



The 44th Annual International Congress of the
**EGYPTIAN SOCIETY OF
 CARDIOLOGY**
 CardioEgyt2017

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“Sometimes We Make The Right Decision And Sometimes We
 Make The Decision Right”.

**A complex PCI with successful total re-vascularization of CTO
 ostial RCA, LM ostial sub total occlusion and ostial LCX total
 occlusion.**


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Clinical History:

A 68-year-old man with multiple risk factors for CAD(HTN, DM, X-smoker) Presented on January 8, 2016 with new-onset CCS class III angina.
 “suffocation on minimal exertion”

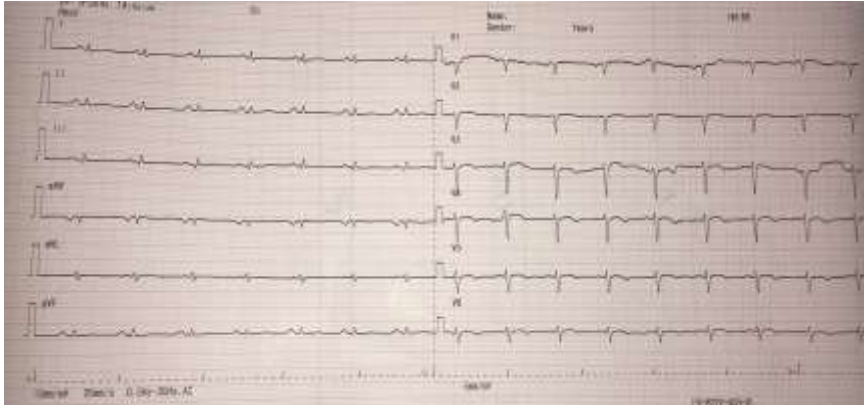
Cardiac catheterization revealed 3-vessel and LM CAD with normal LV function; Syntax score was +33.

CABG was recommended but the patient declined the procedure and underwent PCI and total re-vascularization

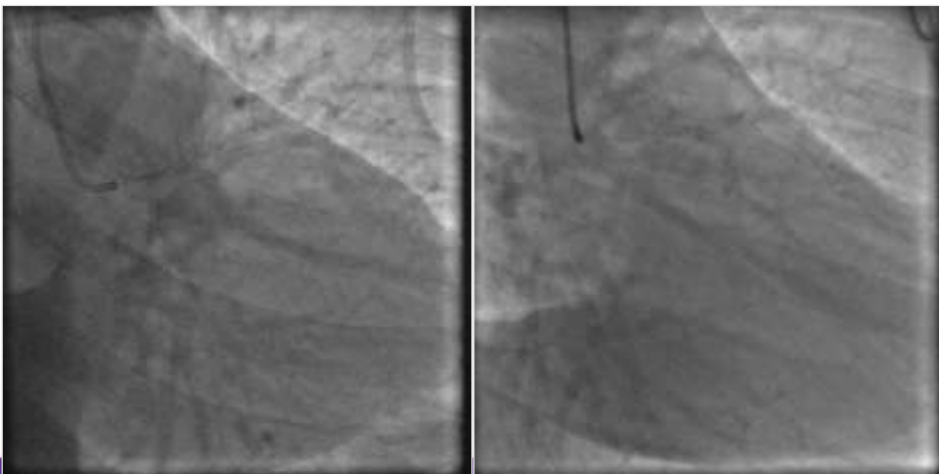


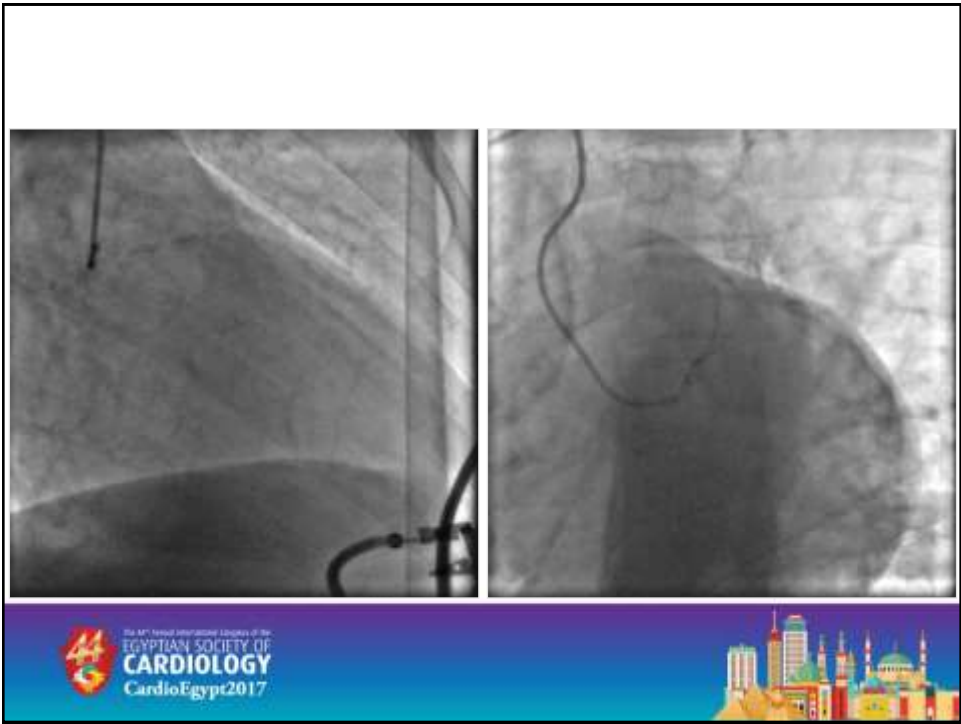
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ECG: Flat T wave in I II AVF, T wave inversion V1-V6.



Index Coronary Angiogram





Coronary Angiogram

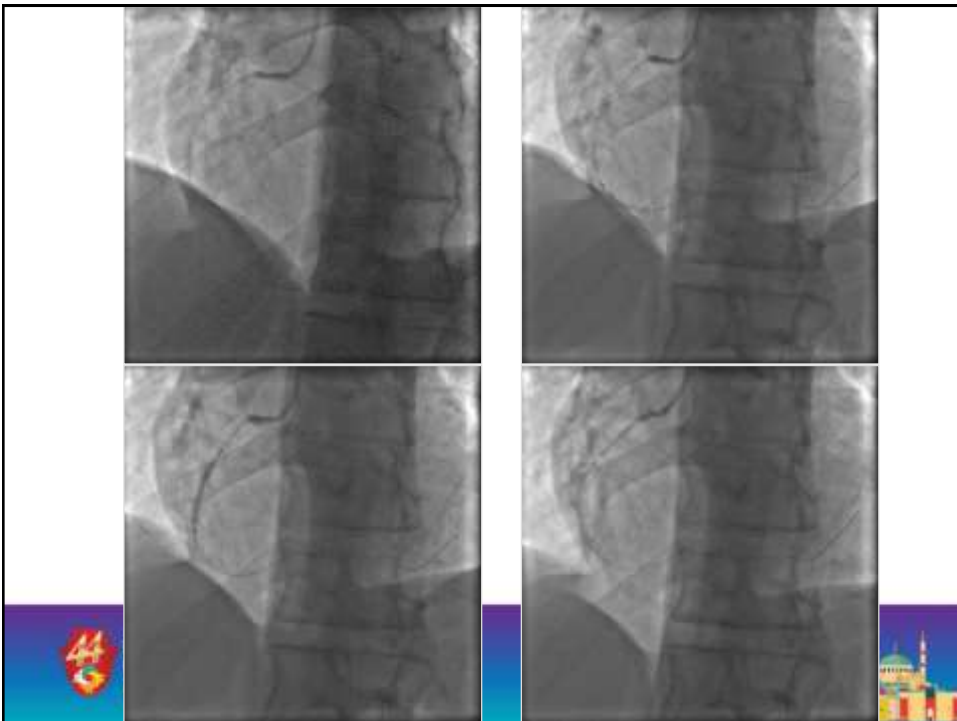
- **LM:** short atherosclerotic vessel that shows ostial long calcified lesion.
- **LAD:** atherosclerotic vessel showing proximal to mid tight long tubular lesion, gives diseased large diagonal branch.
- **LCX:** atherosclerotic vessel showing ostial total occlusion with faint ante & retro-grade flow.
- **RCA:** atherosclerotic vessel with ostial chronic total occlusion with retrograde filling from left system.

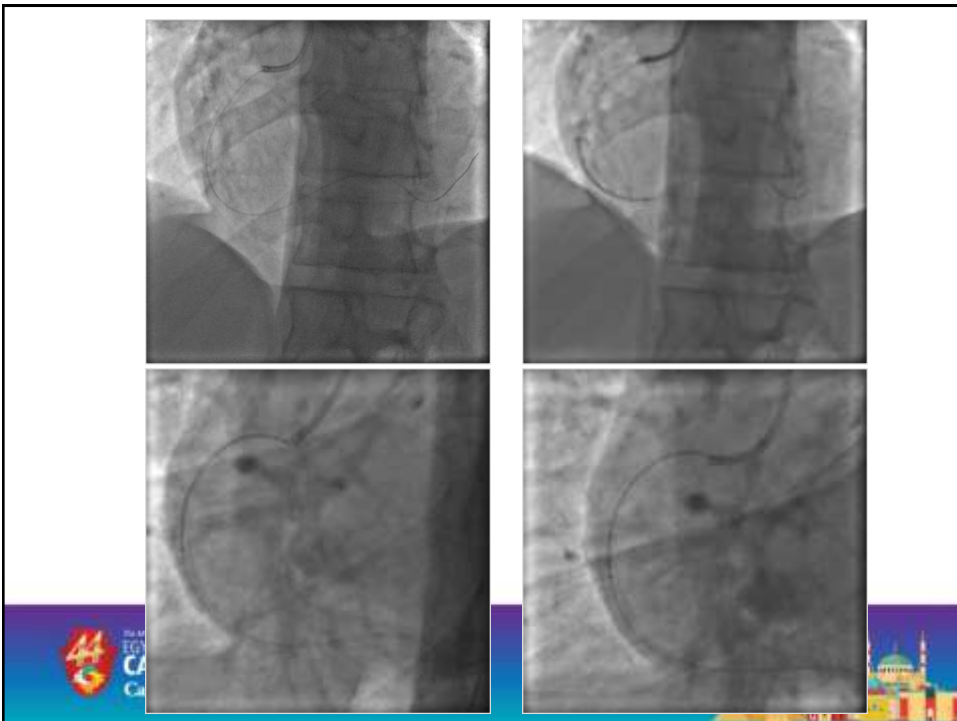


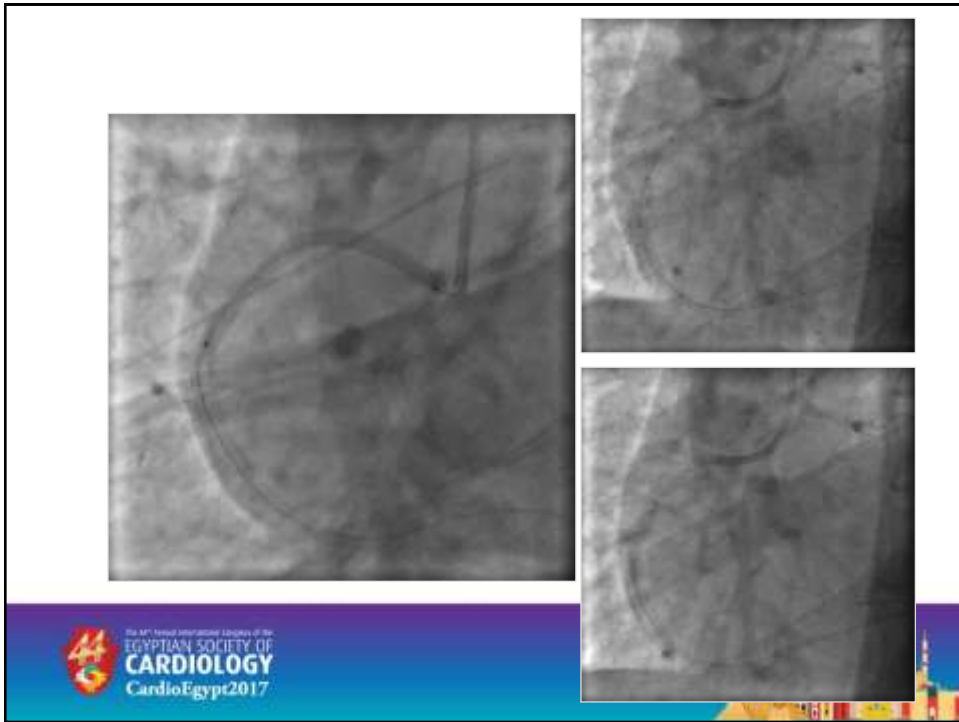
On Physical Examination

- ABP 140/90 mmhg
- Pulse 80 Beats per minute regular equal on both arms
- Chest examination: Harsh vesicular breathing
- The first and second heart sounds were normal
- No lower limb edema
- RBS 130 mg per deciliter
- Hg 12 g per deciliter
- International Normalized Ratio (INR) 1.0
- Creatinine level :1.1 mg per deciliter

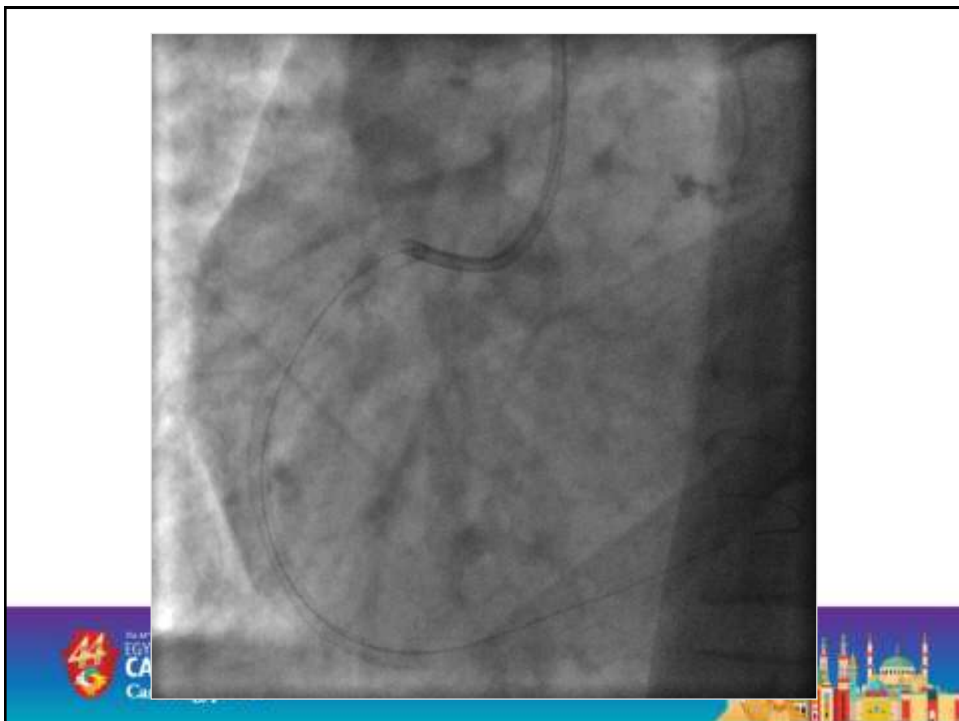




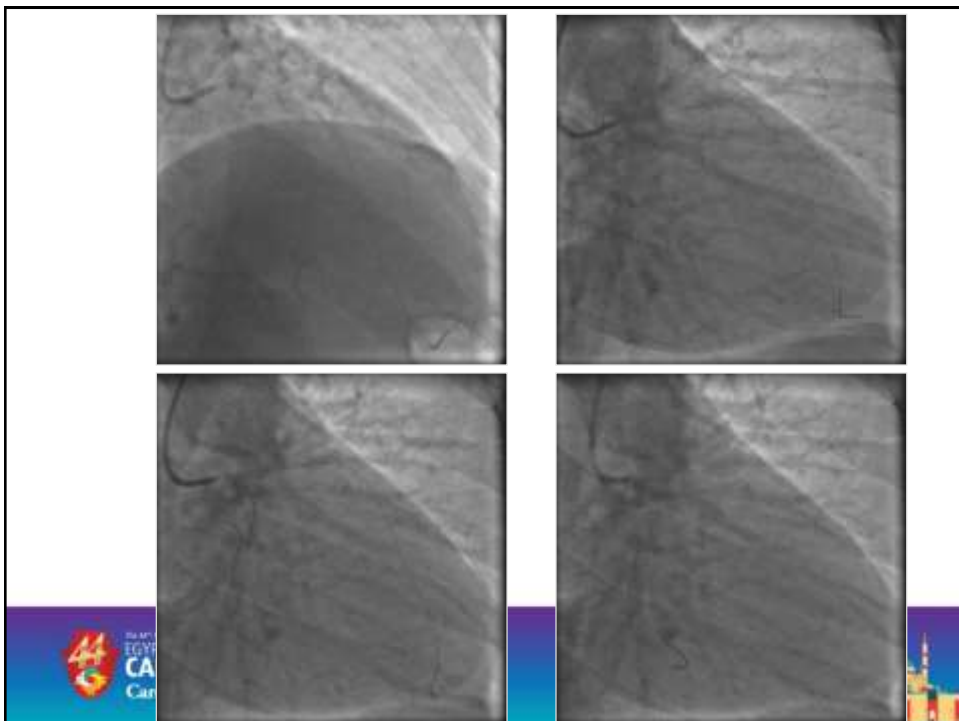
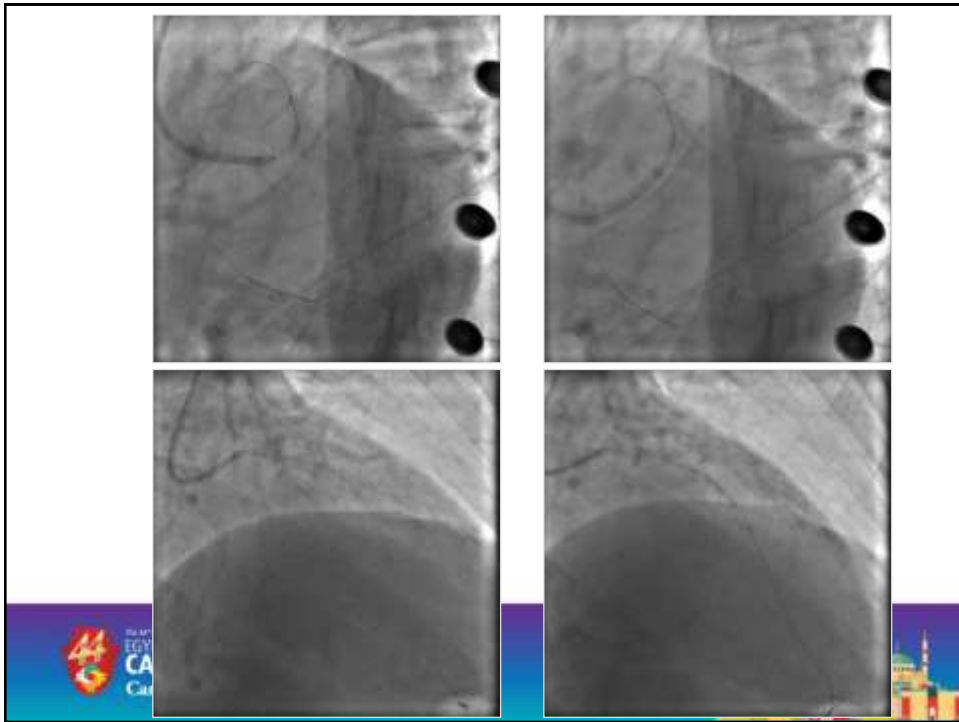


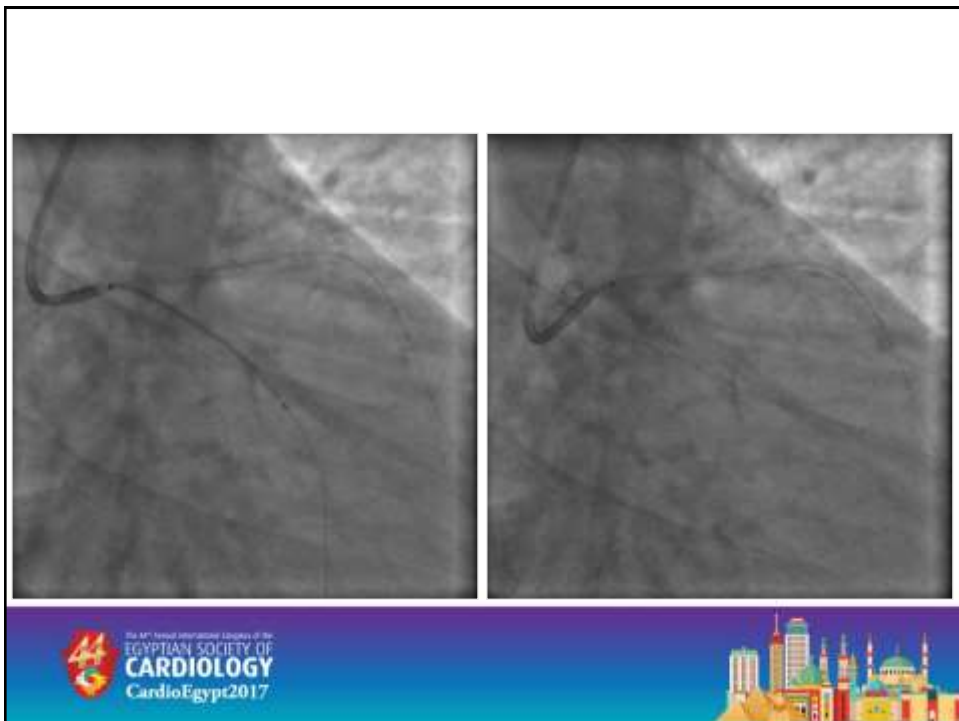
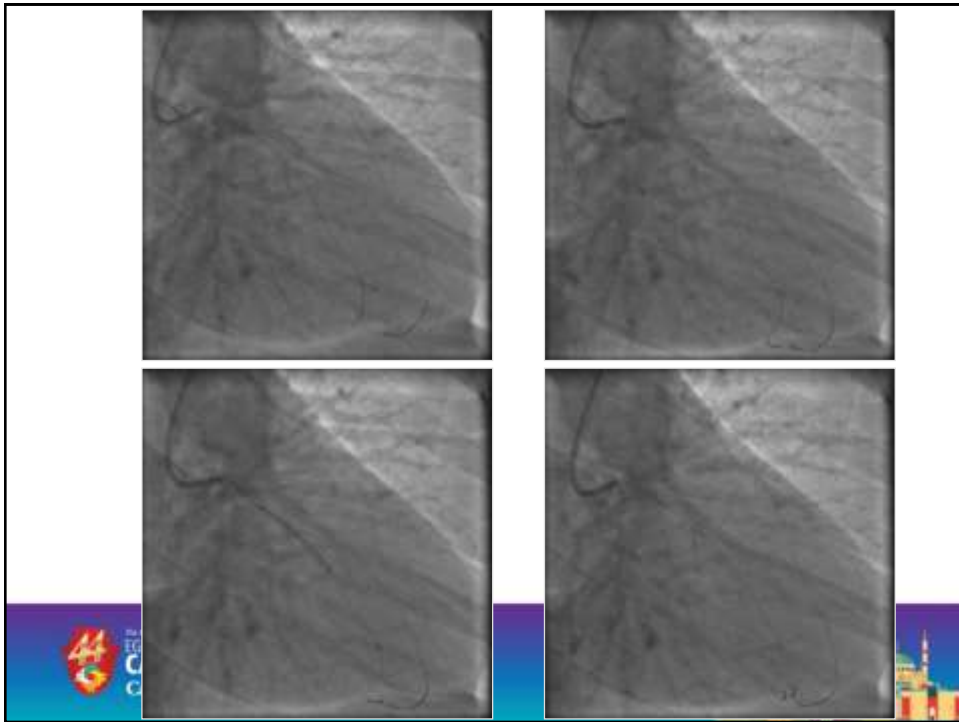


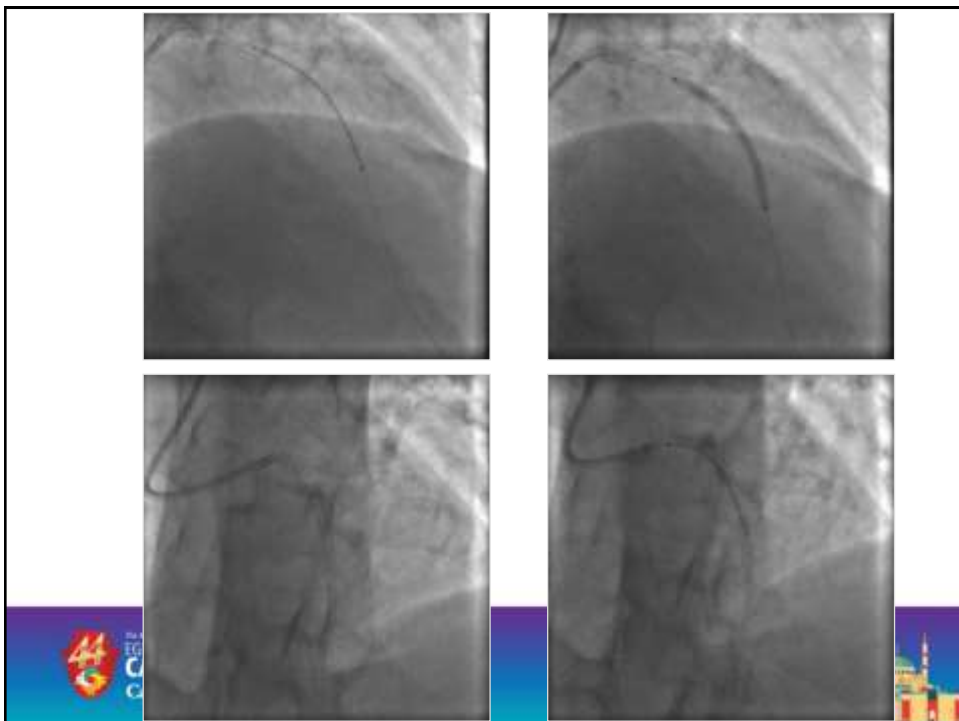
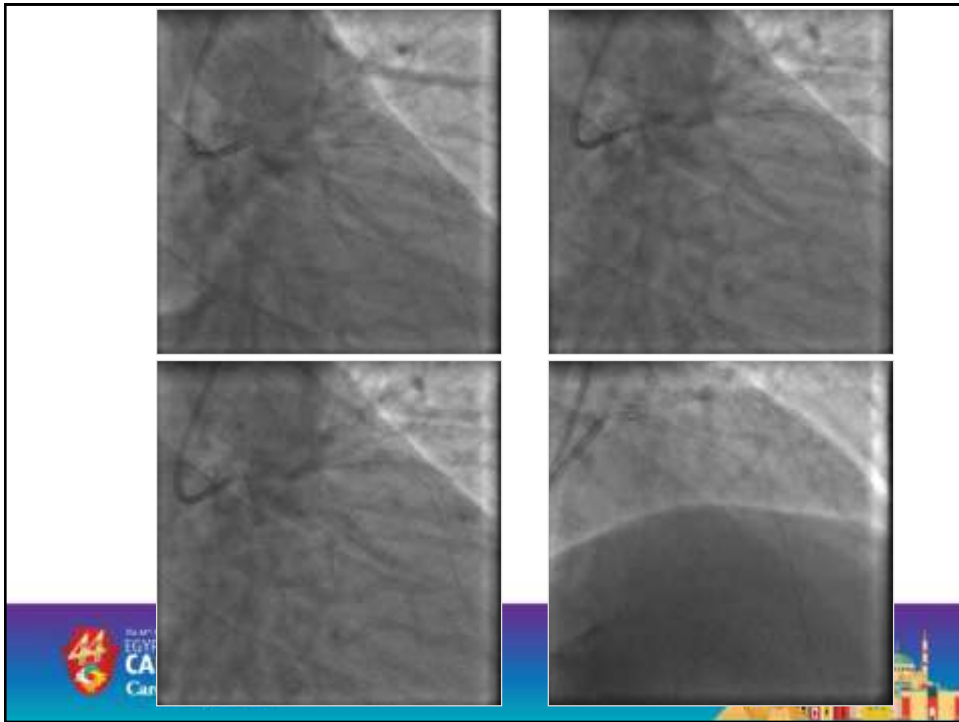
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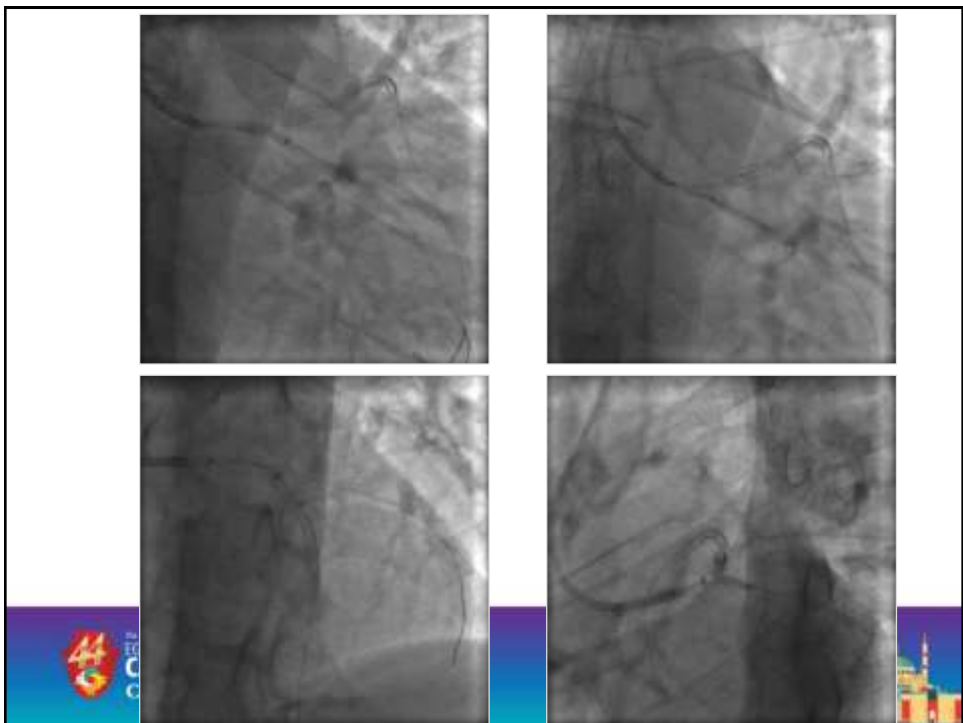
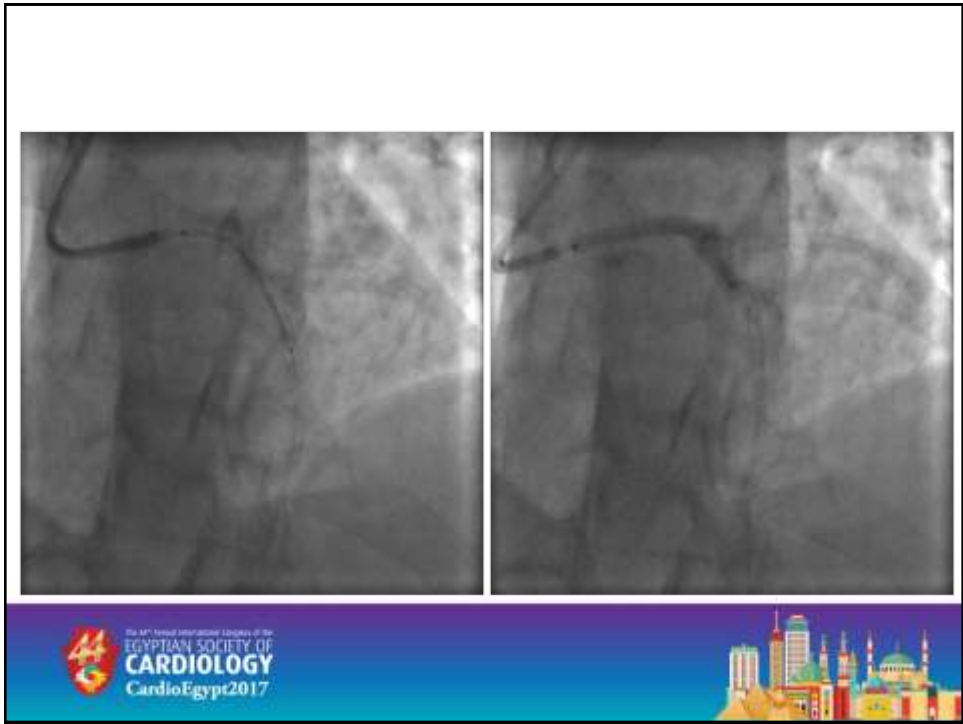


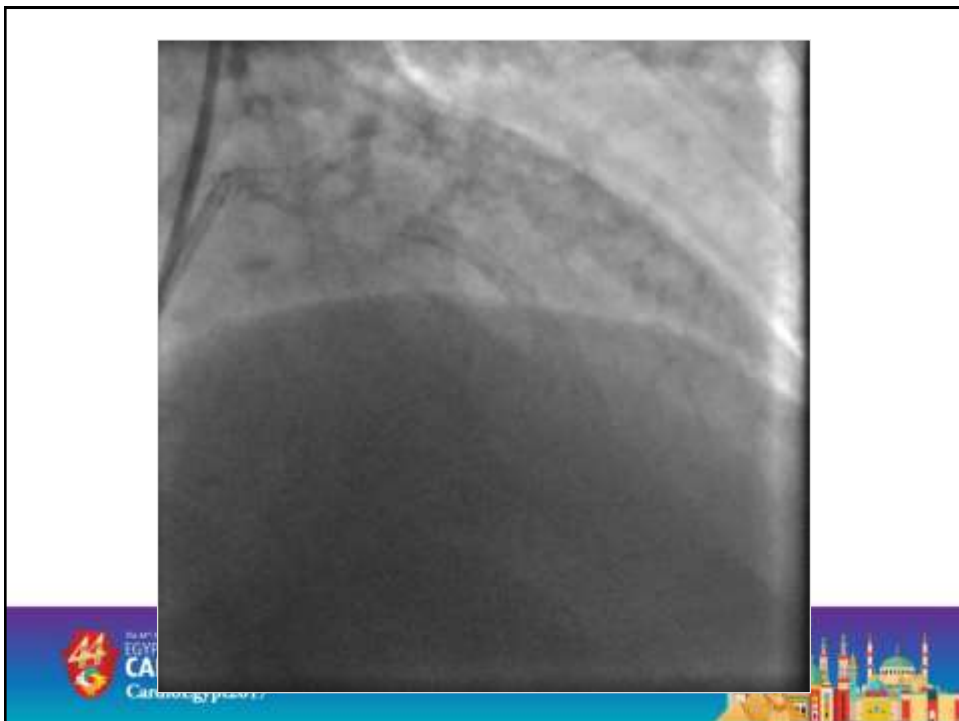
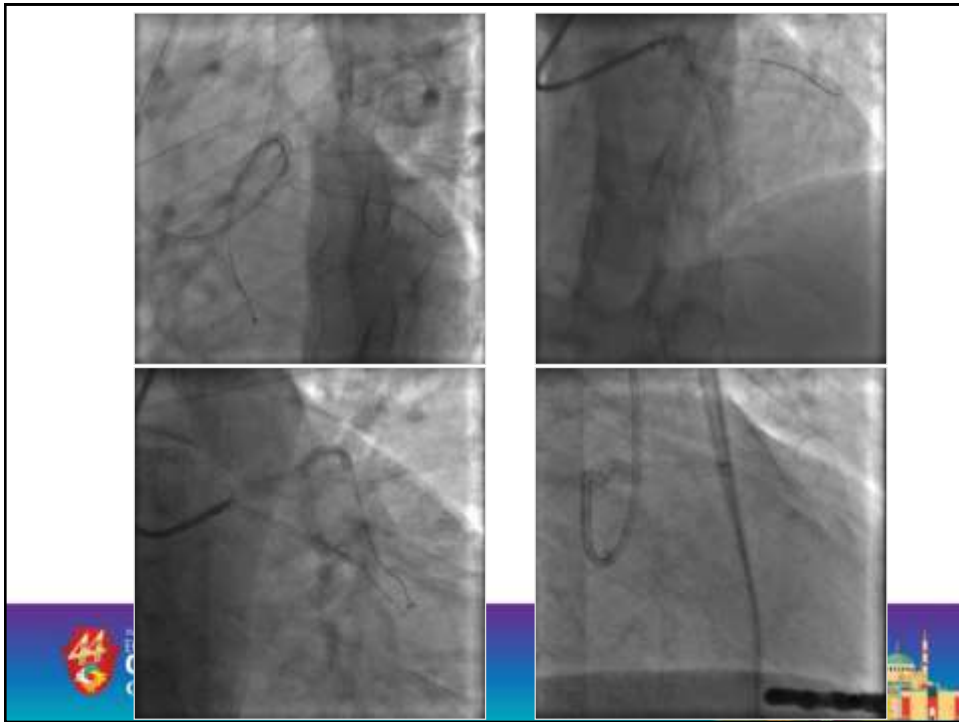
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Procedure Step

- **A radial approach using a left EBU 3.5 ,6f guiding catheter used to cannulate the right and left coronary artery.**
- **Successful ante grade re-canalization of the RCA CTO.**
- **Pre-dilatation to LM, LAD lesions, LCX.**
- **Then Mini Crush technique to LM-LAD and LCX, followed by final simultaneous kissing balloon with excellent results.**



Q?

- 1- RCA first ?
- 2- Do you agree that LM intervention in the setting of MVDs and High SYNTAX score is feasible ?
- 3- Is SYNTAX score still reliable ?
- 4- After seeing the end result of PCI and Total re-vascularization in this case, Is CABG really a better Option?
- 5- Is Re- POT mandatory after bifurcations technique ?



Conclusions :

- **PCI to LM disease in the setting of totally occluded RCA is feasible, and should be considered given its low invasiveness in patients at high surgical risk or multiple co-morbidities, but only after RCA re-canalization.**
- **before total re-vascularization, time, contrast load and radiation dose needed & Patient co-morbidities should be considered.**
- **In the setting of MVDs, total re-vascularization should be achieved, in a staged fashion if necessary.**



- **No 2 bifurcations are identical, & no single strategy exists that can be applied to every bifurcation**
- **Thus, the more important issue in bifurcation PCI is selecting the most appropriate strategy for an individual bifurcation and optimizing the performance of this technique**





Thank You

