$  40 ml / min
- Hospital admission for bleeding during past year
- Thrombocytopenia ( $<$  100.000 / mm<sup>3</sup>)
- Any prior intra-cerebral bleed
- Any stroke during the past year
- Severe liver disease
- NSAID or steroids planned after PCI
- Anticipated poor DAPT compliance for other medical reason



# Primary Efficacy Endpoint (Clinically-Driven TLR)



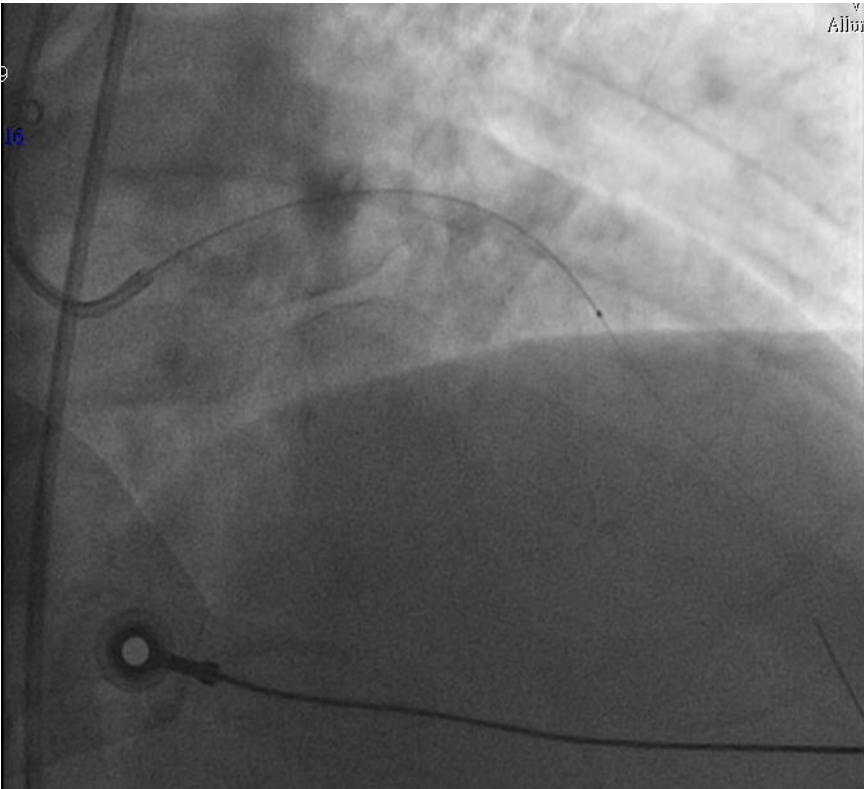
Number at Risk	0	90	180	270	390
<b>DCS</b>	1221	1167	1130	1098	1053
<b>BMS</b>	1211	1131	1072	1034	984

390 days chosen for assessing primary EP to capture potential events driven by the 360 day FU contact

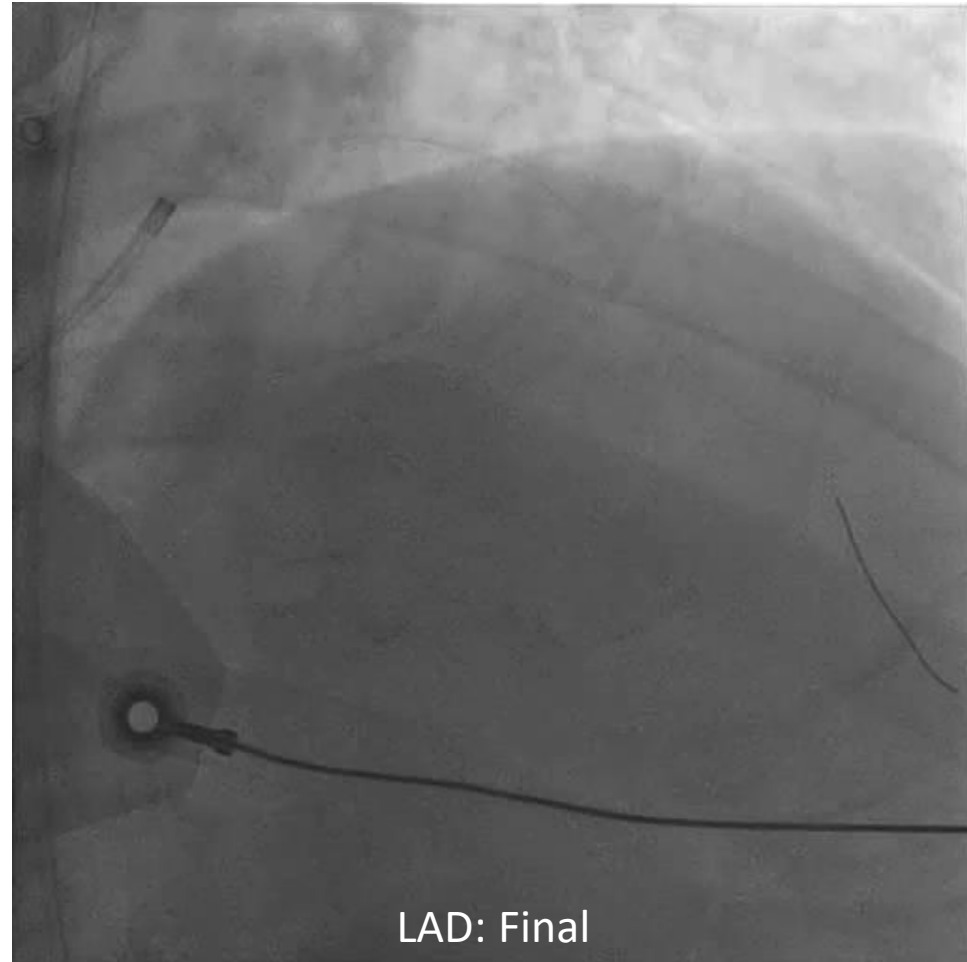
# PCI Strategy

- Not easy to fix RCA in short time, (torturous and aneurysmal like RCA) → fix LAD first
- IABP due to shock.
- Femoral approach +obesity+ possible IIb/IIIa inhibitor → other risk factors for bleeding

# PCI over LAD

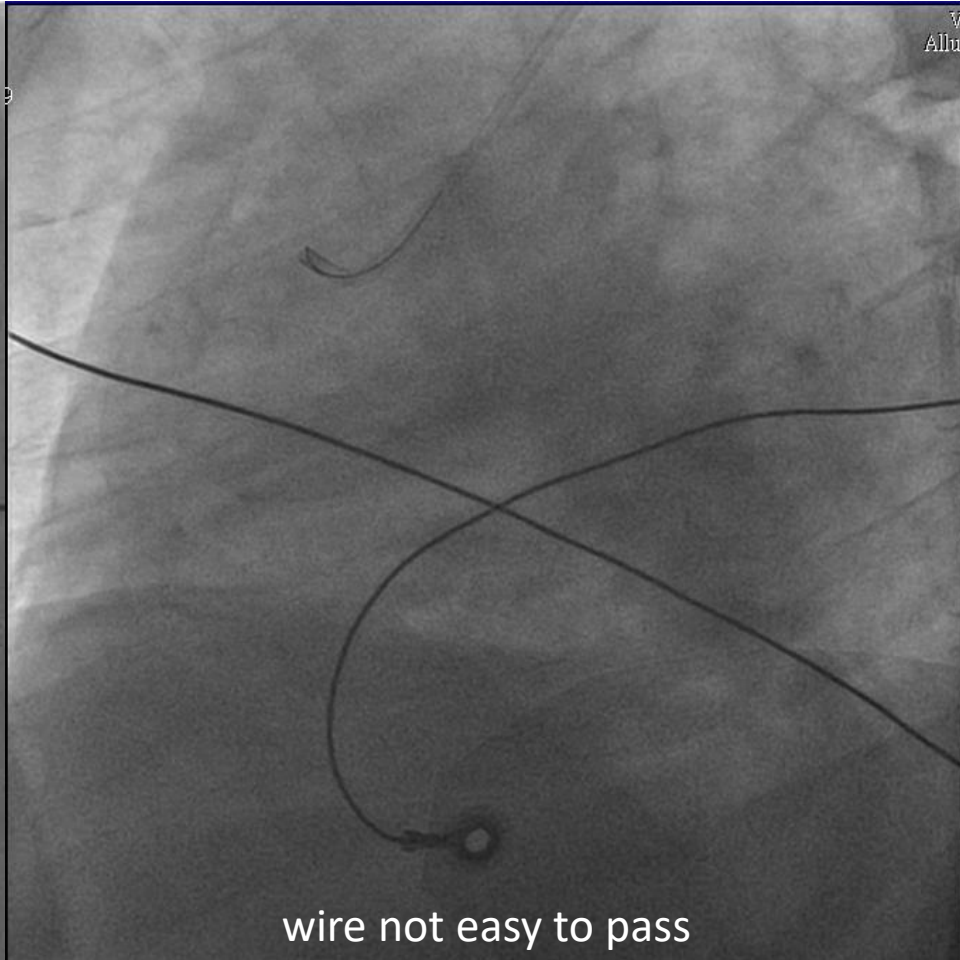
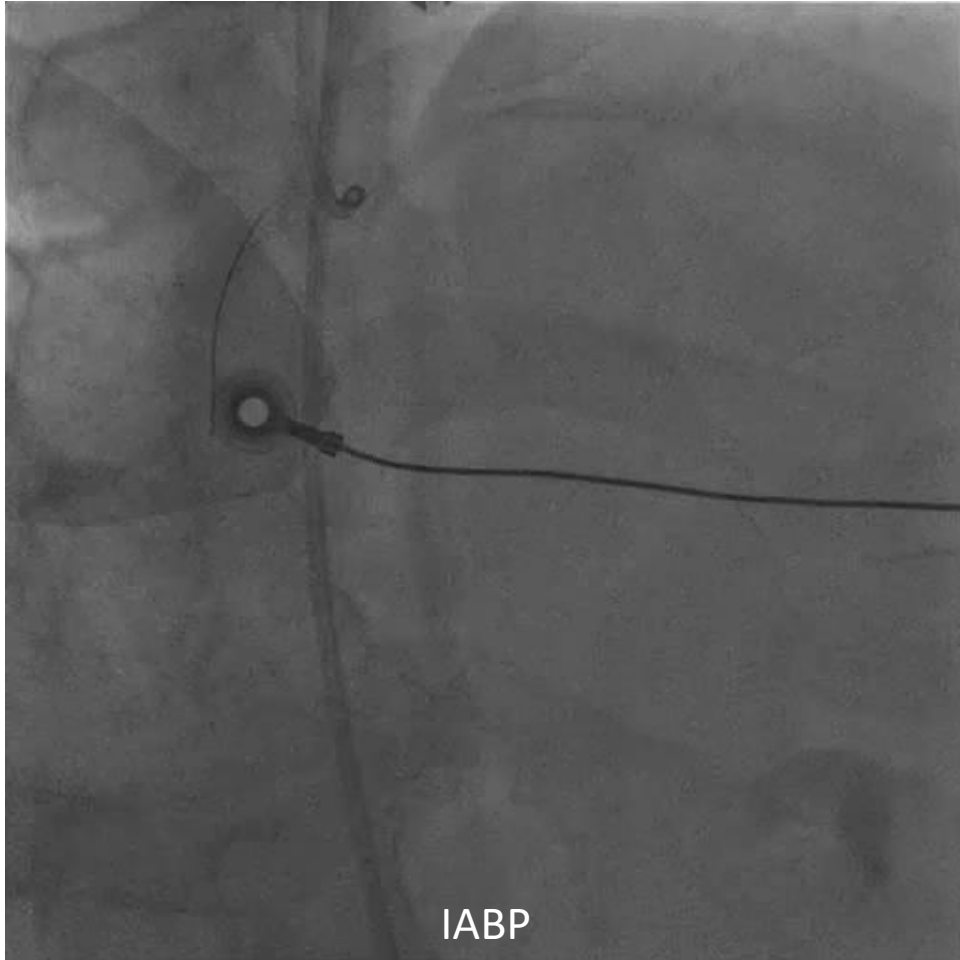


Thrombo suction

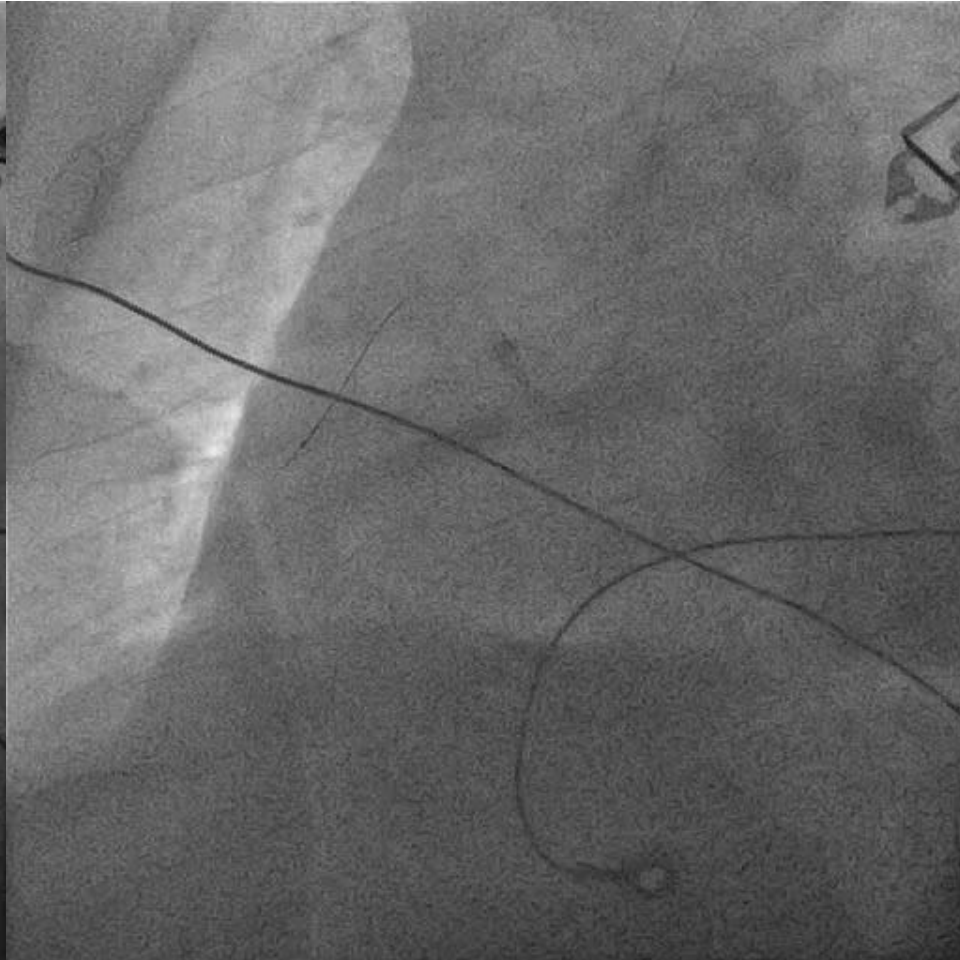
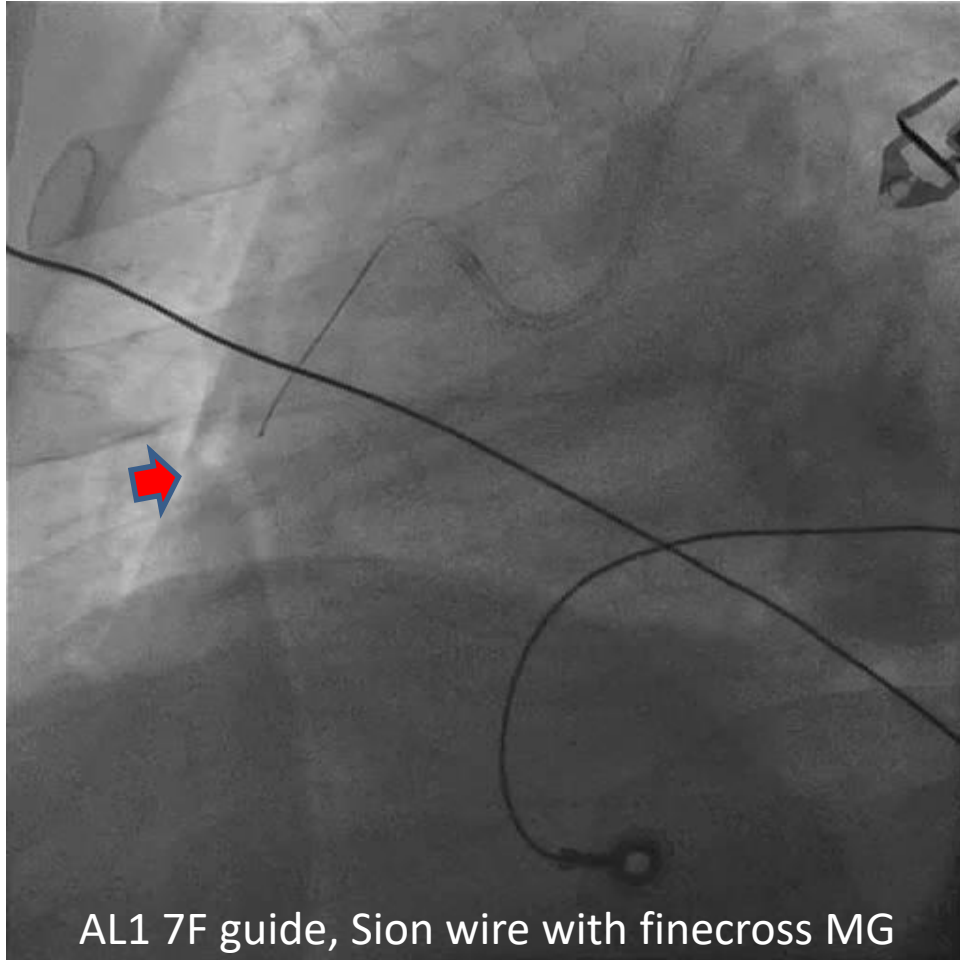


LAD: Final

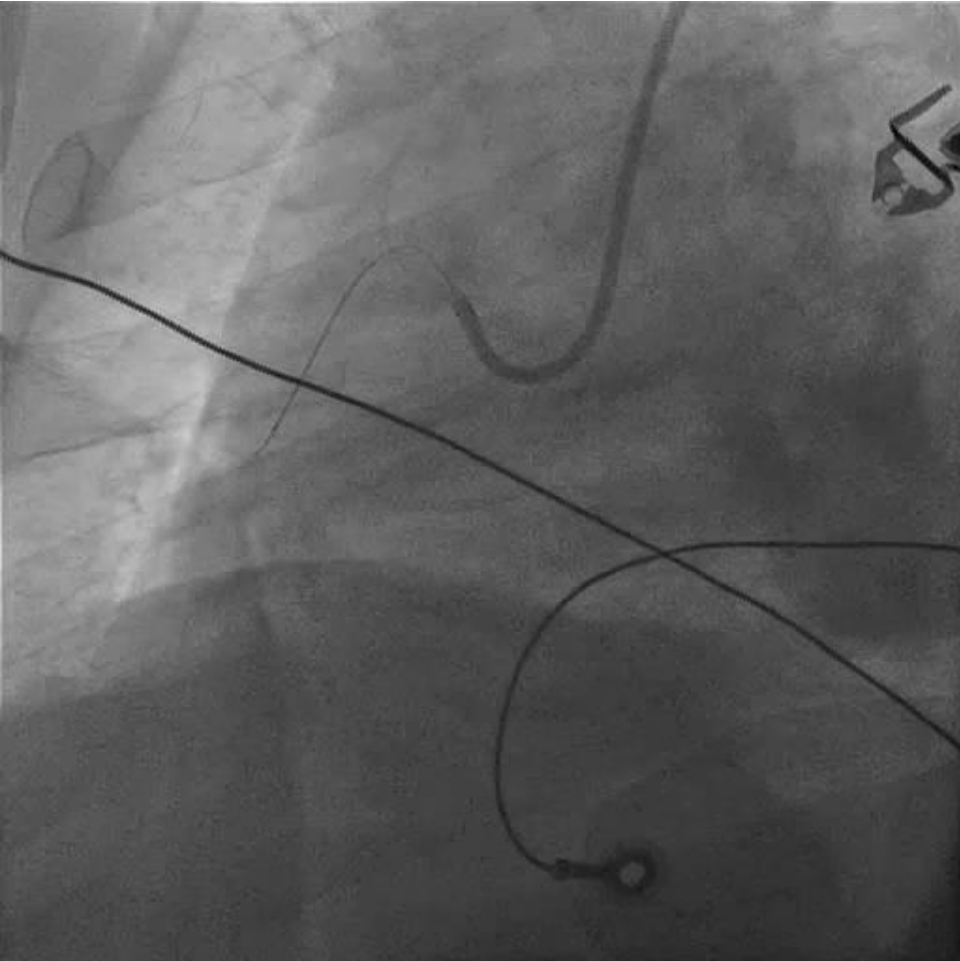
# PCI over RCA



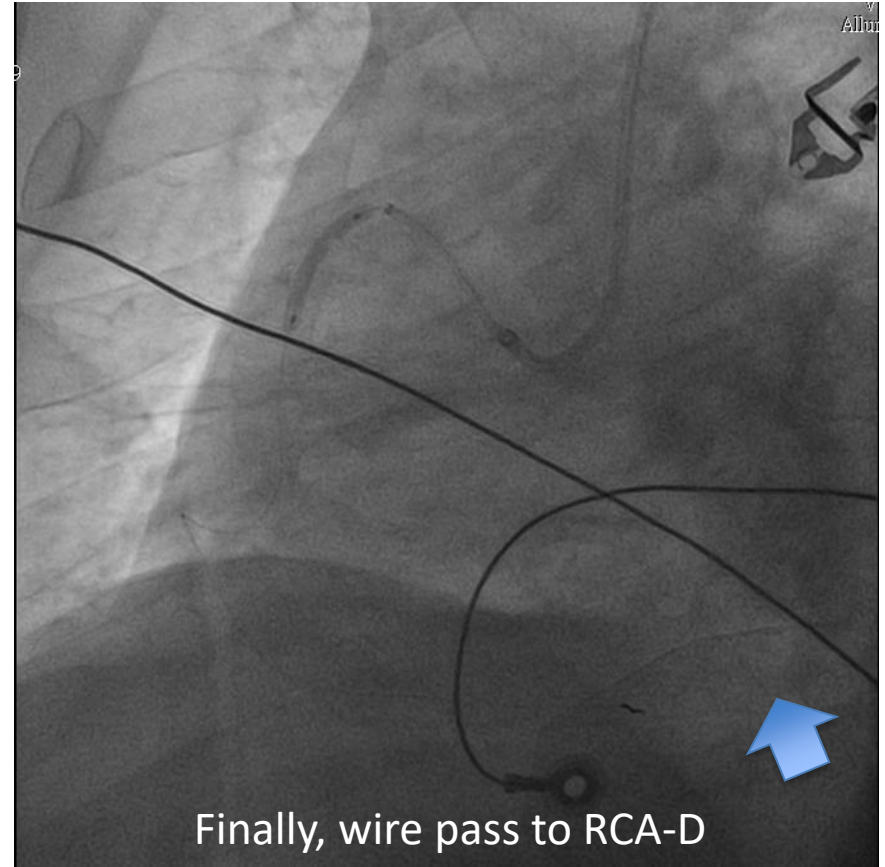
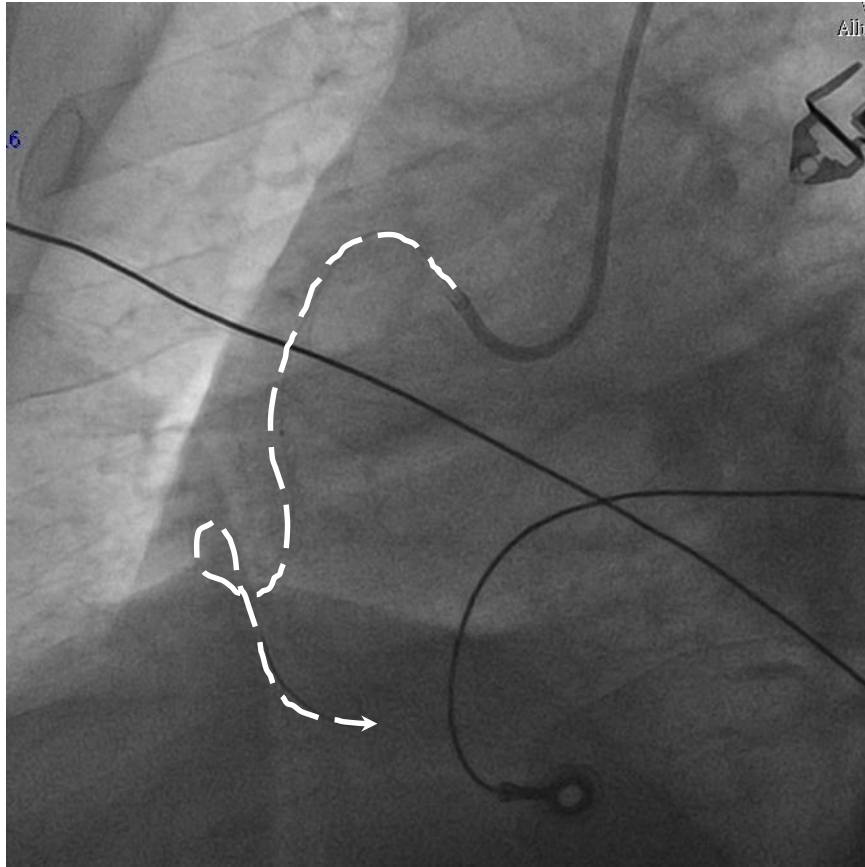
# PCI over RCA



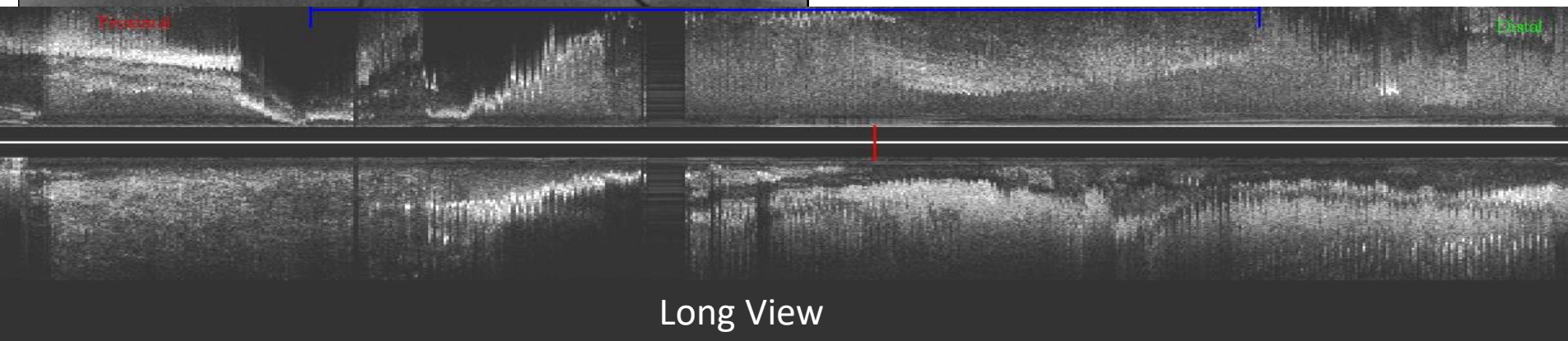
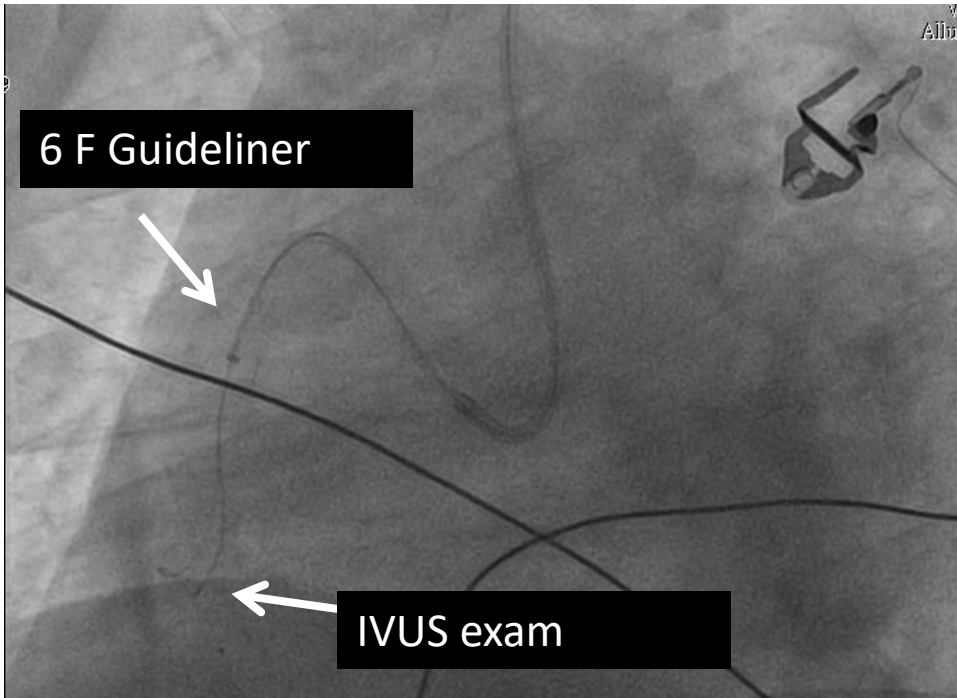
# A lot of Thrombus???



# Keep on wiring

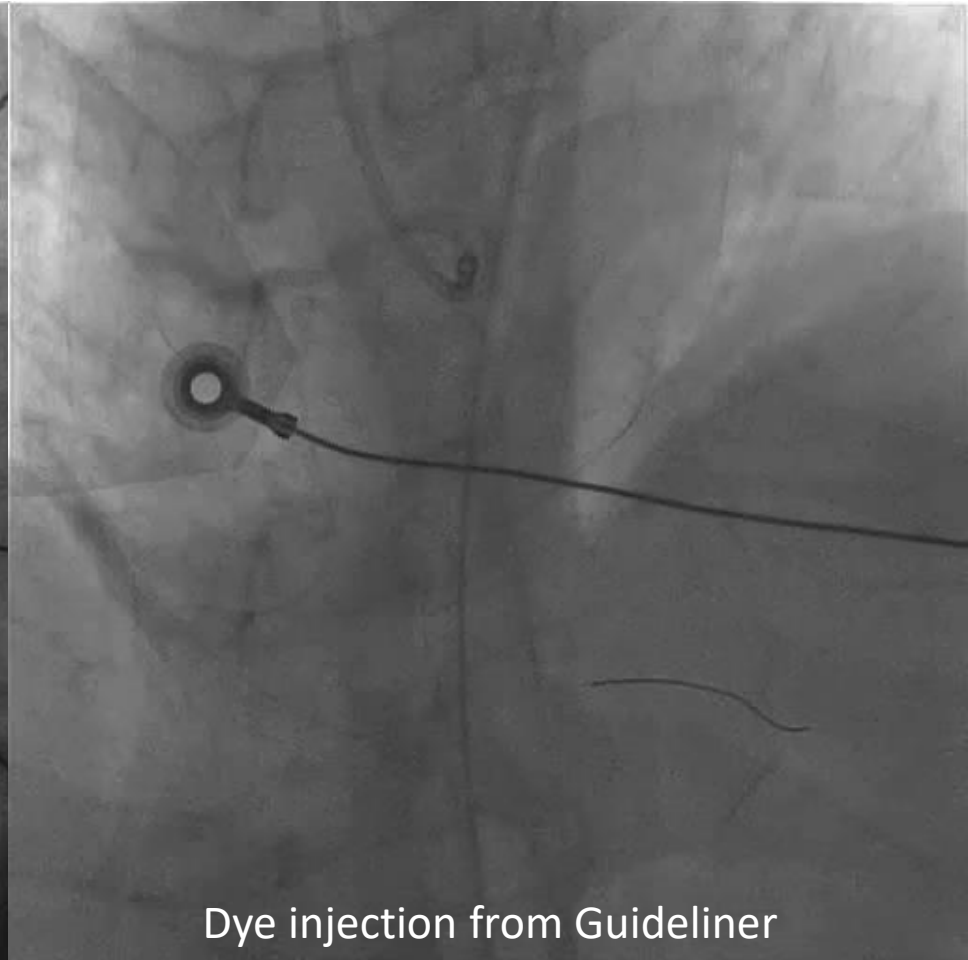
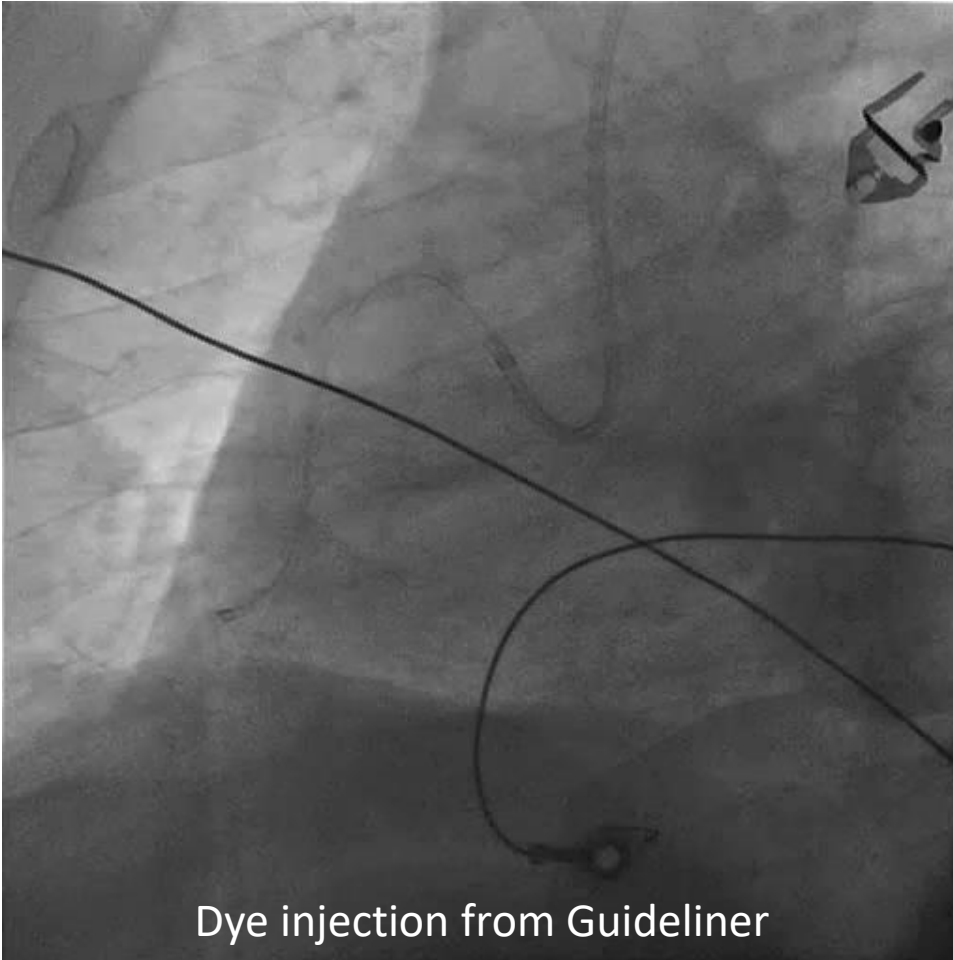


# IVUS for RCA-P to -D

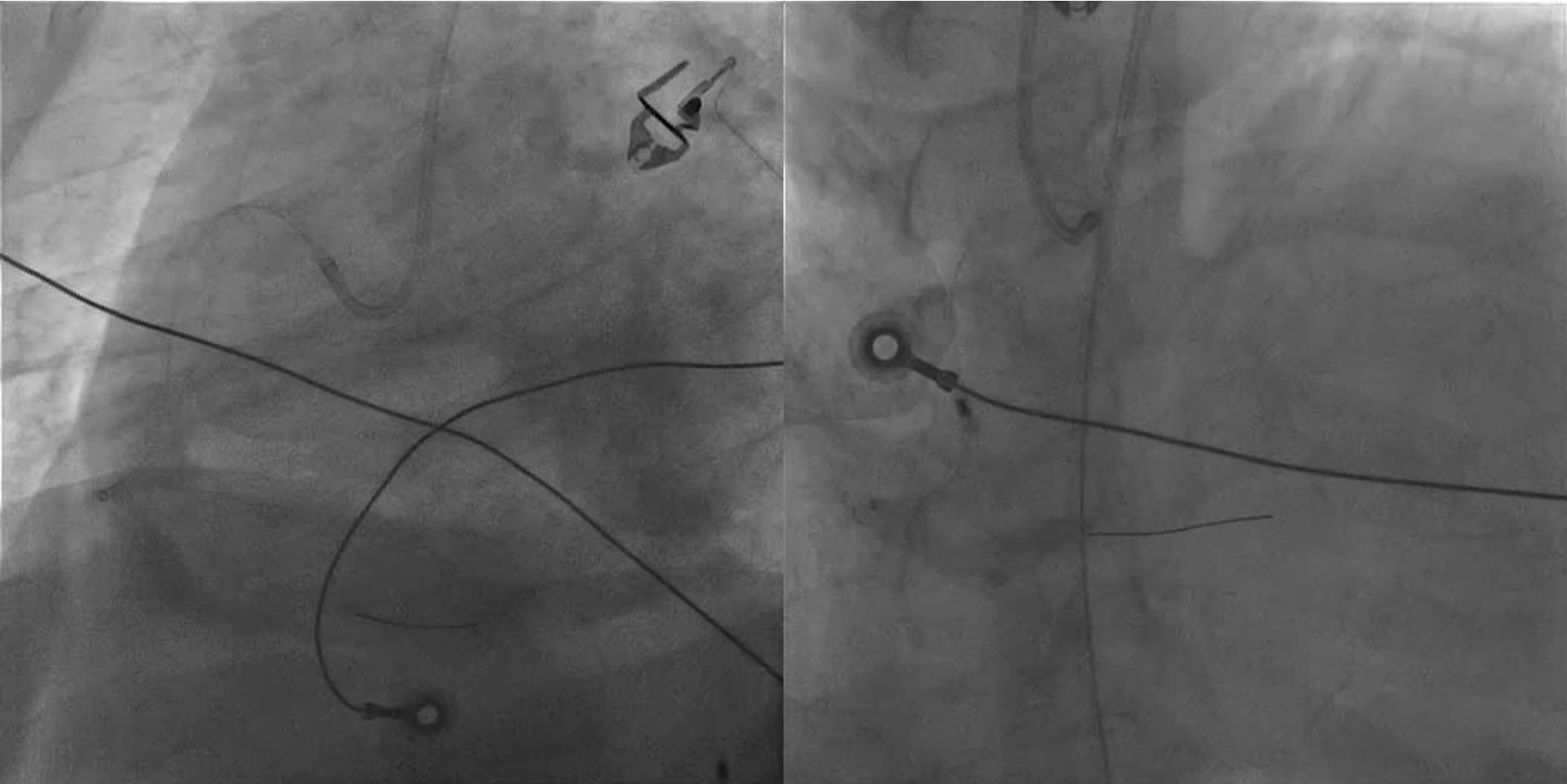




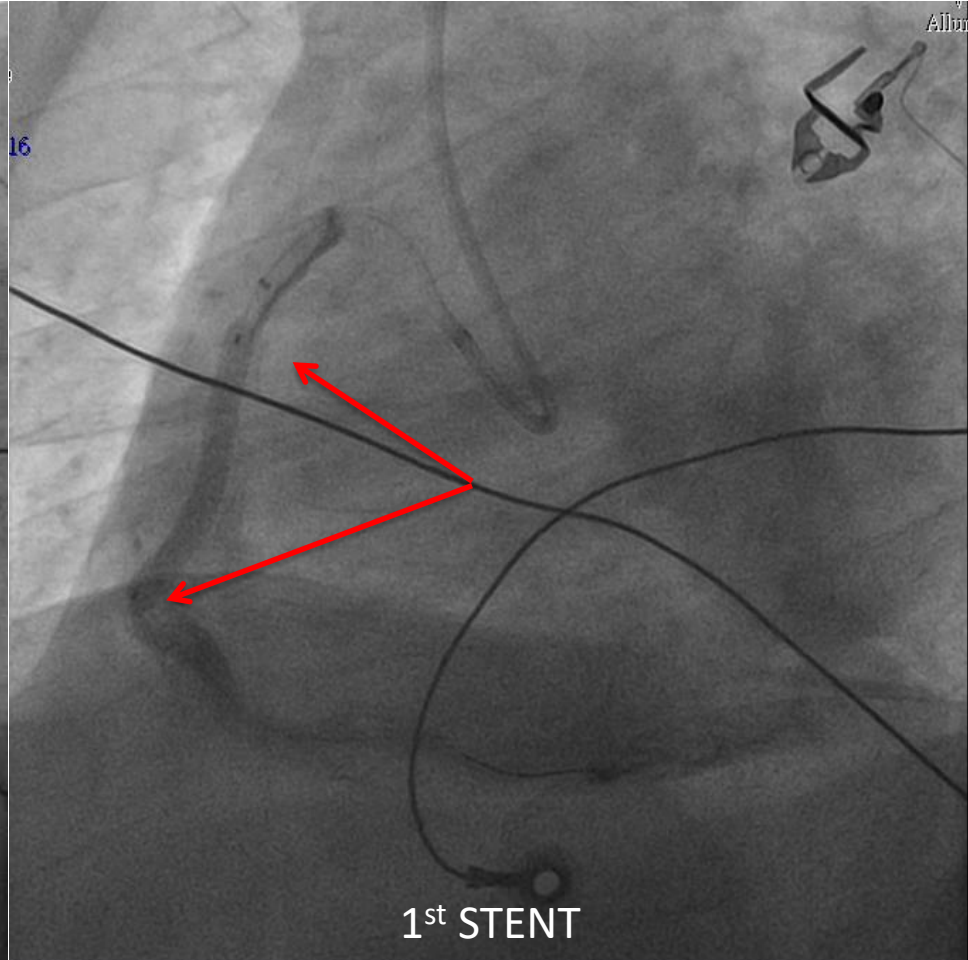
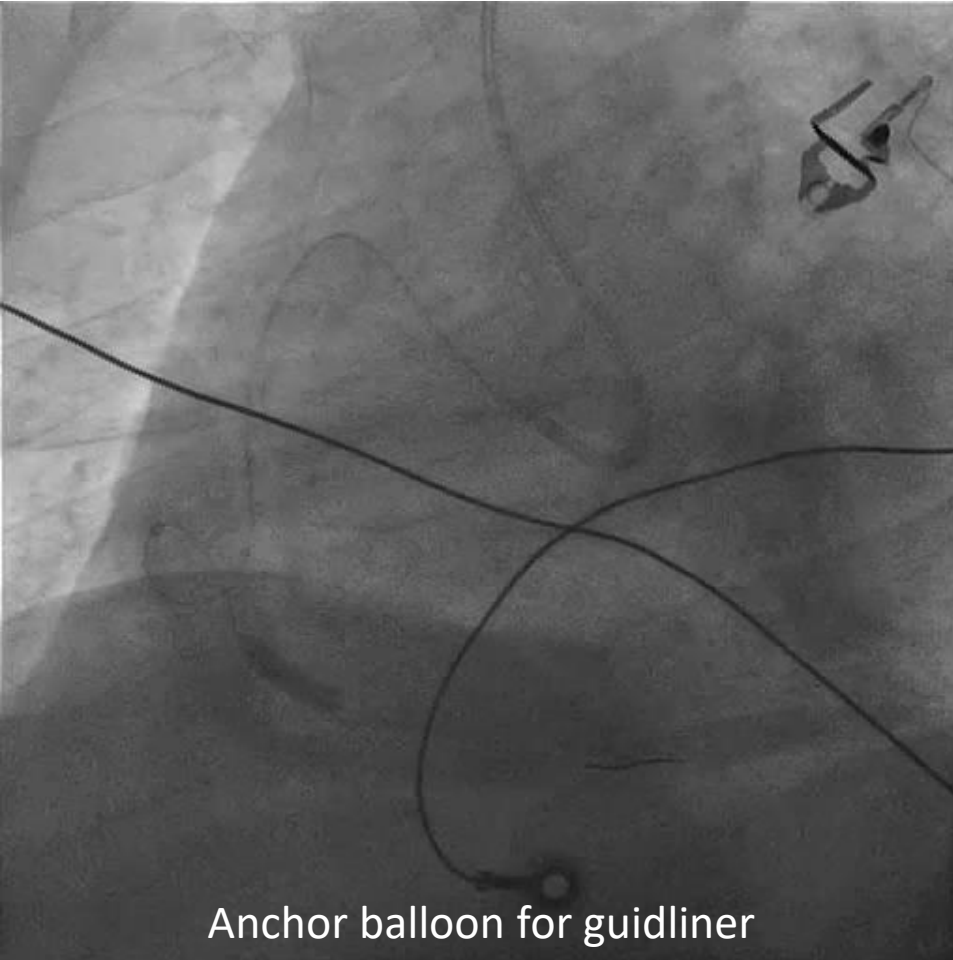
# After repeated thrombo suction



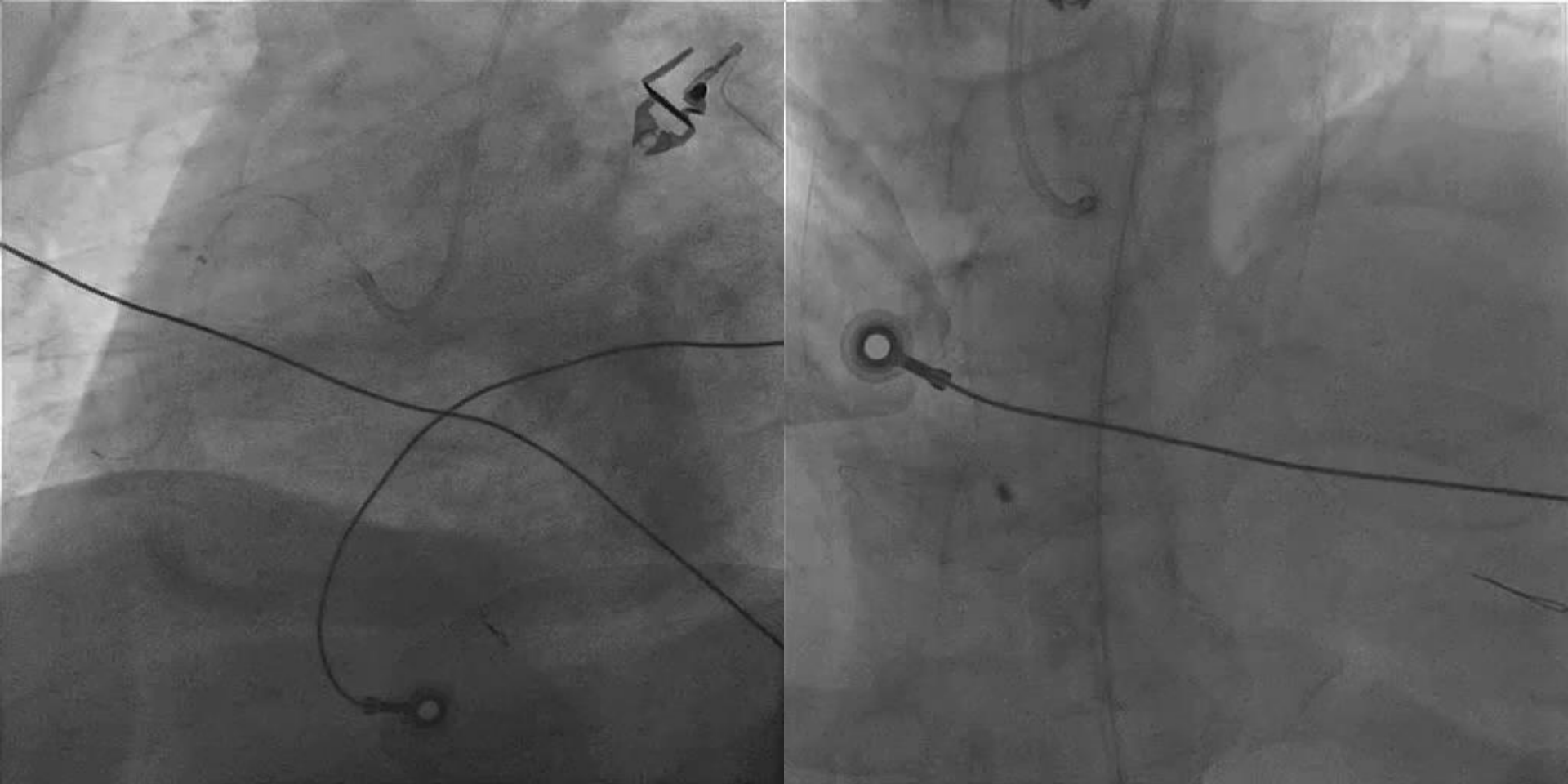
# Improved distal flow after thrombus suction

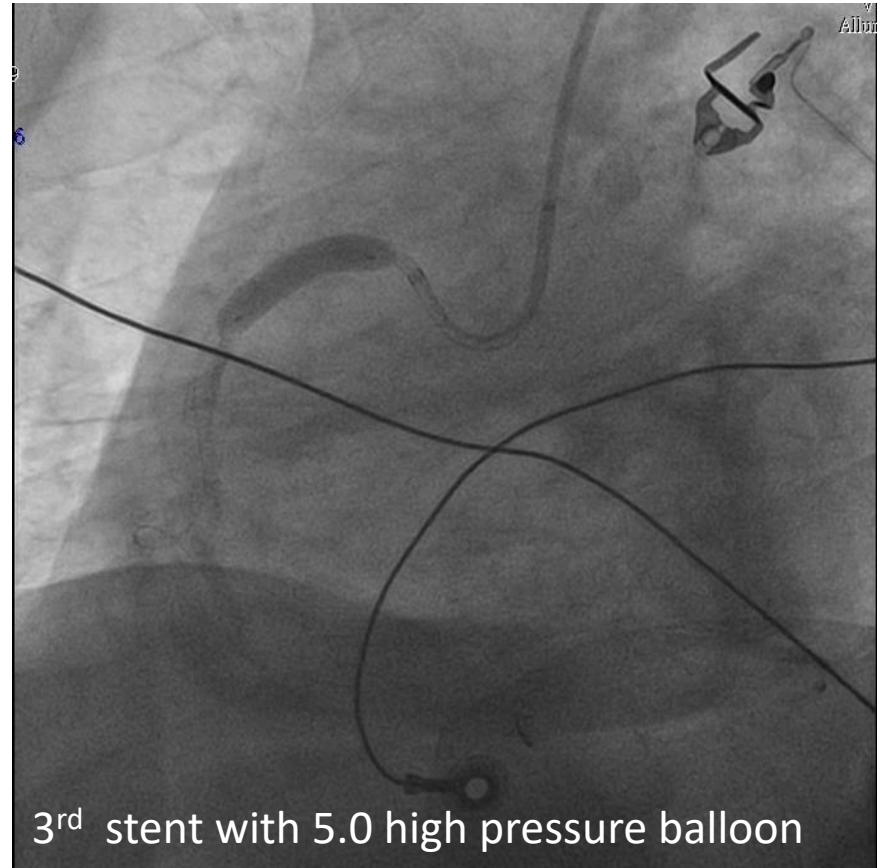
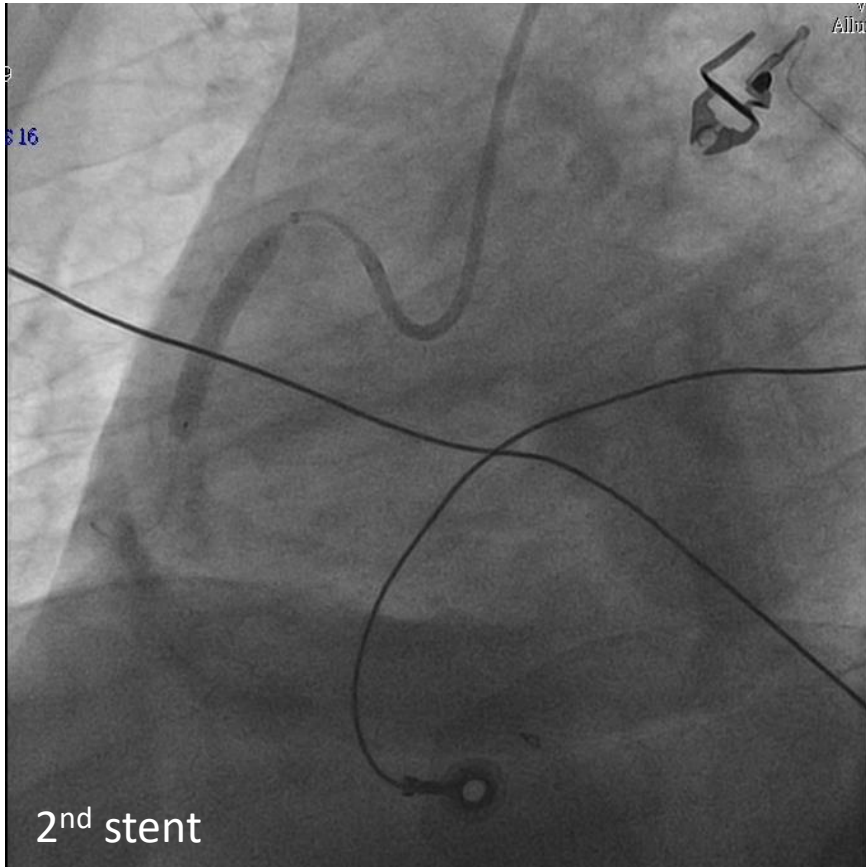


# Anchor balloon for guidliner

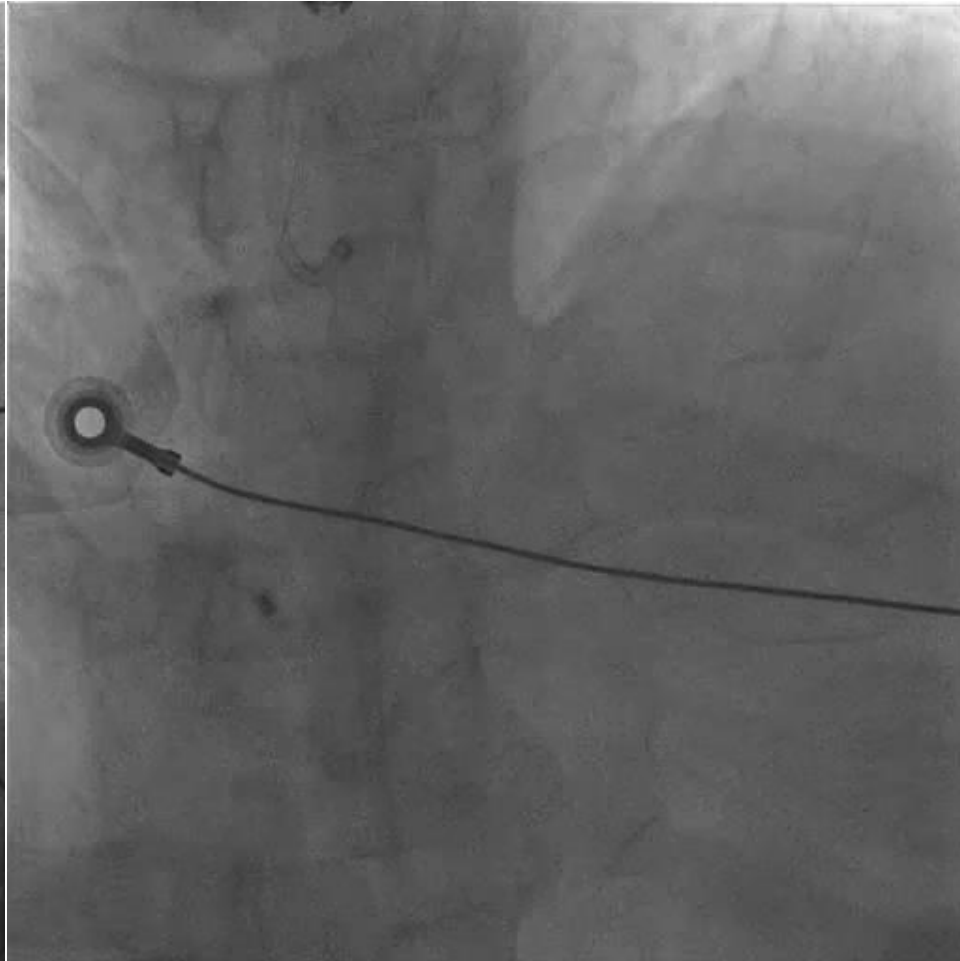
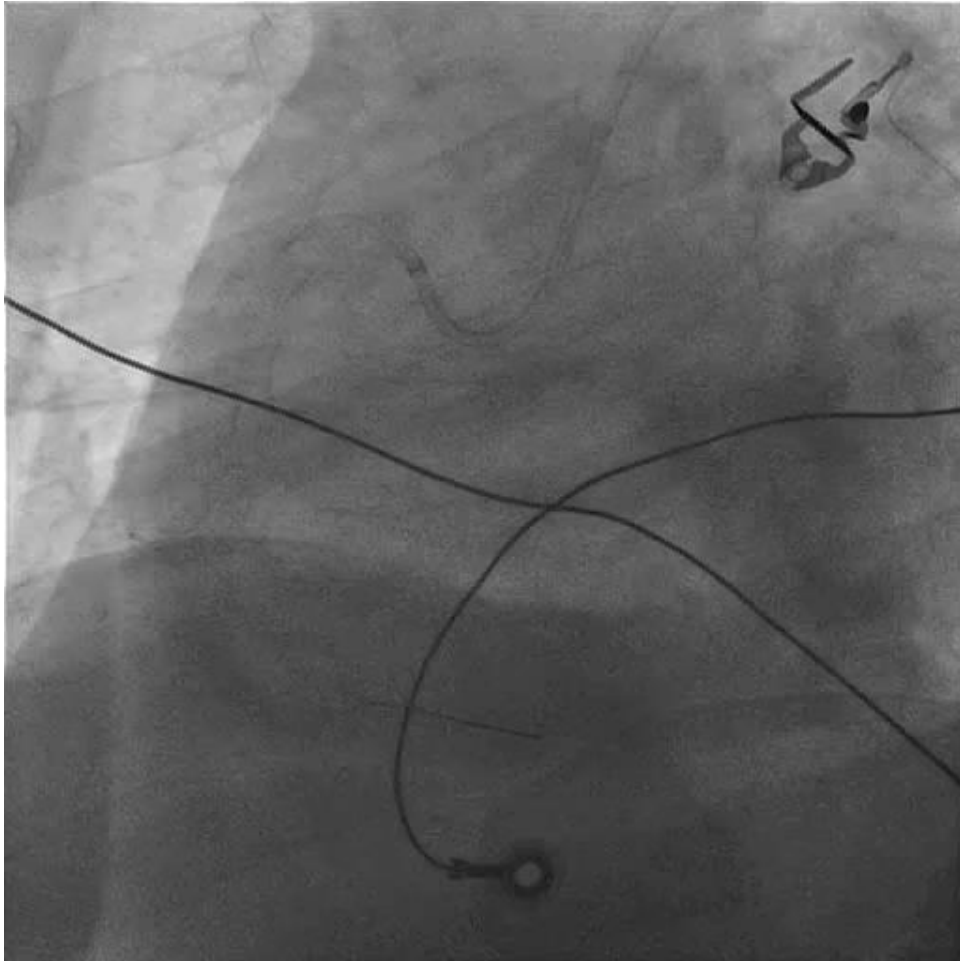


# After 1<sup>st</sup> Stent





# After serial high pressure balloon



# Clinical Course

- Procedure time: 86 mins, contrast: 150 ml.
- Temp. H.D after cath. Remove IABP 3 days later
- Discharge 1 weeks later.
- Echocardiogram:
- Severe hypokinesia over basal to middle inferoposterior wall, apex, apical anterior wall and apical anteroseptal wall, LVEF: 41%
- Hold Aspirin after 1 month DAPT, doing well till now (2 year)

# Take Home Message

- For HBR patient ( including patient with poor drug compliance), using BA9 DCS had better clinical outcome as compared with BMS



Thanks for your attention



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World  
OF  
Steve Wang

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