How would I treat?
Bifurcation lesion

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Potential conflicts of interest

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I have the following potential conflicts of interest to report:

Receipt of grants / research supports: Abbott
Receipt of honoraria or consultation fees: Abbott, PlaqueTec Ltd
Stock shareholder: PlaqueTec Ltd
Bifurcation lesions

Bioresorbable stents (BRS) in bifurcation lesions
The use of bioresorbable stents (BRS) may offer potential advantages compared with metallic DES for bifurcation PCI. However, intrinsic limitations thickness and limit increased early and action of BRS as a st:

Provisional strategy using BRS
The provisional strategy remains the default technique for bifurcation treatment using Verification by fully recommended.

Two-stent techniques using Absorb BRS
Bench studies and anecdotal cases demonstrated the feasibility of various two-stent techniques utilising either two BRS or a combination of BRS and DES\(^3\). With the present level of evidence, it is not recommended to perform routine two-stent techniques using BRS outside carefully protocolled studies.

When SB stenting is required as a crossover from provisional, metallic DES or BRS implantation on the SB should be considered utilising preferentially the T-stenting technique\(^3\).

Due to the major differences in platform properties, strut thickness, radial strength and resorption time, it is unknown whether the above-described recommendations apply to other BRS to be introduced shortly.

Lassen et al. 11\(^{th}\) EBC Consensus doc. Eurointv 2016; 12: 38-46
BRS in ‘true’ bifurcations: Can we?

Seth et al. Cathet Cardiov Int 2014; 64: 80-81
BRS in ‘true’ bifurcations: Can we?
CONCLUSION

These findings suggest that BRS implantation for bifurcation lesions is technically feasible. The rates of TLR tended to be higher in the DS group compared to when a PS strategy was employed. Based upon our
BRS in bifurcations: Should we?

Bifurcations in GHOST-EU

Naganuma et al. Cathet Cardiov Int 2017; 89: 47-56
How would I treat?

True bifurcation: Medina 1,1,1

pLAD ≥ 3.5 mm

D1 ≥ 2.0 mm

Unpredictable need for D1 stenting

Metallic DES with provisional strategy
(T/TAP if 2nd stent required)