2021 euroPCR

When the enemies gather, you have to be ready

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Presented by

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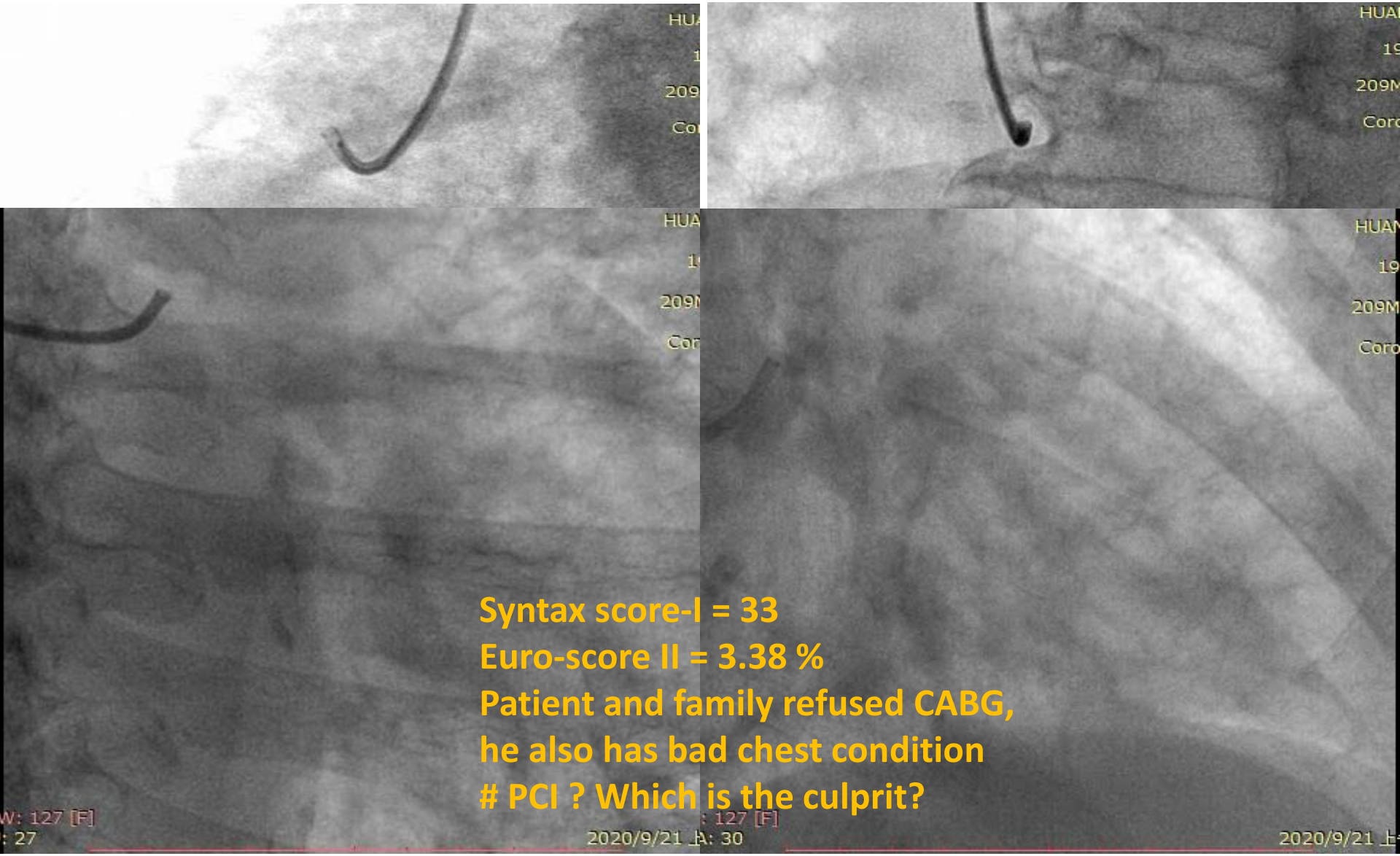
History and Investigations

- A 58 y/o male with interstitial lung disease, recurrent pneumonia, hypercholesterolemia, smoker.
- **C/O** Chest pain, NYHA-III CHF
- **ECG** Qs V1-V4 & T inv II,III,aVF
- **LVEF** 30%, sever hypokinesia, II/IV MR
- **Labs** Cr = 0.86 mg/dl, cholesterol = 305 mg/dl, TG = 151 mg/dl, HBA1C = 6.1%, trop +ve.

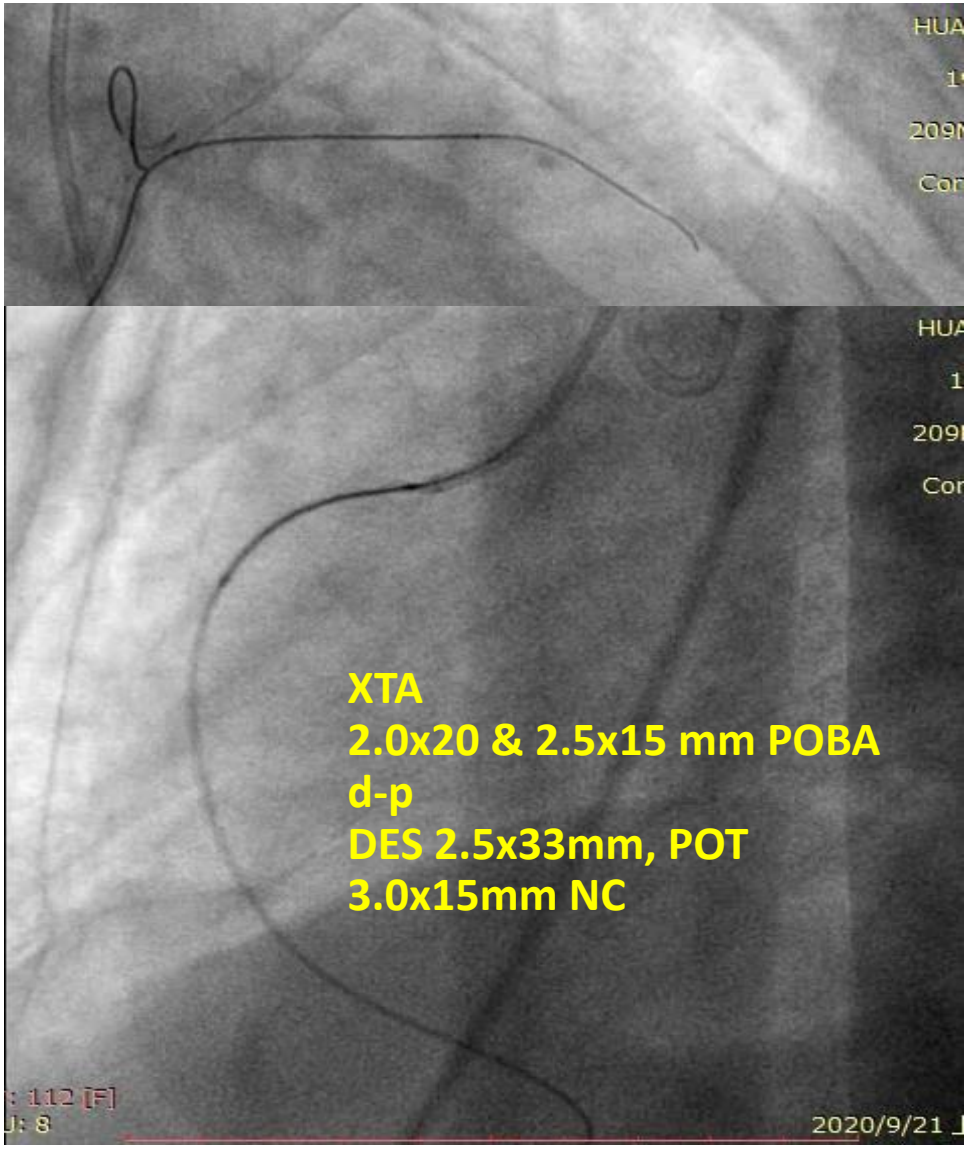
Diagnosed as NSTE-ACS

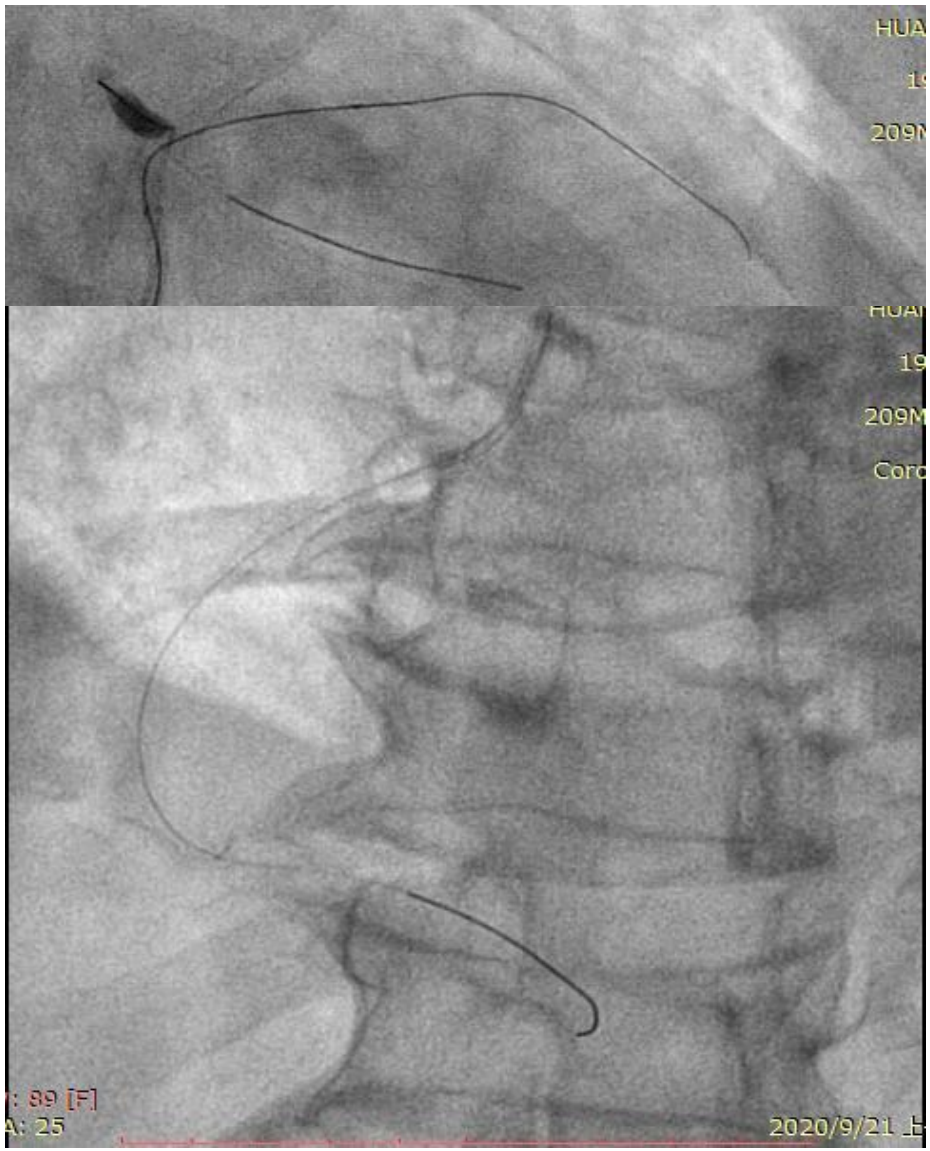
Coronary Angiography

LRA access: 6F IL4

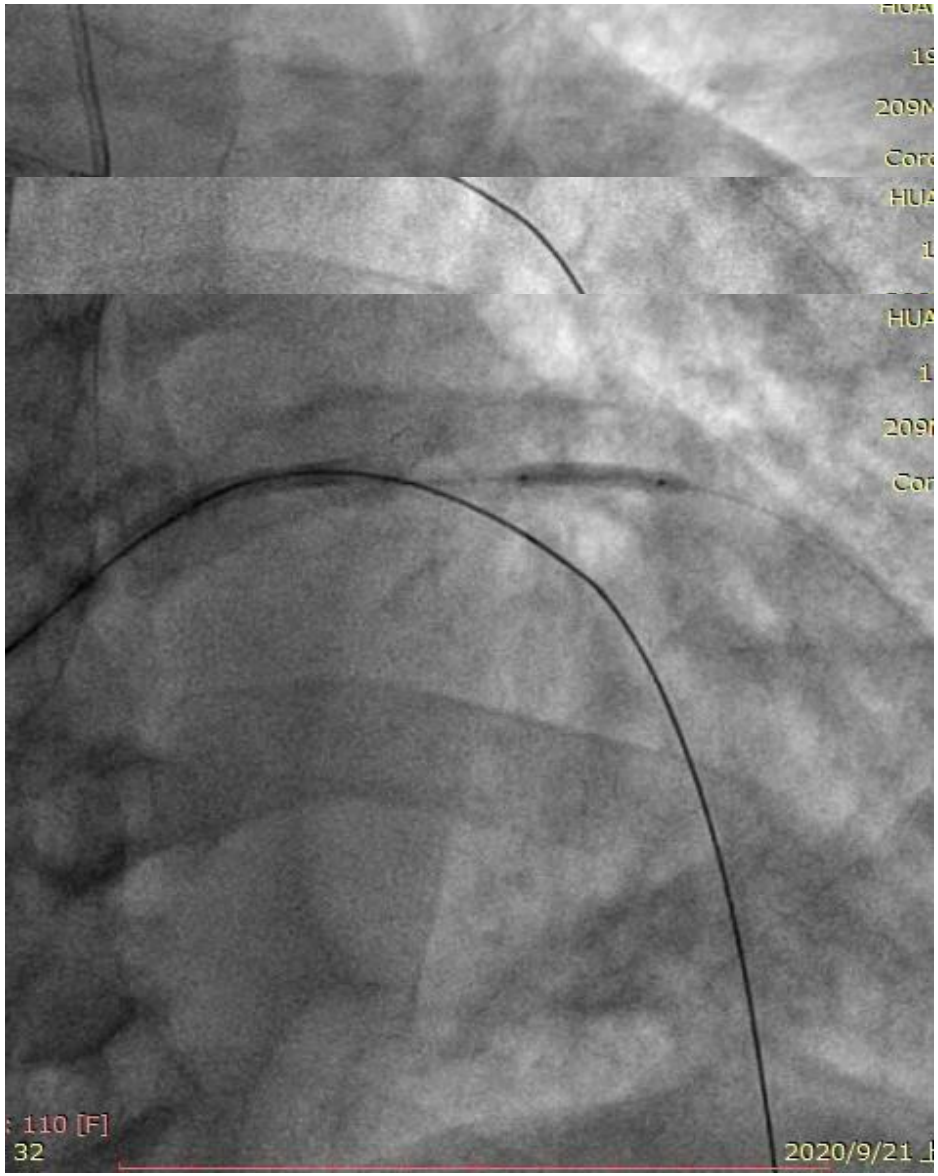


Runthrough>> XTA M.C, contra-lateral injection via 5F IL4 failed>> senior advice>> Switch gear to RCA





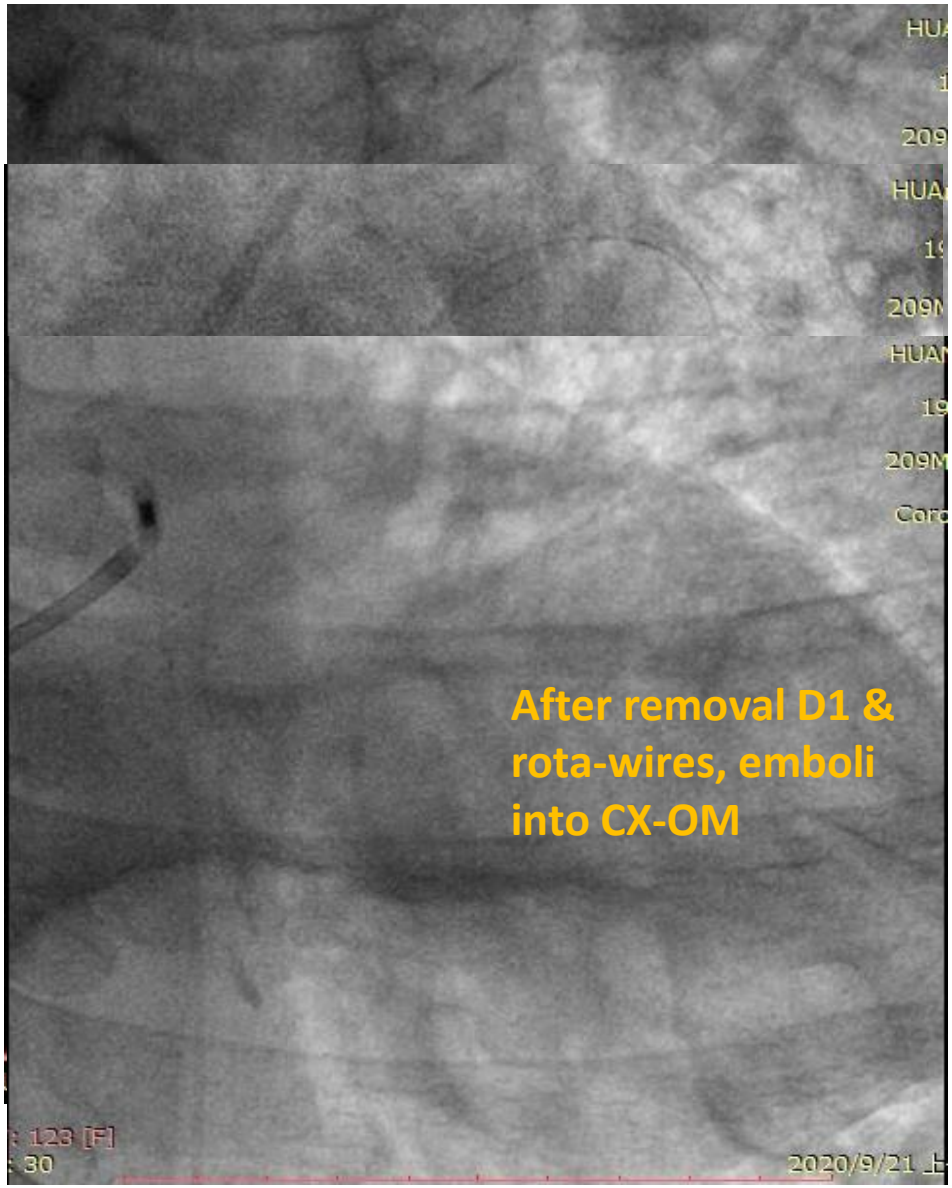
Exchange 6F IL4 to 7F EBU 4
Fixing P-LCX, wiring LAD CTO with CP12, fine cross& turnpike gold MC could not cross

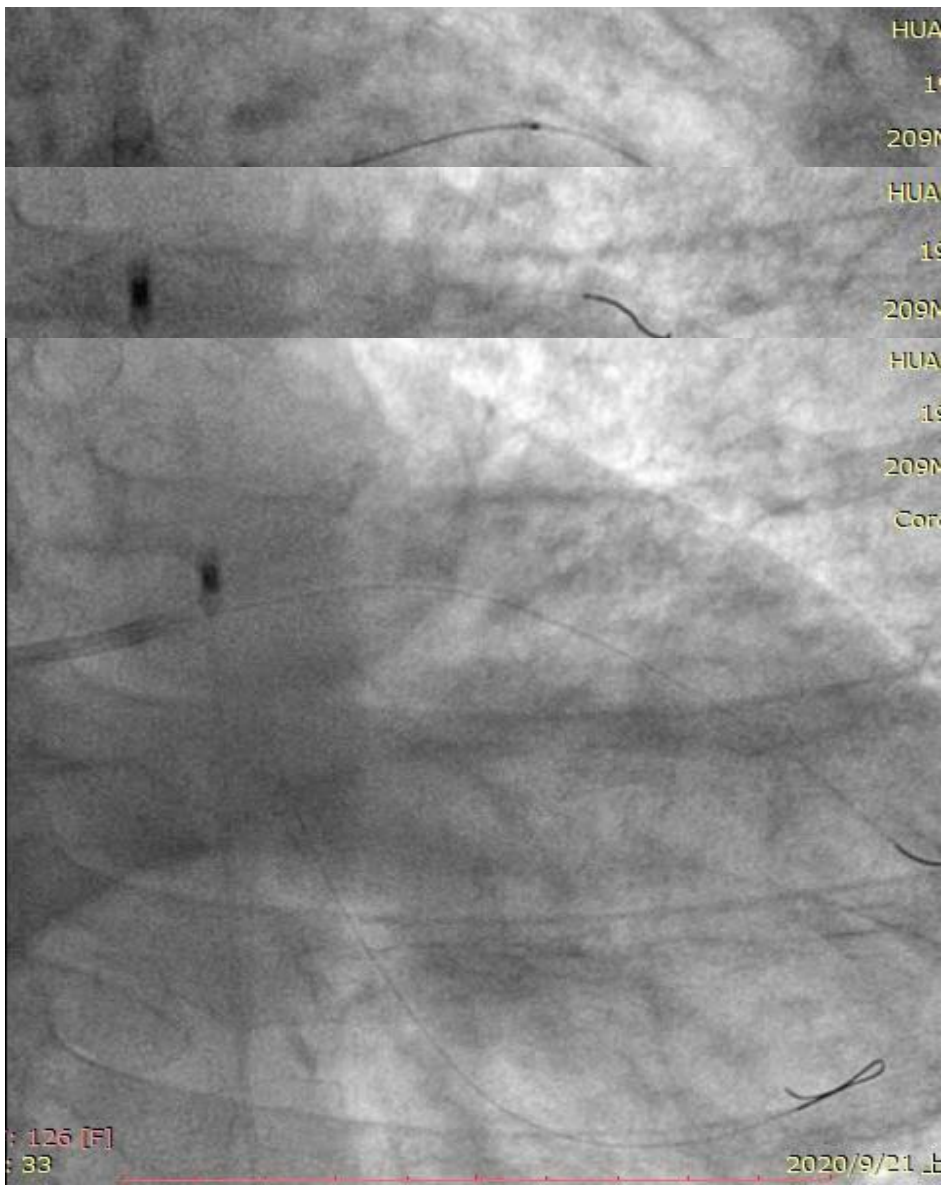


Wire passed but MC could not

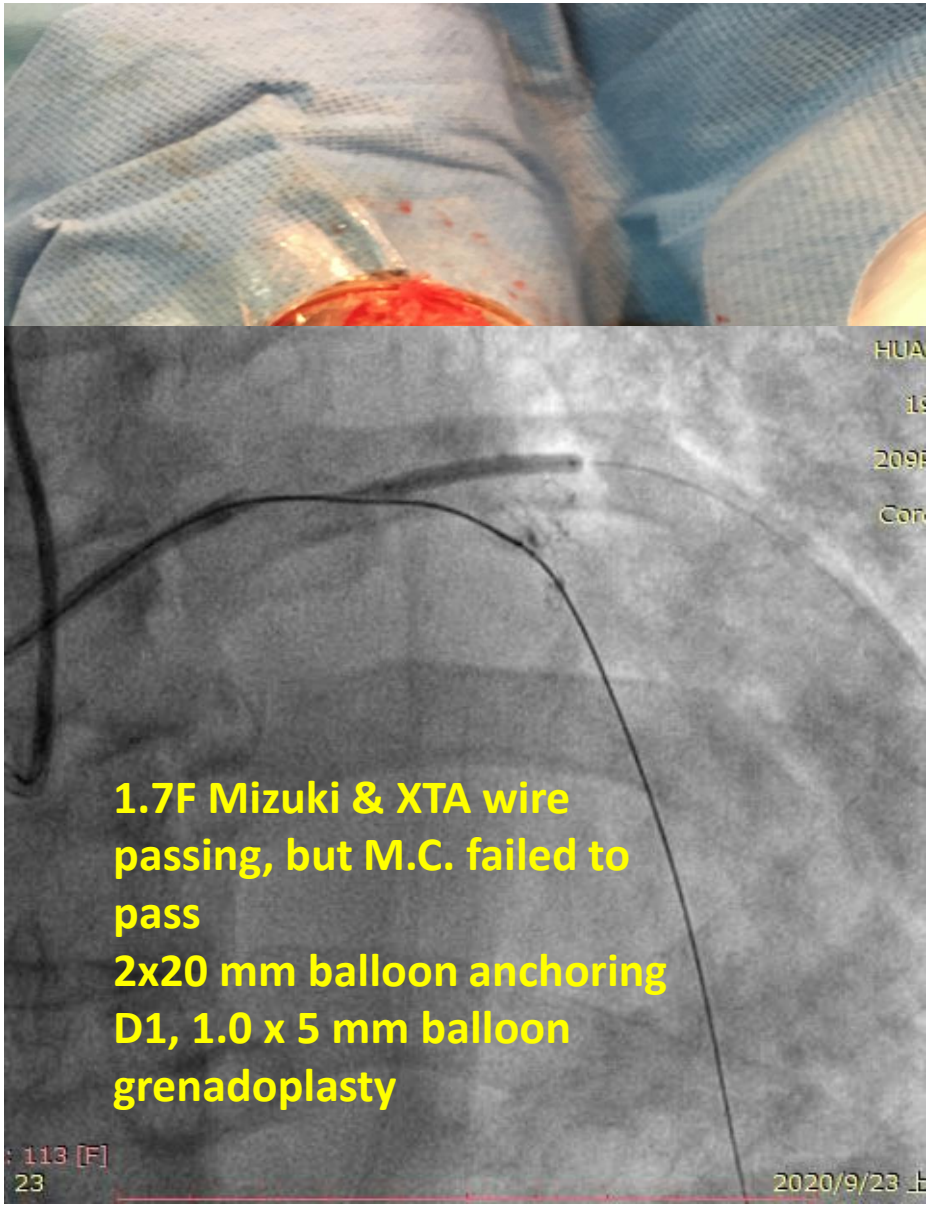
- **Confirm distal true lumen**
- **Increase support**
  - Well seated GC > G Ex> Anchoring
- **Smallest balloon**
- **Plaque modification**
  - MC eg *Tornus, Turnpike Gold*
  - Grenadoplasty
  - Atherectomy

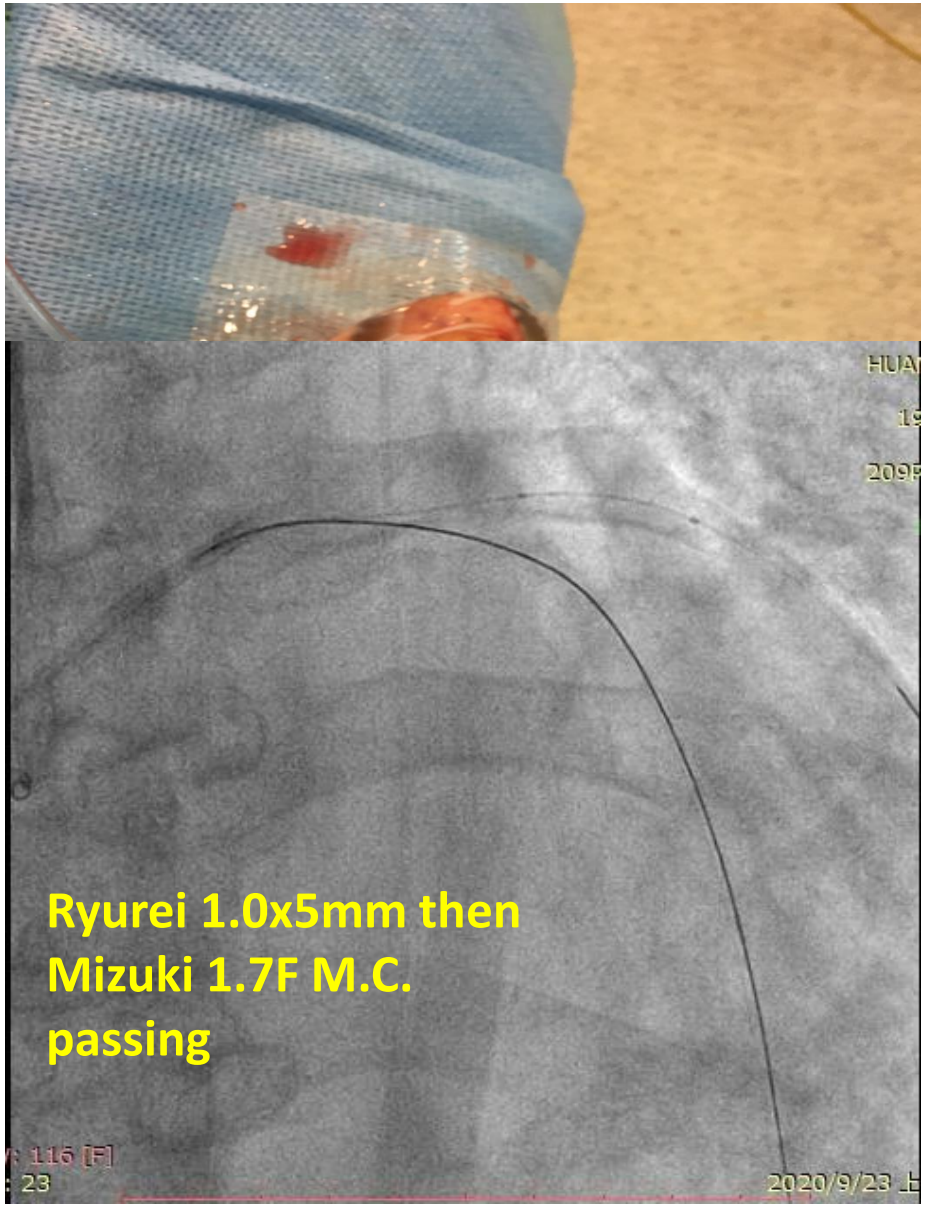
Rota floppy wire> Thrombus at LM-LAD-D1
IABP > Thrombosuction, IC GPIIbIIIa i
Transfer to CCU keep IV GPIIbIIIa i



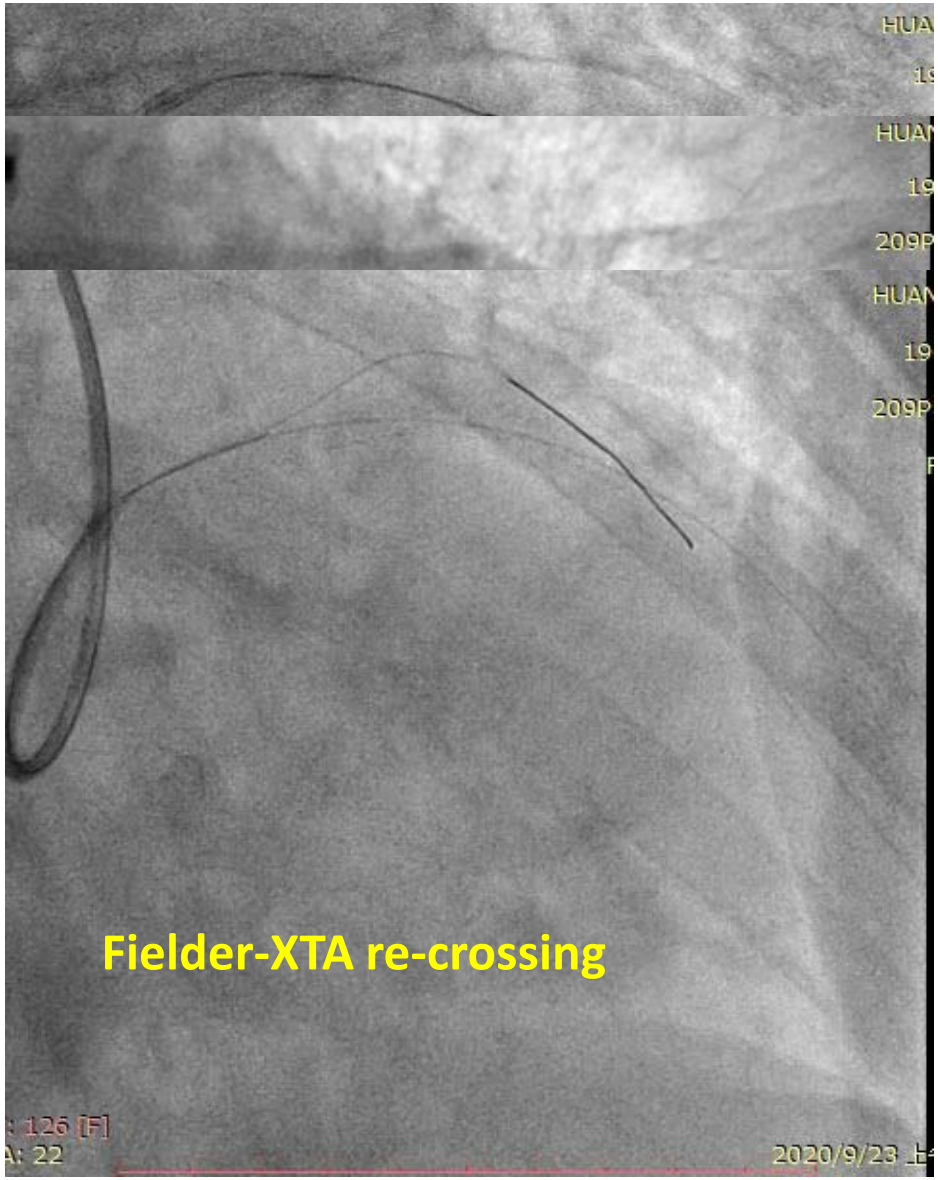


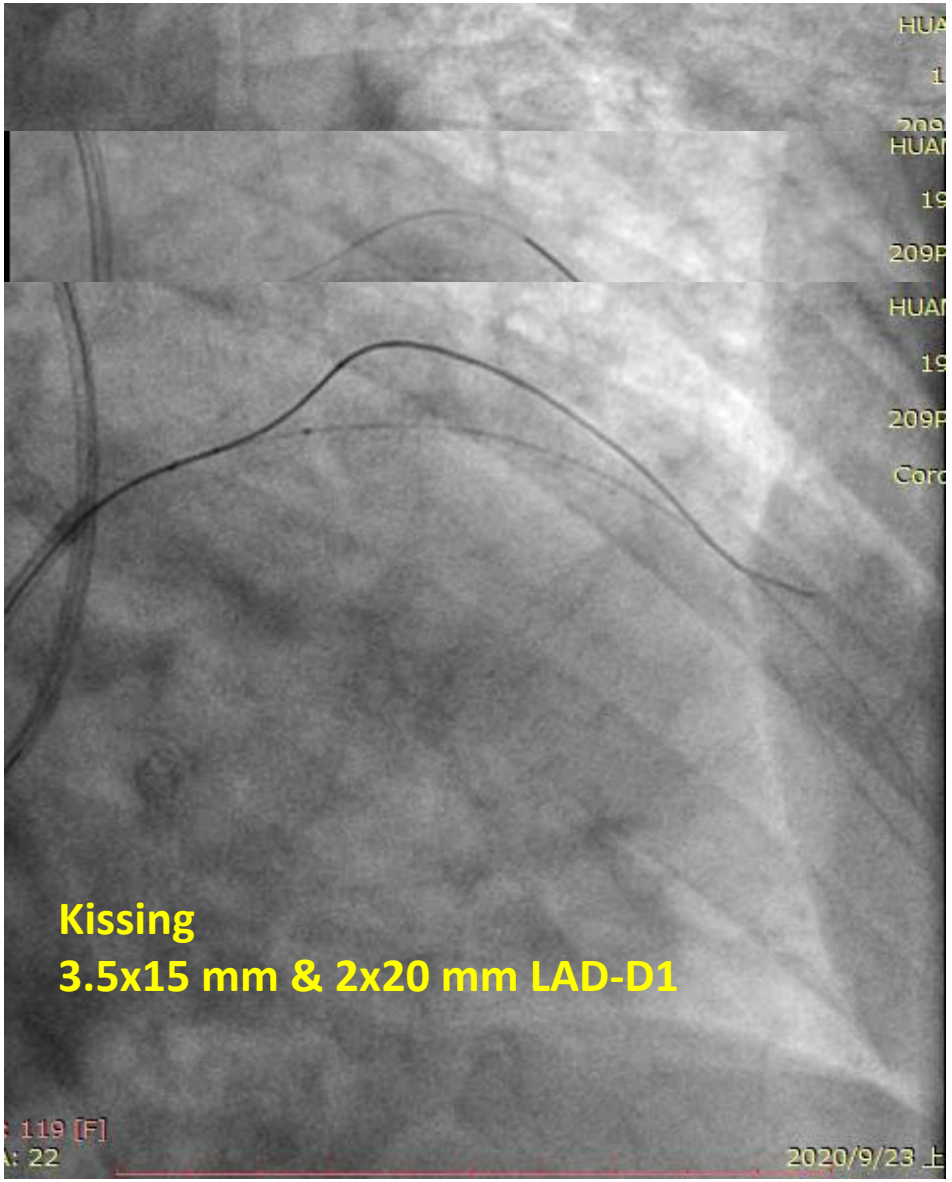
Two days later, d-RRA 7F EBU4, d-LRA 6F IL4 for RCA
Preparation for LAD-CTO rotational atherectomy



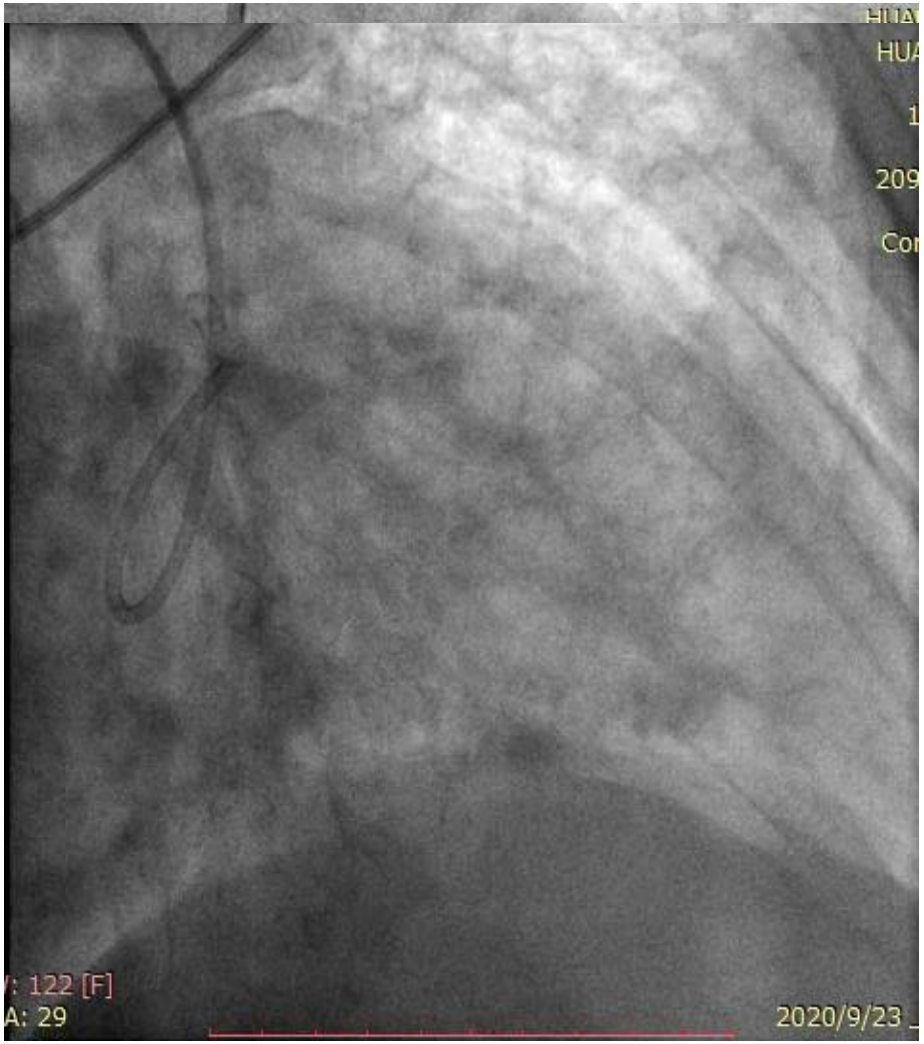


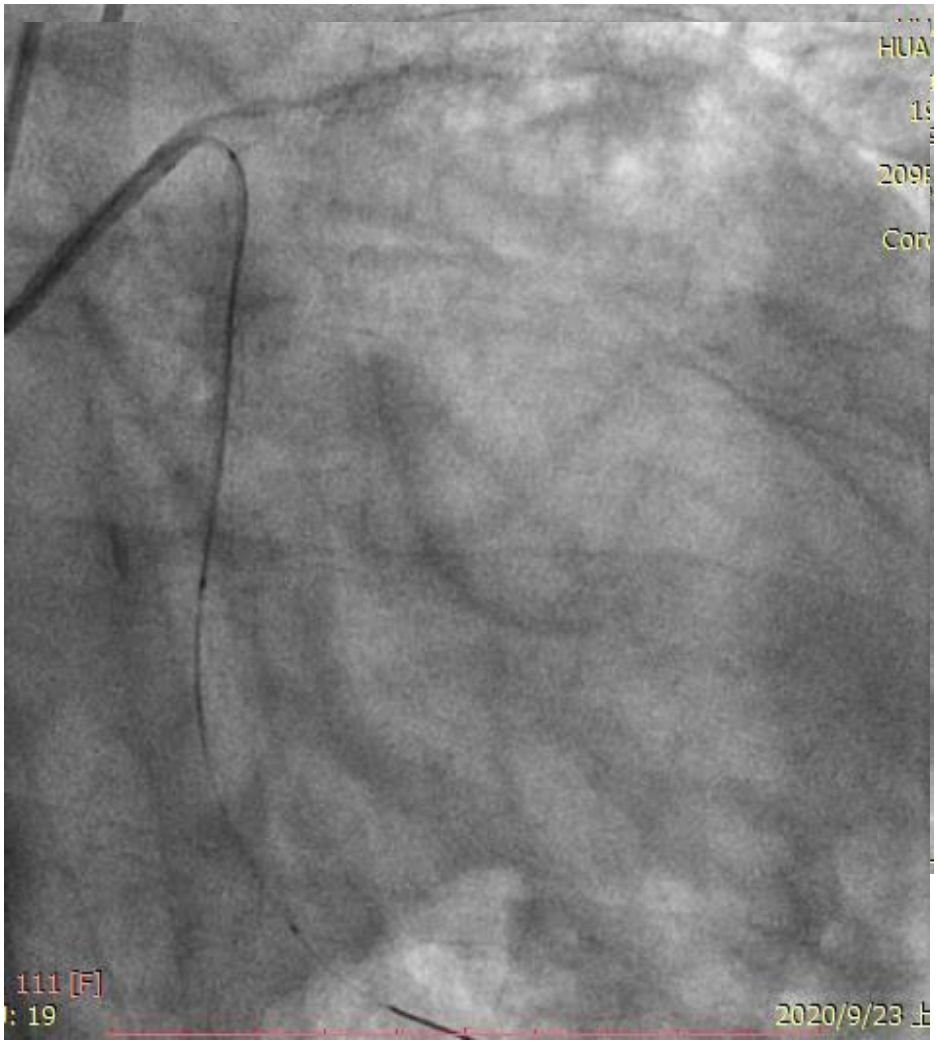
1.5 mm burr rotablation
After exchanged rota-floppy to 0.014 Runthrough wire, sequential POBA>> Kissing>> Stenting>> POT>> Kissing





Attempt CX-CTO for CHF complete revascularization, Final Angiography





Two days later IABP was removed, Patient was discharge after 5 days
Came for OPC and doing well

Take Home Message

- *Triple vessel disease with CX-m & LAD-p CTO & low EF, of course, CABG was the first choice, but bad lung condition and pt requested PCI as an alternative.*
- *Fixing non-CTO lesions first, take time for CTO lesions, IABP, ECMO or Impella preparation is mandatory.*
- *Chronic inflammatory status is a cause of **heparin unresponsiveness** specially in the stetting of ACS. In this patient we started with 100U/Kg then gave 2 more boluses; total 17000u and ACT only 305 s.*
- *When you are fighting calcium, suspect an attack from his girl friend; **THROMBUS.** **Calcium = a lot of tools + long time***
- *Better to check ACT before PCI and every 30 min interval for keeping ACT > 300 sec.*
- *Bil. Arm approach in CHIP CTO setting is better, sparing femoral for hemodynamic support.*
- *Any PCI complication could happen in CHIP pts, therefore, being familiar with managing complications is also very important.*

Thank you