Treating Calcified Left Main Bifurcation Lesion: What to do when you cant burr

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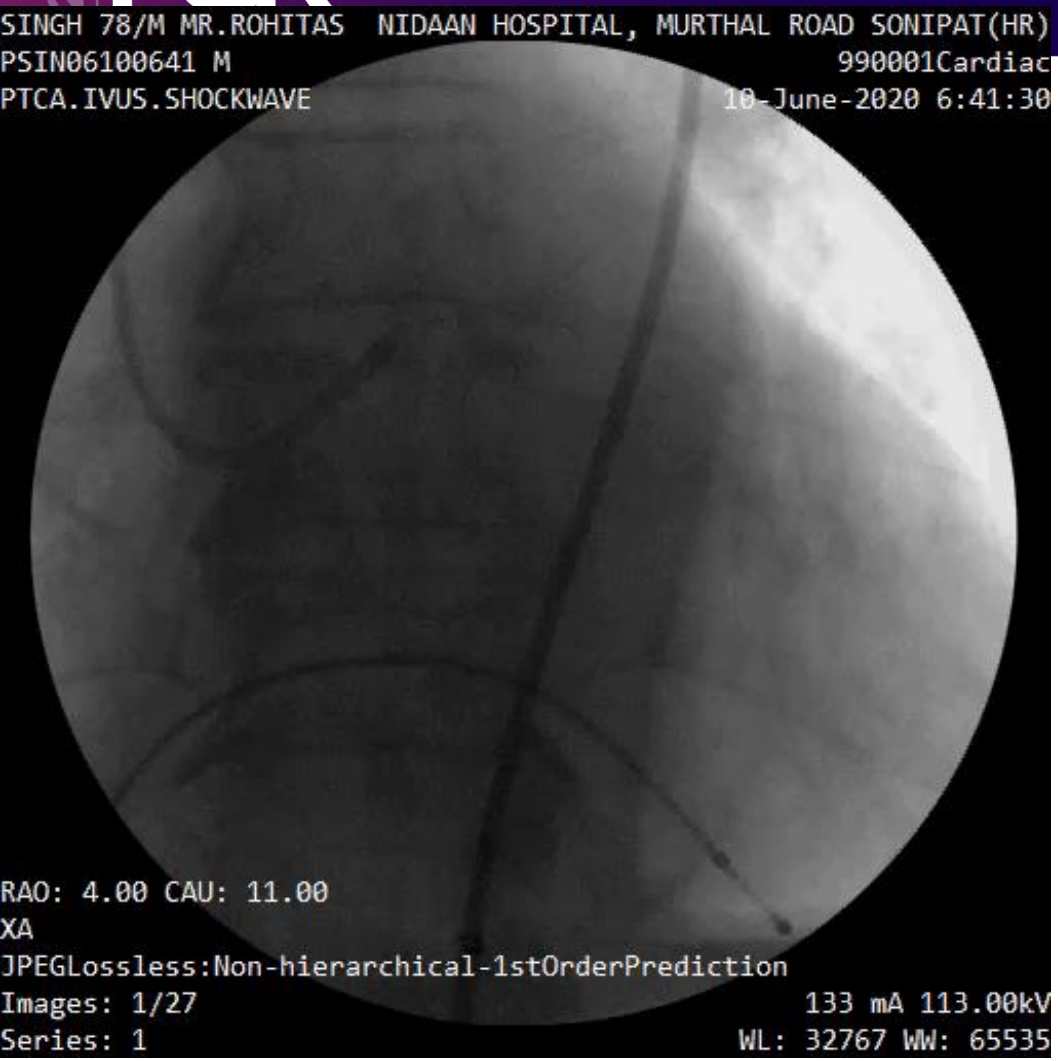
Clinical Presentation

- 78 yr old male
- No comorbidities
- Smoker
- Angina on exertion class II-III since last 1 week
- Presented with rest angina since 2 hours
- CKMB- 68IU/L hsTrop I : >5000pg/ml
- ECG: ST depression in anterior leads and aVR ST elevation.
- Echo: Global Hypokinesia of LV with LVEF 35% with Grade II MR, Moderate PAH
- Out of Hospital CAG done revealed Left dominant system with Left Main bifurcation calcific Medina 1,1,1 stenosis: was adviced CABG.
- While being referred he developed pulseless VT which was DC cardioverted and the patient was planned for urgent LMB- PCI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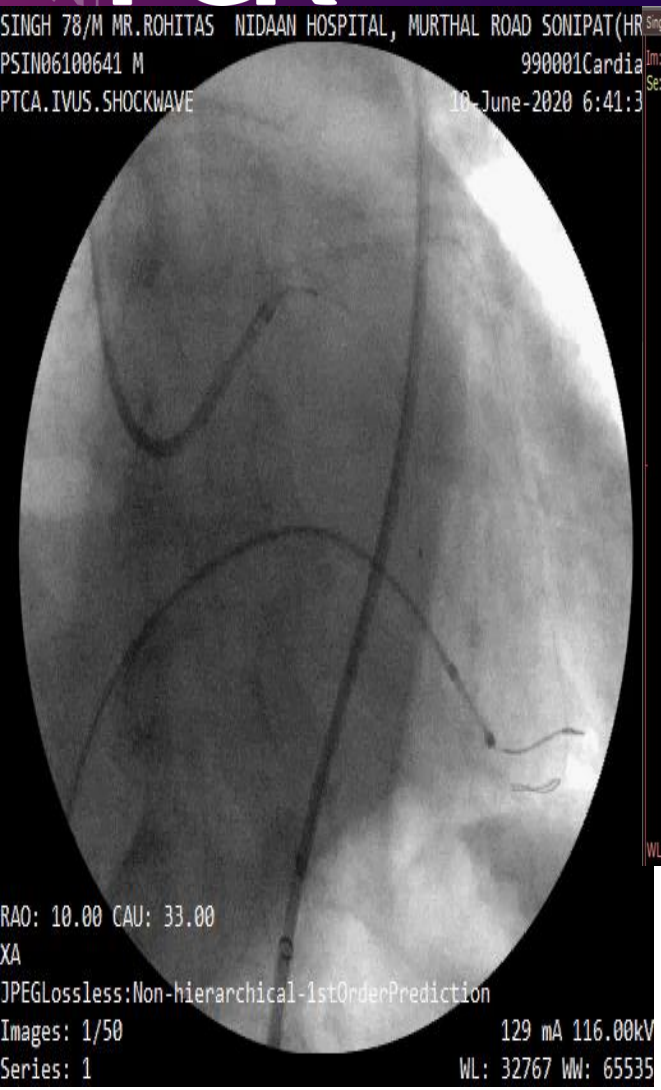
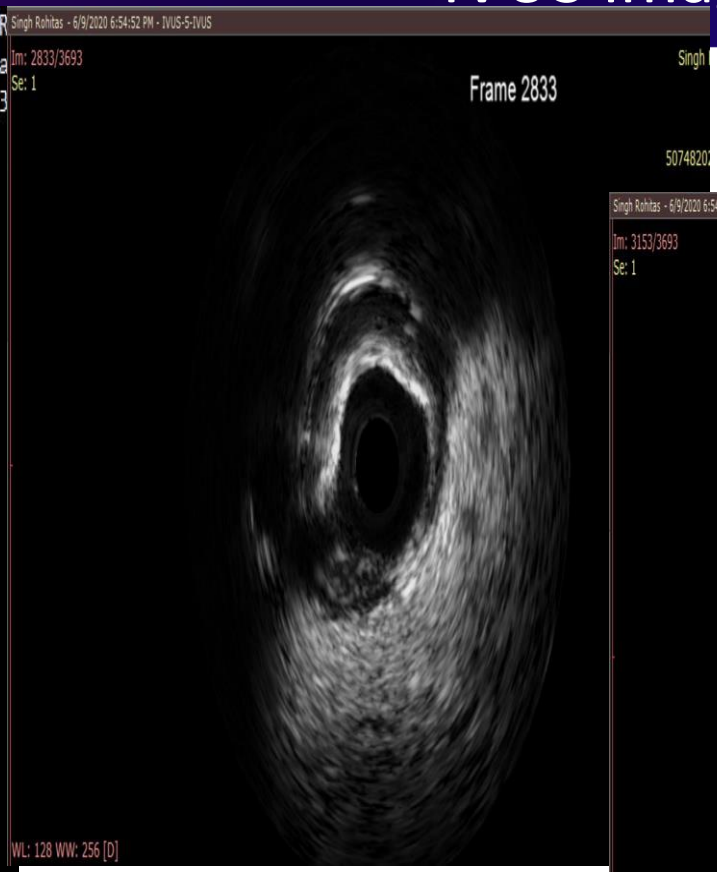
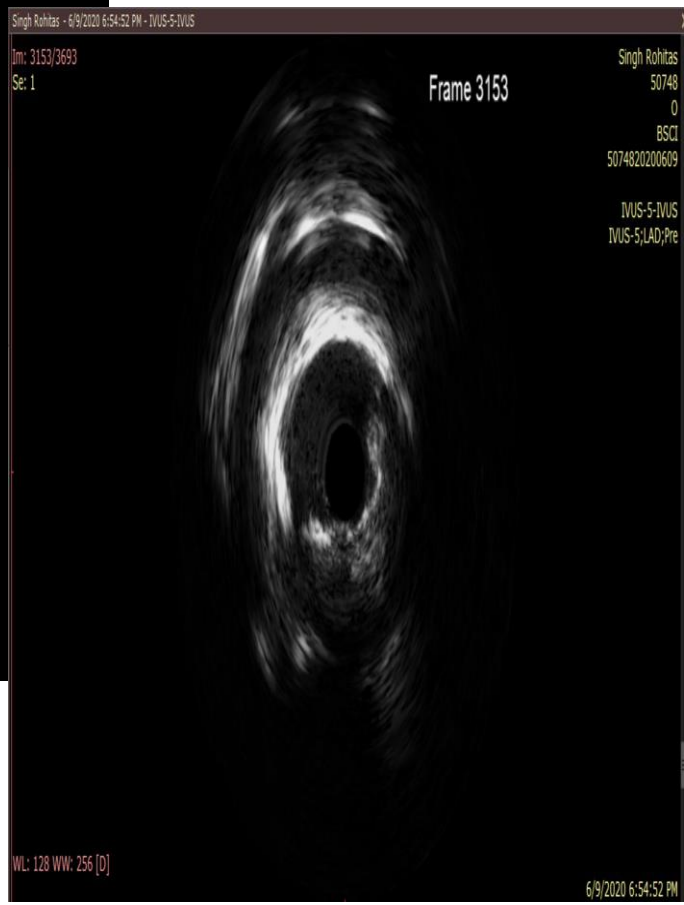
RAO: 4.00 CAU: 11.00
XA
JPEGLossless:Non-hierarchical-1stOrderPrediction
Images: 1/27 133 mA 113.00kV
Series: 1 WL: 32767 WW: 65535

IVUS imaging of LCX Ostia

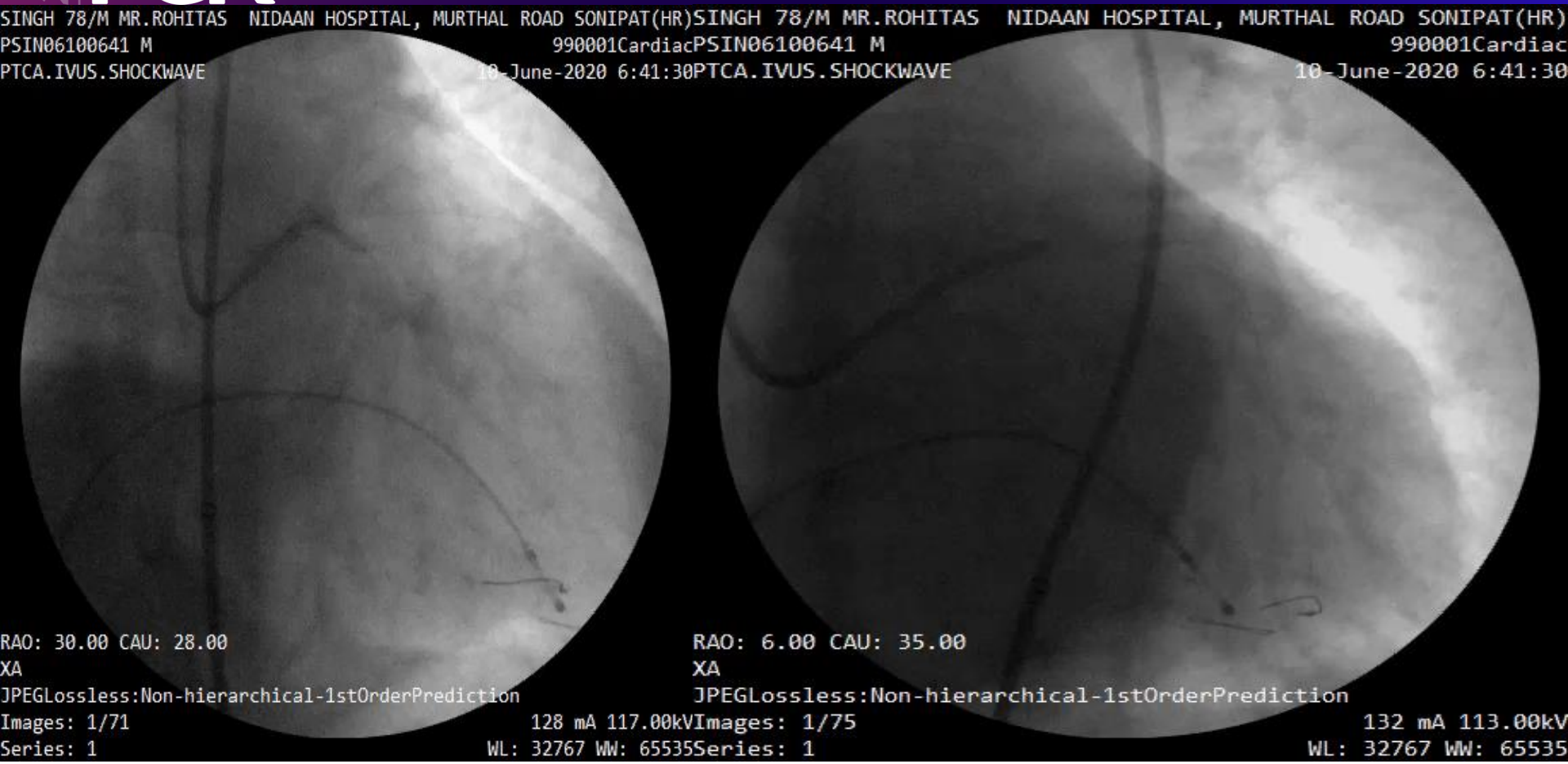






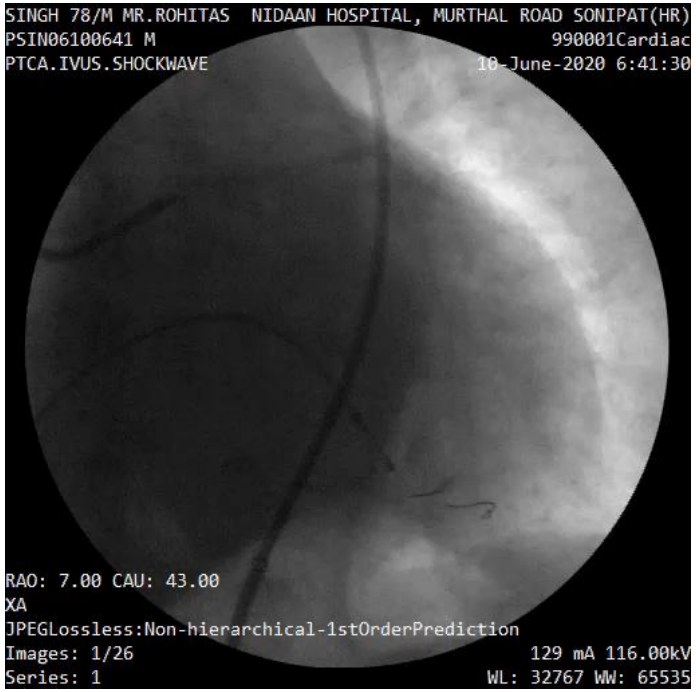
How to deal with this?

1. **Cutting balloon**: Dense Calcific Arc> 200deg, high risk of failure and complications
2. **High Pressure OPN balloon**: Risk of dissection with retrograde extension
3. **Rotablation**: Acute coronary syndrome, Eccentric Calcium, Advanced age, risk of slow flow in dominant LCX
4. **Orbital Atherectomy**: Unavailable
5. **Intravascular Lithotripsy**: Low risk of complications with great periprocedural outcomes



IVL at distal LM to Ostial LCX
3.5x10 mm 50 pulses

IVL at distal LM to LAD : 30 pulses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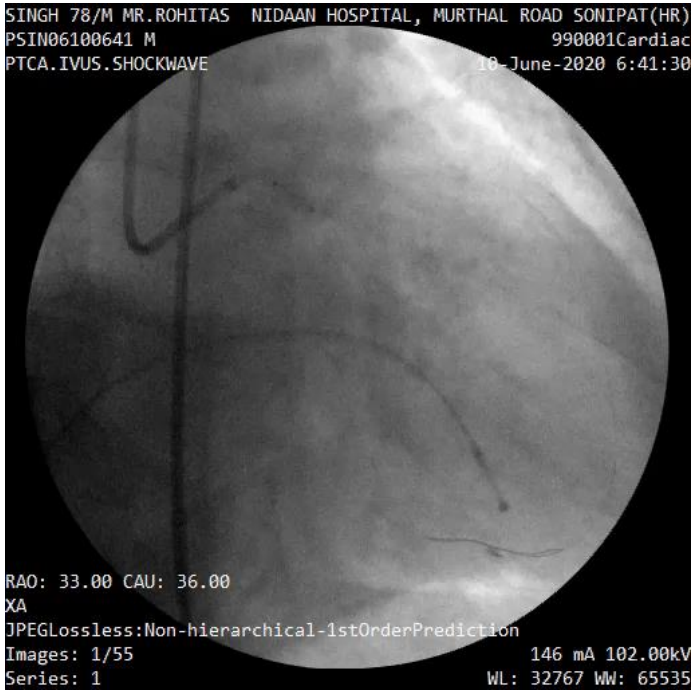
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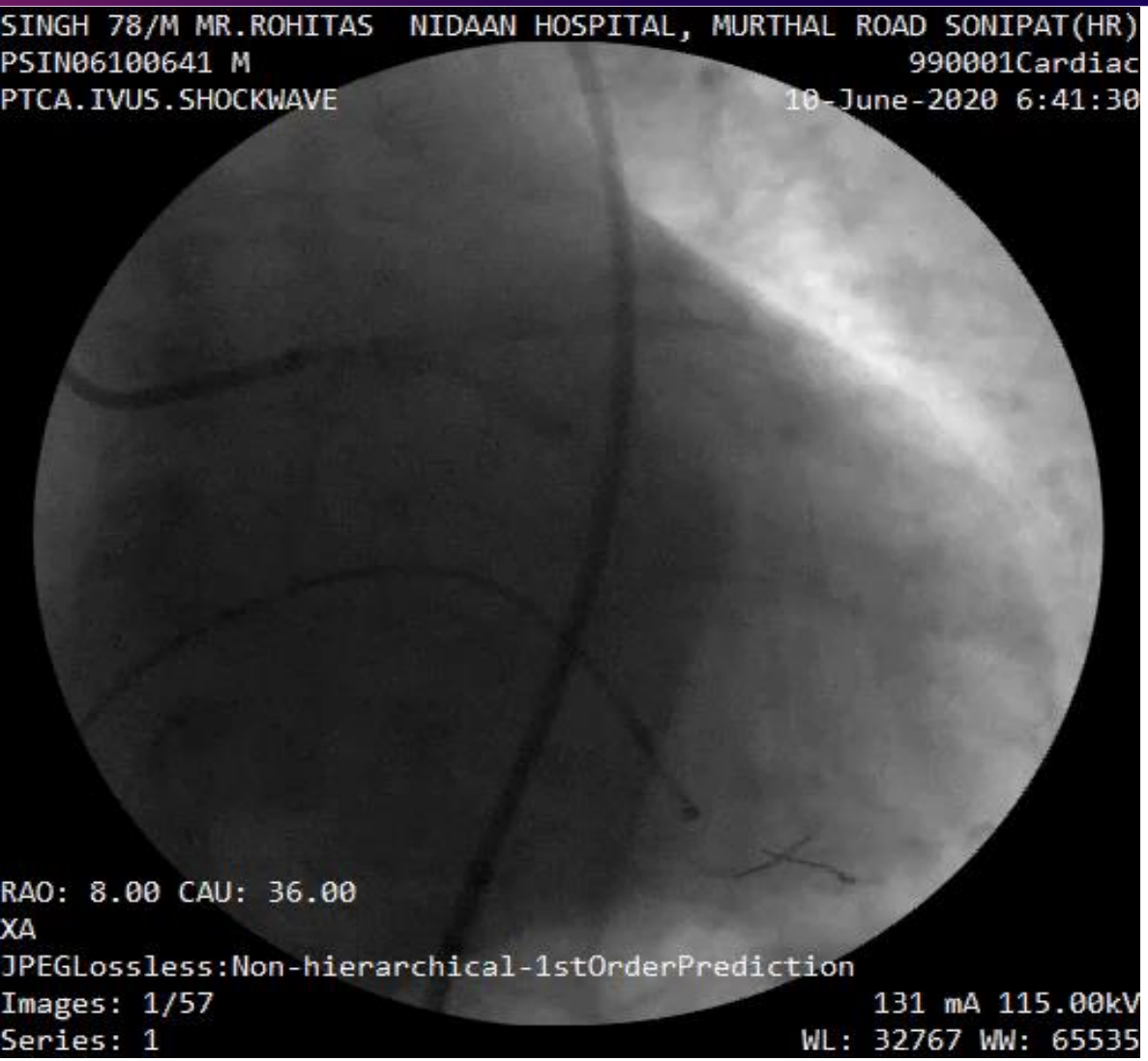
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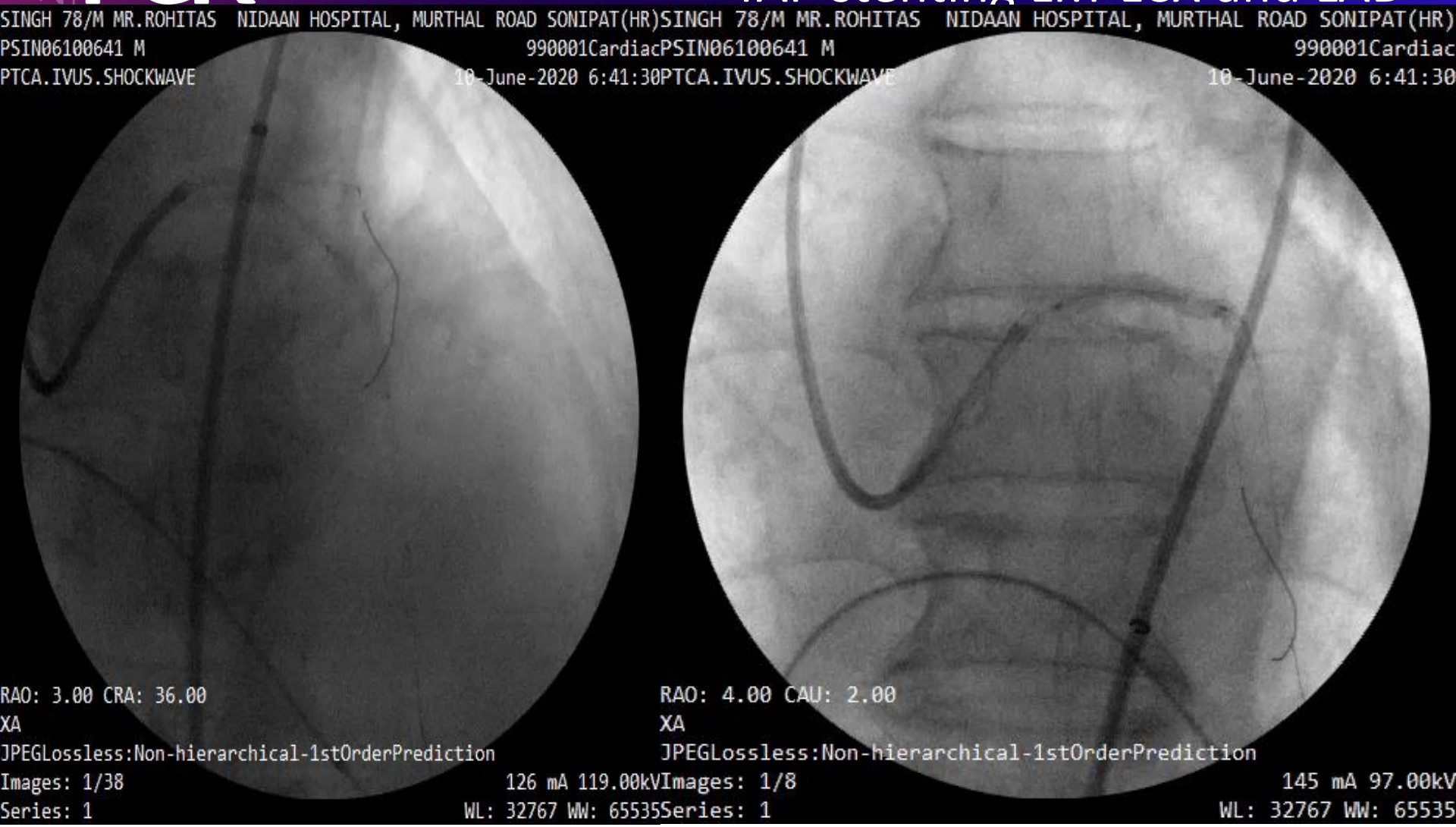
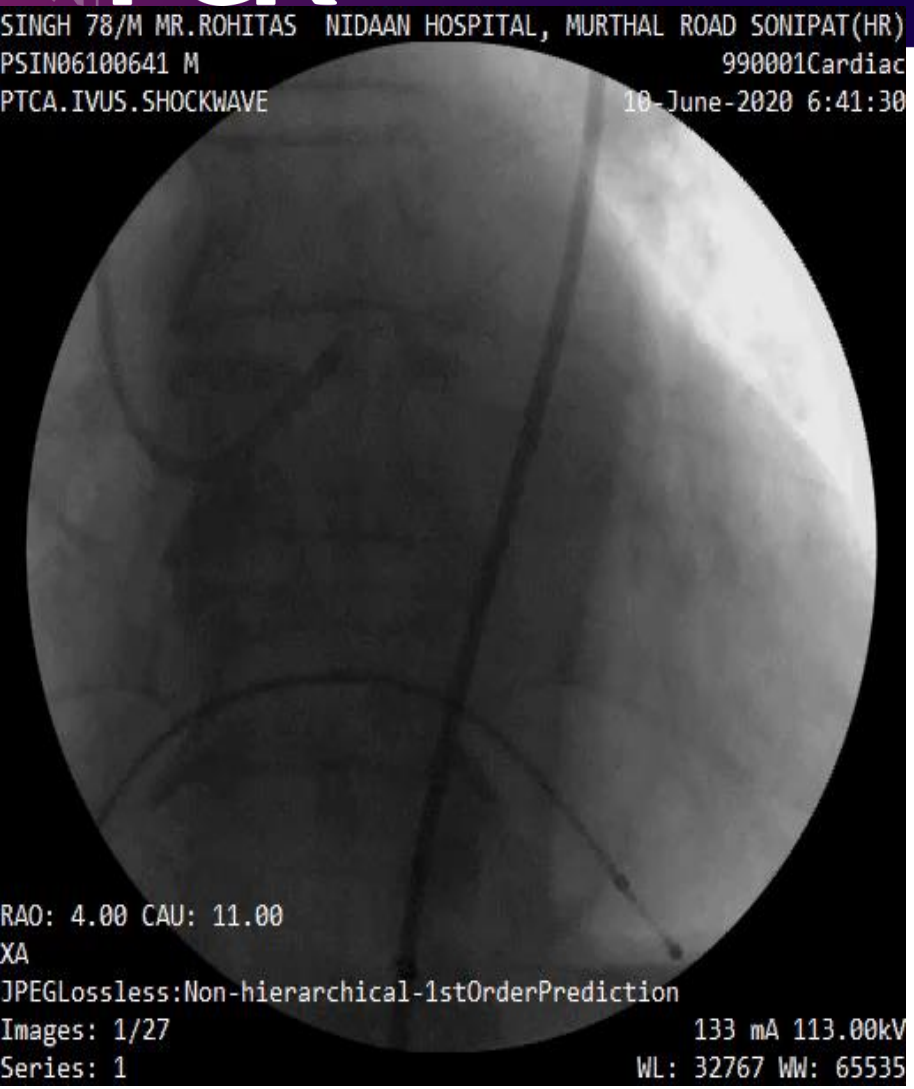
TAP stenting LM-LCX and LAD

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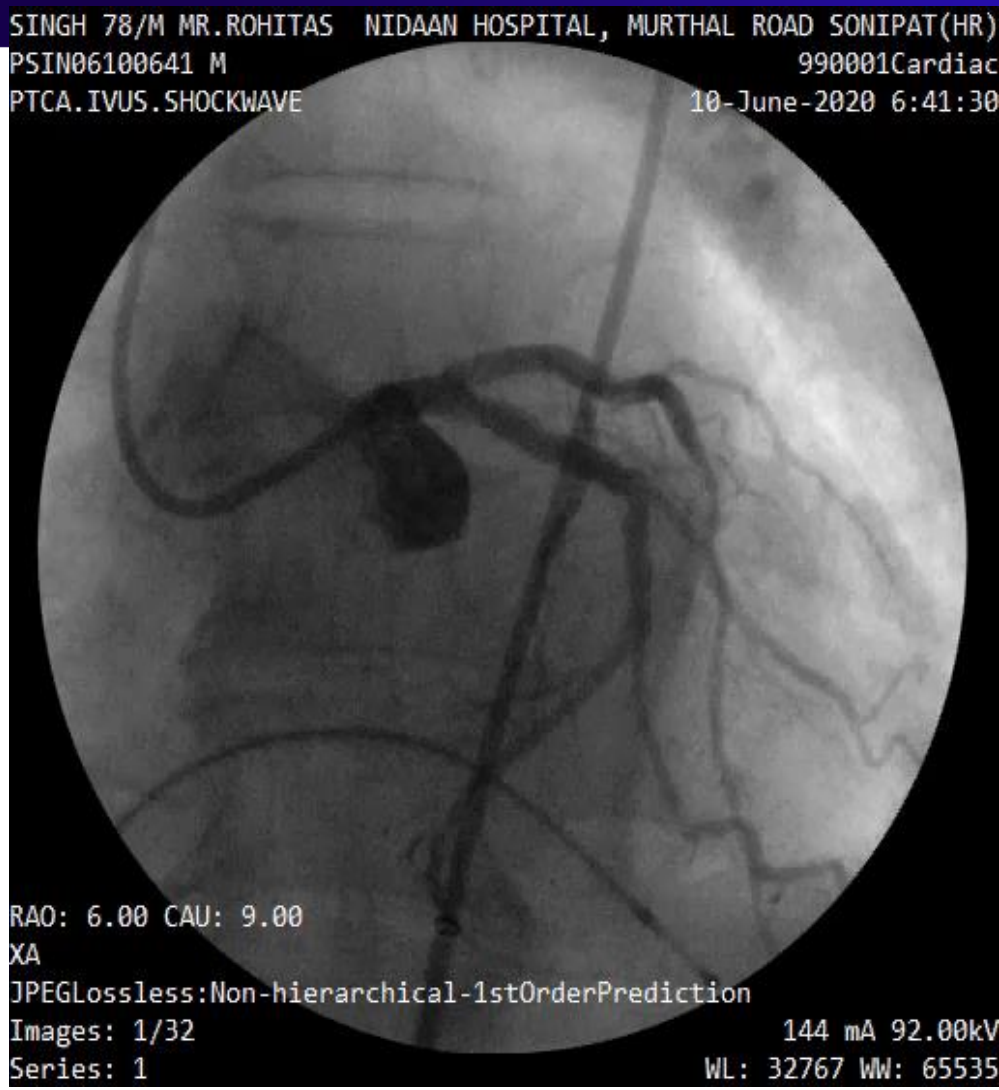
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Conclusion

- Patient subsets with advaced age, calcific eccentric lesions and Left main disease pose a significant challenge to the cardiologist in providing a safe result for the patient.
- Intravascular shockwave lithotripsy is a safer, faster and effective alternative in lesions where rotablation has prohibitive risk particulary in elderly patients with acute coronary syndrome

THANK YOU FOR KIND ATTENSION