

The 44th Annual International Congress of the
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Do you Leave It or do you Stent It?

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Clinical History:

A 48-year-old man with multiple risk factors for CAD(HTN, DM, smoker) Presented on May 8, 2016 with new-onset CCS class III angina.
Cardiac catheterization revealed multi vessel disease; Syntax score was +33.
CABG was recommended but the patient declined the procedure and underwent PCI and total re-vascularization



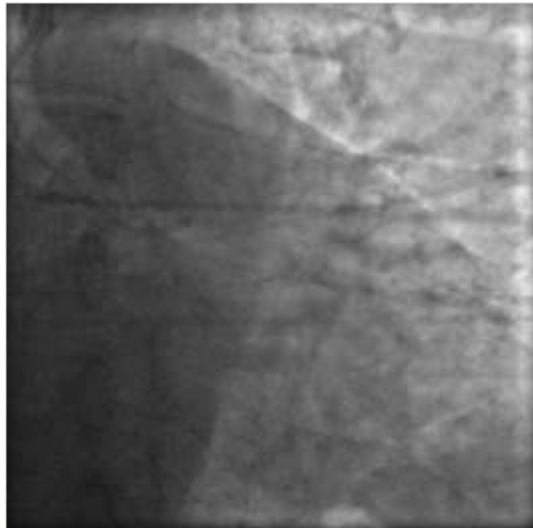
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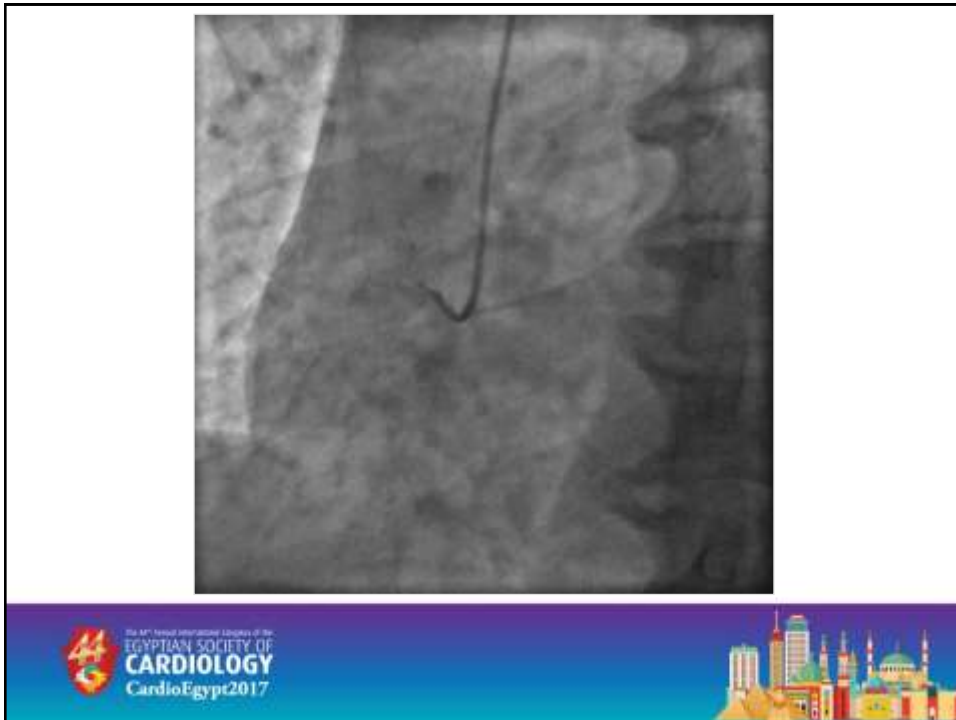
On Physical Examination

- ABP 135/90 mmhg
- Pulse 75 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 127 mg per deciliter
- Hg 13 g per deciliter
- International Normalized Ratio (INR) 1.1
- Creatinine level :1.0 mg per deciliter



Index Coronary Angiogram

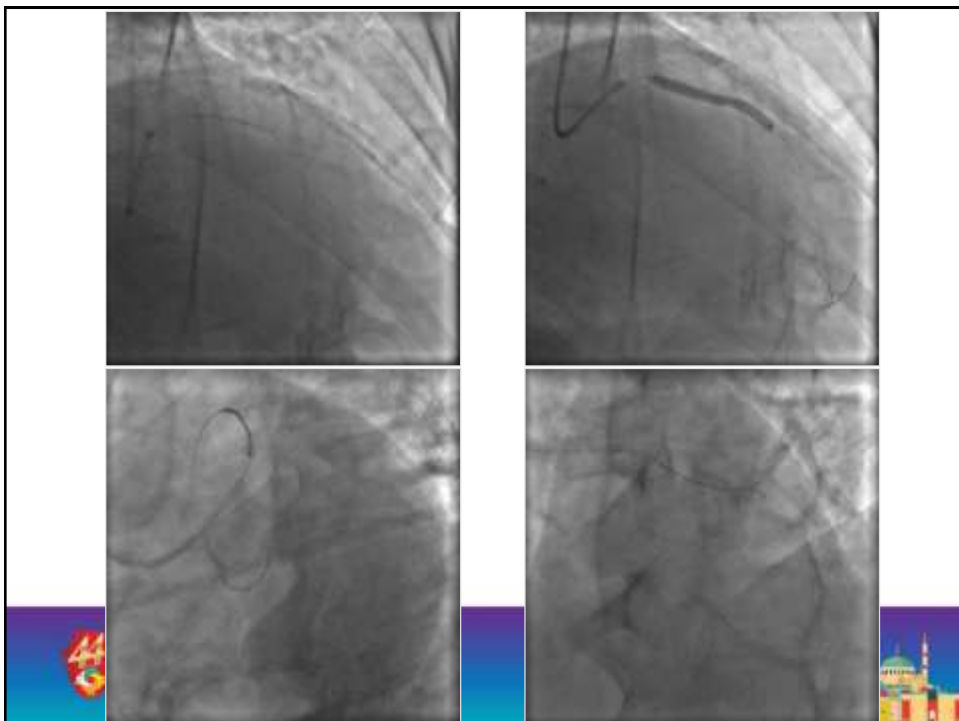


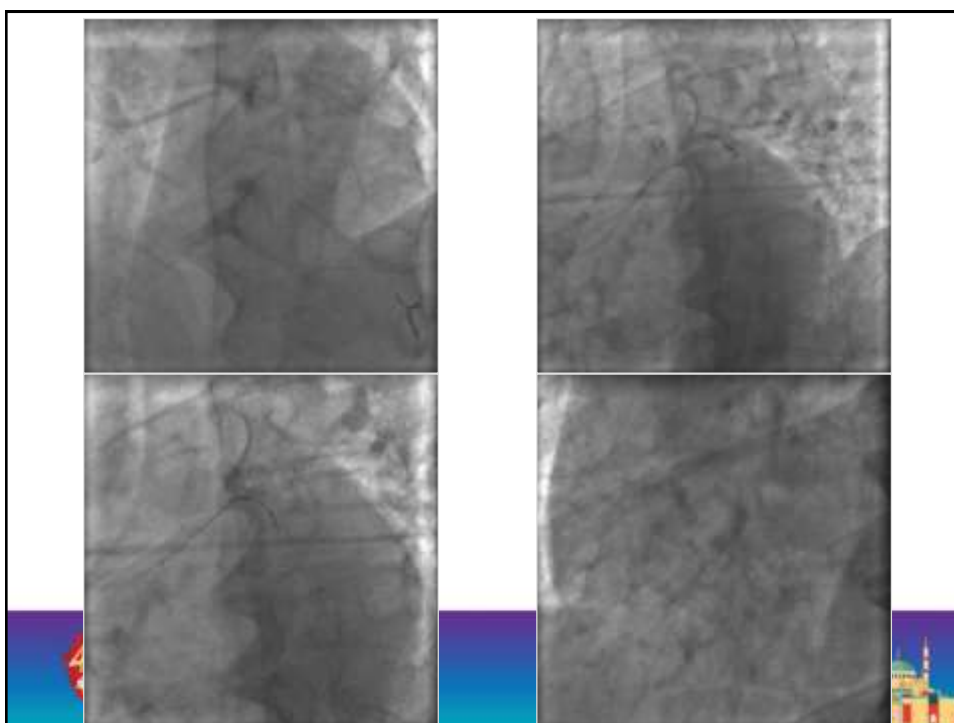
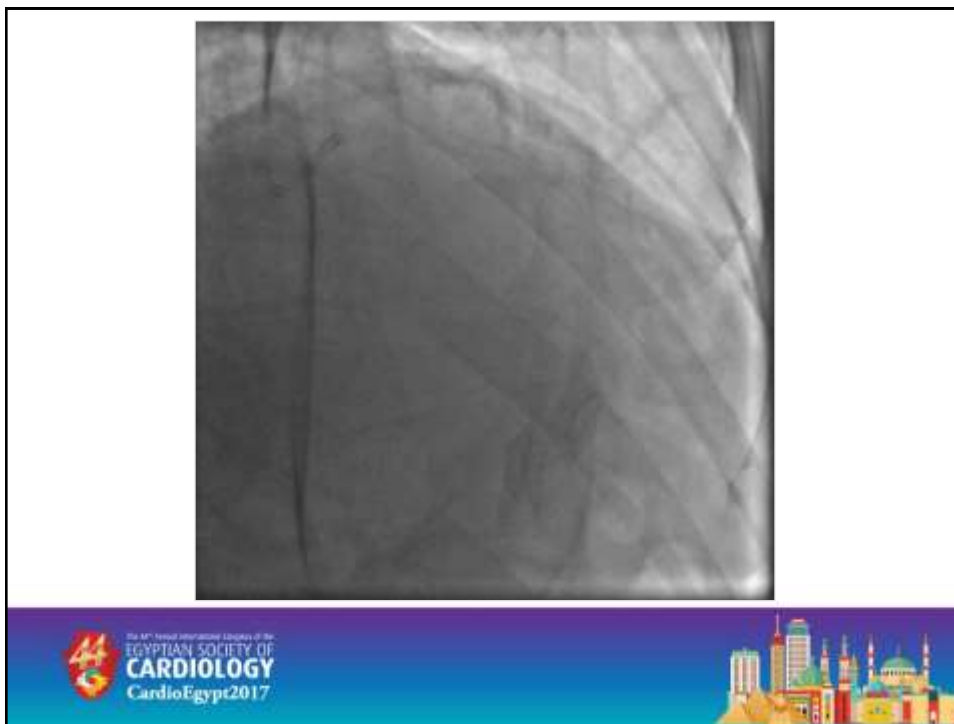


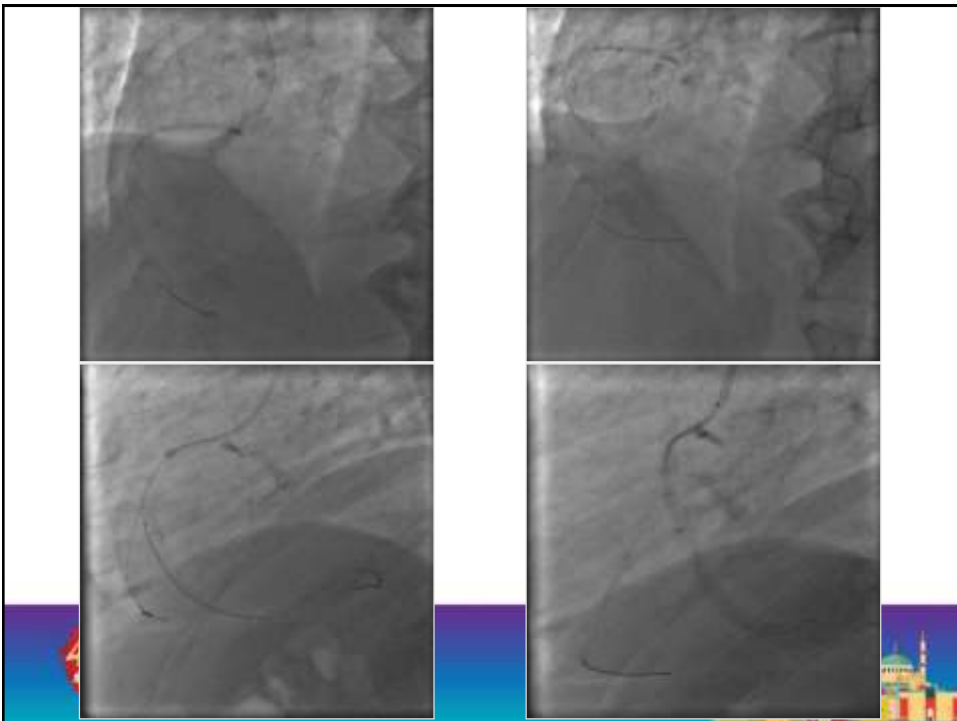
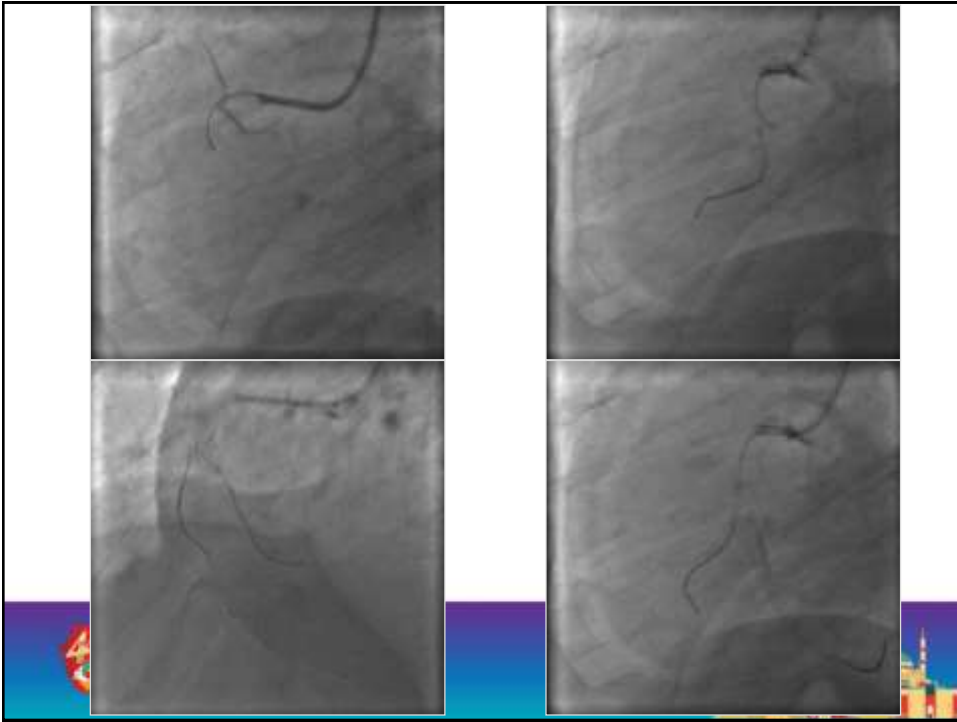
Angiography:

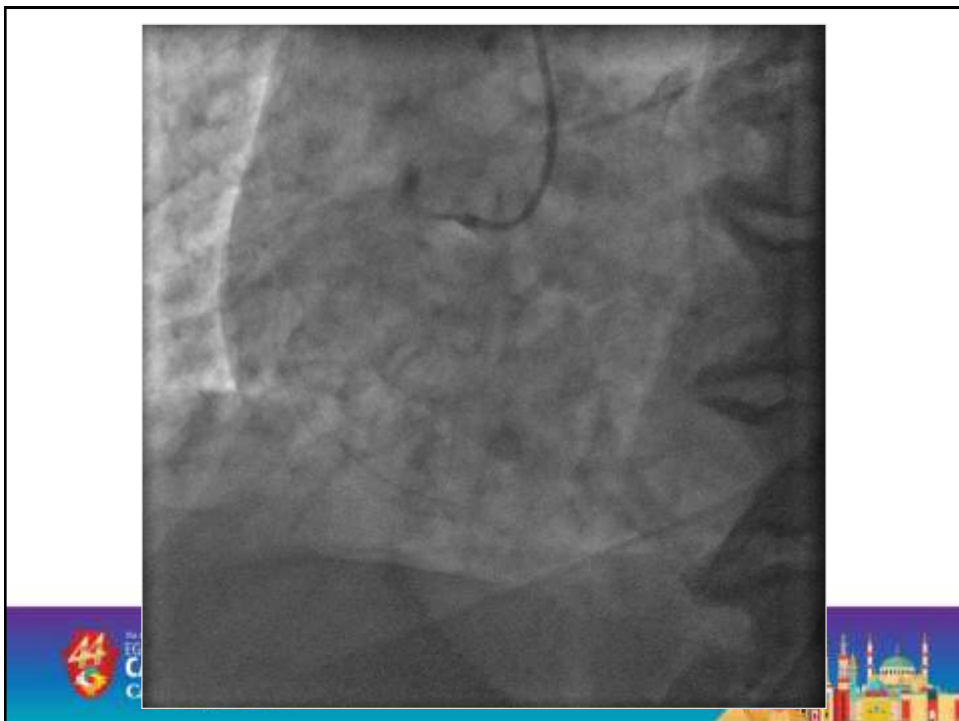
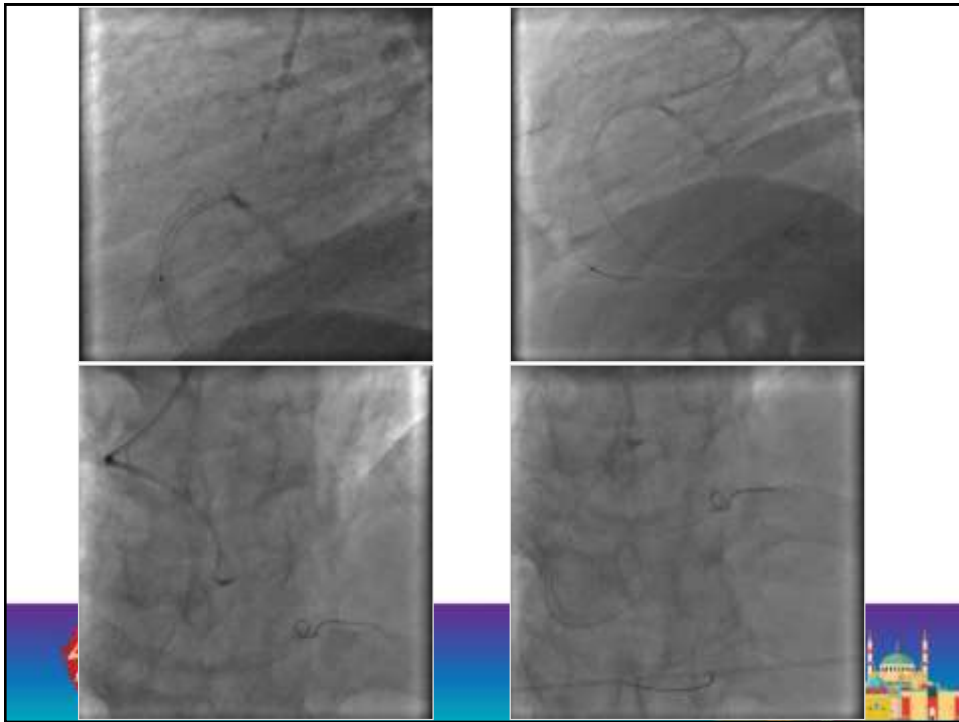
- LM: atherosclerotic vessel that bifurcates into LAD & LCX.
- LAD: atherosclerotic vessel showing proximal to mid calcific subtotal long lesion.
- RI: atherosclerotic vessel showing proximal subtotal lesion.
- LCX: atherosclerotic vessel showing proximal chronic total occlusion with retro-grade flow from right system collaterals.
- RCA: atherosclerotic vessel with Proximal chronic total occlusion with retrograde filling from left system.



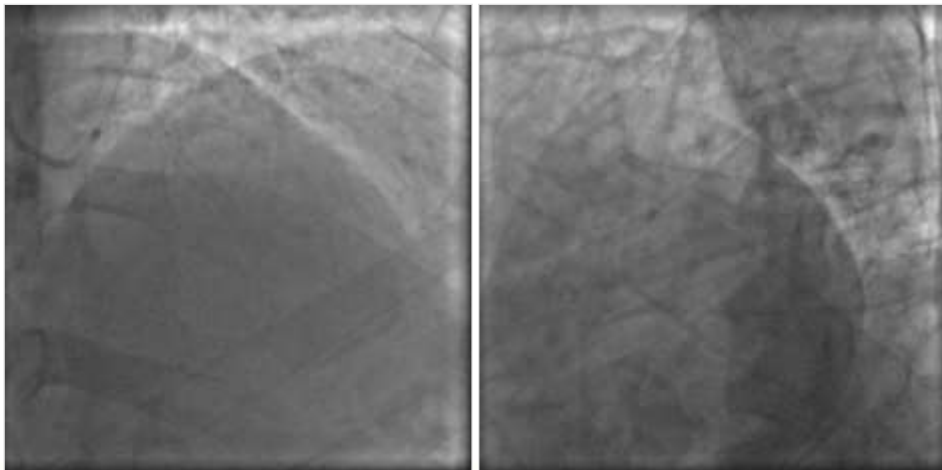




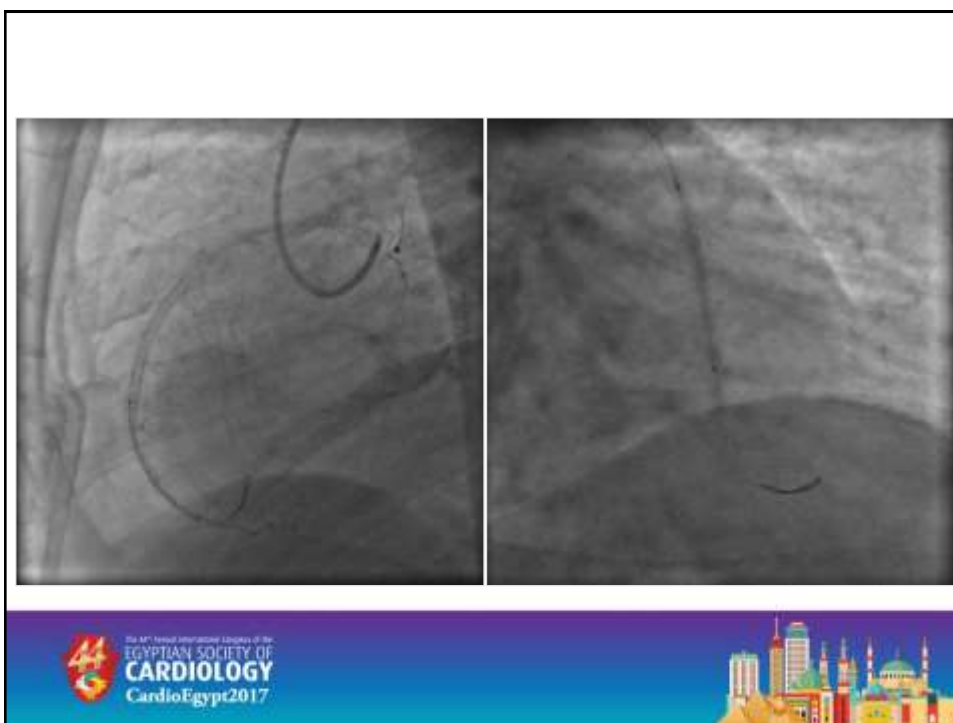
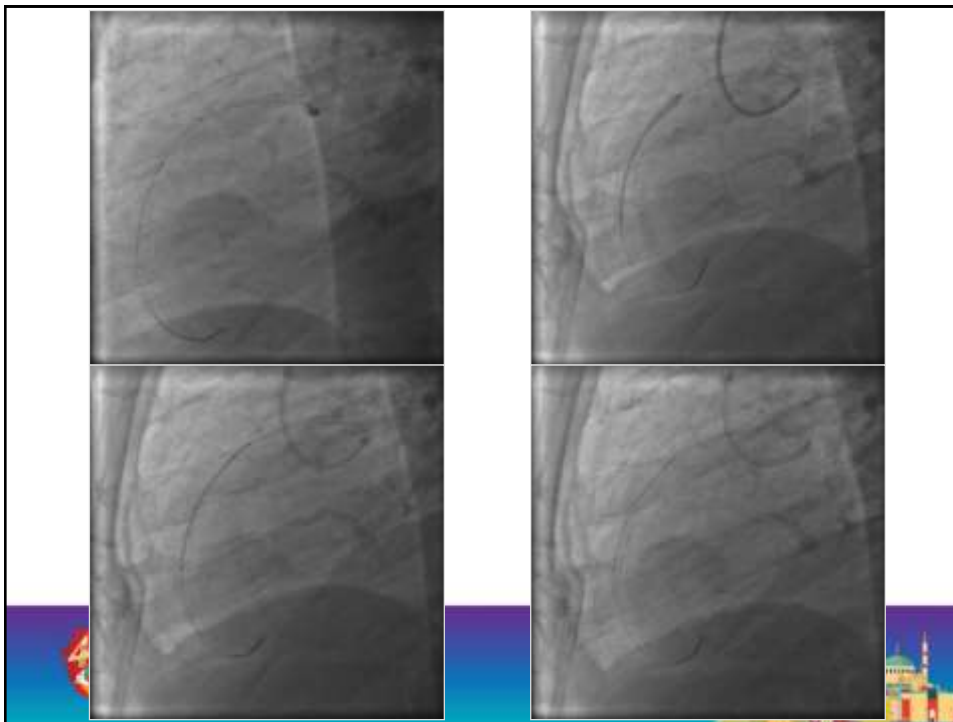


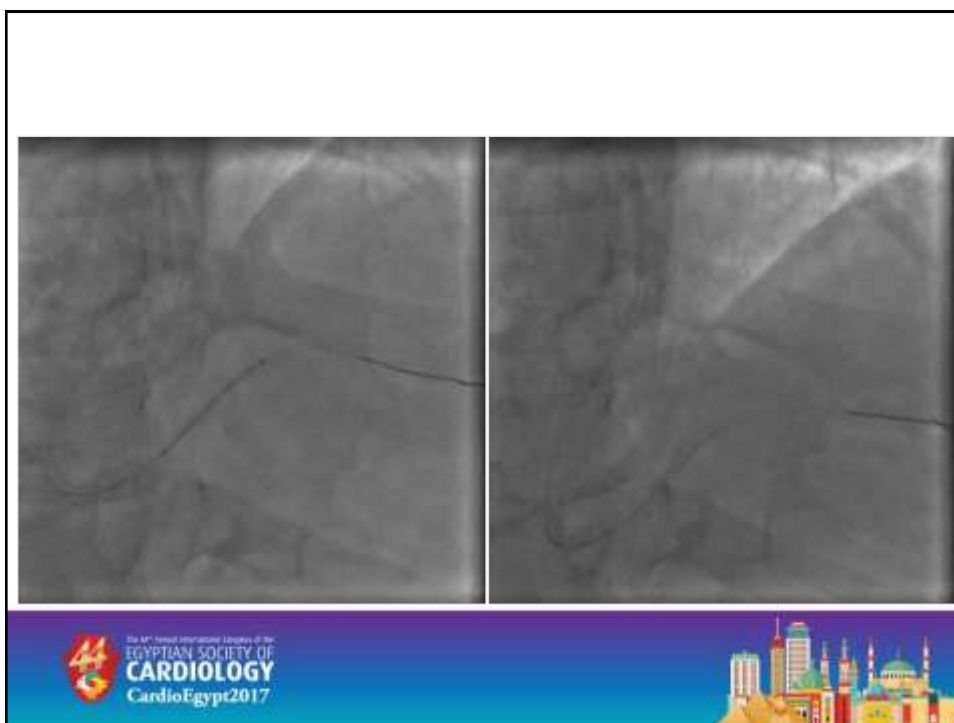
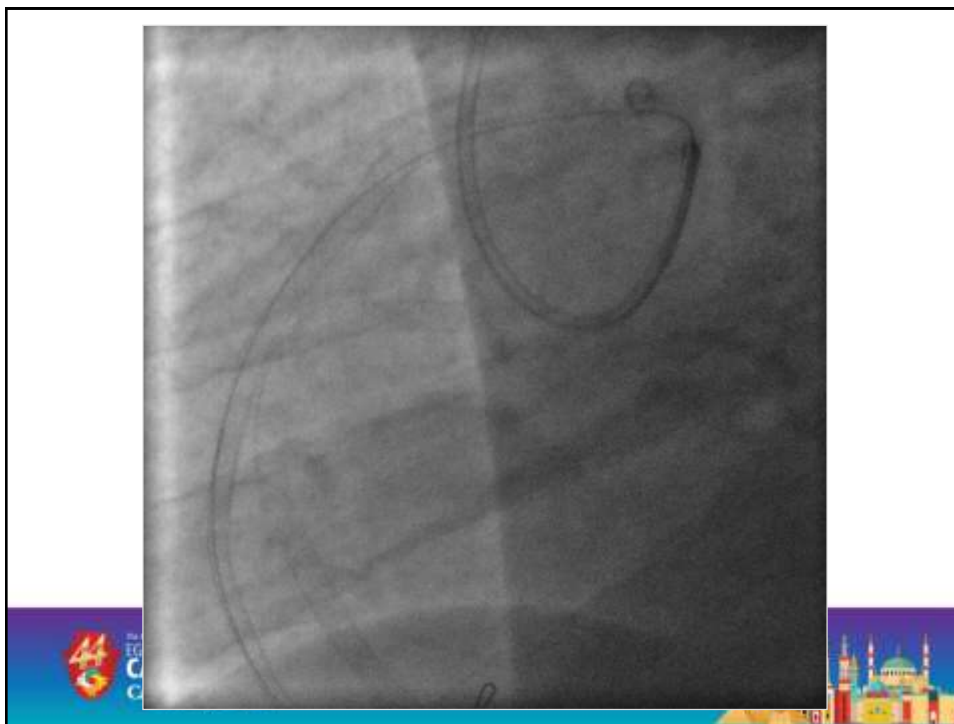


**Patient scheduled for CTO LCX re-vascularization
in another session.
after 6 months patient came complaining of angina
and a control angiography and a plan of LCX
intervention.
which revealed A TIMI III double lumen dissected
LAD**









Procedure Step:

A radial approach using a left XB 3.5 ,6f guiding catheter used to cannulate the left coronary artery.

Pre-dilatation and stenting to RI.

Followed by Pre dilatation and stenting of LAD which resulted in non flow limiting small edge dissection which resolved spontaneously.

Then RCA CTO intervention and re-vascularization with excellent results.

Patient was scheduled to CTO-LCX intervention in another session after 6 months.

Control angiography 6 months later revealed extension of the LAD stent edge dissection to a double lumen LAD, so stenting the LAD using 2 long stents, and re scheduling the patient for LCX intervention.



Q?

1- Regarding this Case scenario, do You stent this edge dissection or do you leave it ?

2- Use IVUS or nor?

3- How to select the true lumen ?

4- After seeing the end result of PCI and Total re-vascularization in this case, Is CABG really a better Option?



Conclusions

In the setting of MVDs, total re-vascularization should be achieved, in a staged fashion if necessary.
before total re-vascularization, time, contrast load and radiation dose needed & Patient co-morbidities should be considered.

Greater stent expansion and the presence of large, calcified, and/or attenuated plaques were independent predictors of stent edge dissection,
with prevalence of 5% TO 58% in balloon angioplasty era & 1.7 % in DES era, which now increased to 7.8% in IVUS guided PCI only around 15% of which visible by angiography, with higher rates of intimal dissection, medial dissection, intramural hematoma, and extramural injury.



Given the propensity for extension of dissection with or without mechanical re-vascularization, and documentation of spontaneous healing, medical therapy remains a rational approach, Depending upon hemodynamics stability, however, it is recognized that therapy must be individualized.

Advancement of operators experience and dealing with complications increased the procedural success



Thank You

