Case PRESNETATION

By

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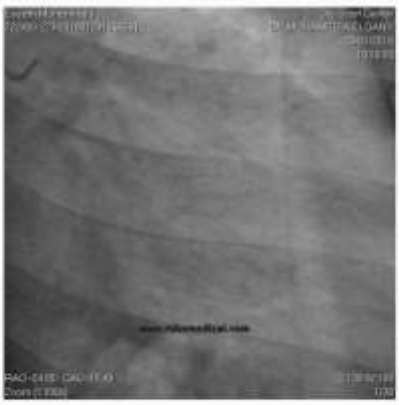
Clinical characteristics

- E. M , 54 years old , male , hypertensive, diabetic on oral treatment.
- Presented with anterior MI for which he received thrombolytic
- ECG : pathological Q waves in anterior chest leads
- Echo : Hypokinea of antertior , lateral and IVS walls of LV , EF = 45 % .
- He referred for CA and PCI

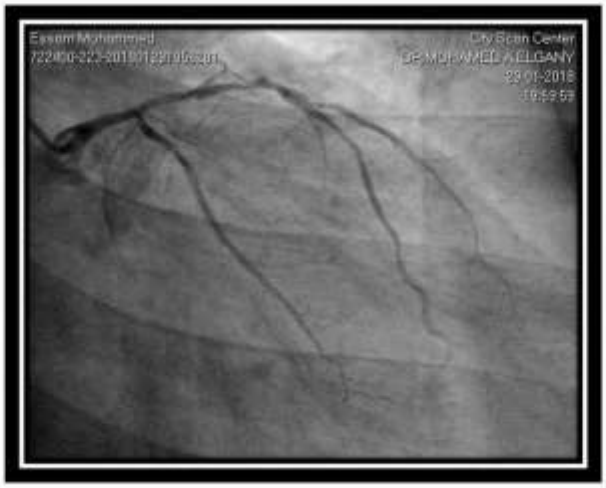
Coronary angiography

- LM : diseased with 30 % distal stenosis
- LAD : Totally occluded at its mid segment at the origin of DI which showed osteal 90 % stenosis.
- LCx : small with osteal stenosis
- RCA: dominant , normal with no collaterals for Lt system

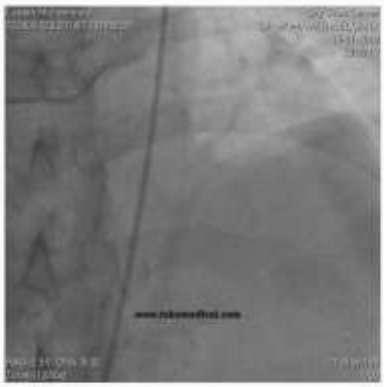
Diagnostic RAO caudal



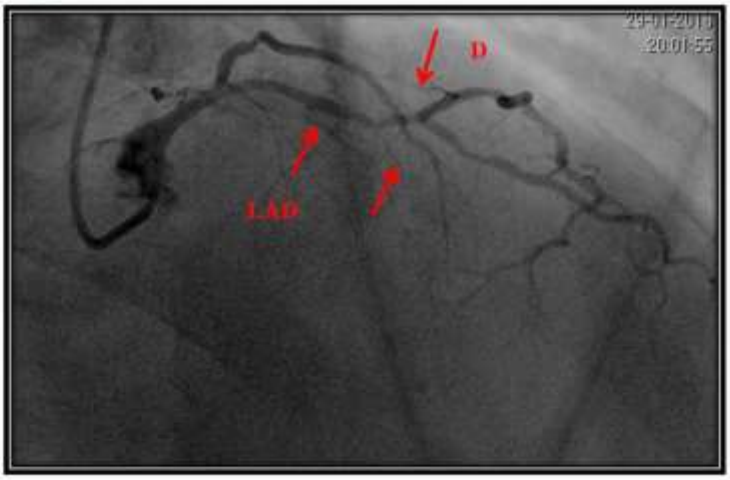
RAO – Caudal



Diagnostic AP Cranial



Diagnostic AP Cranial



LAO Cranial

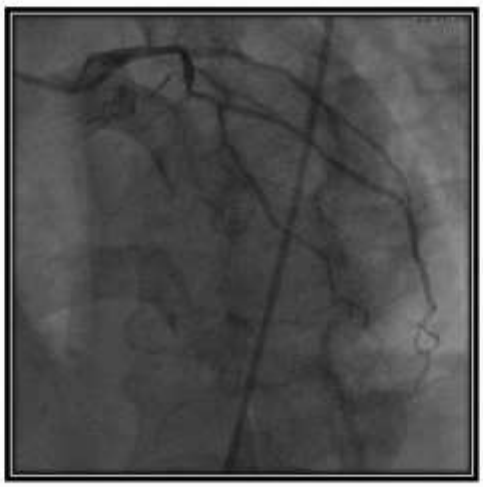
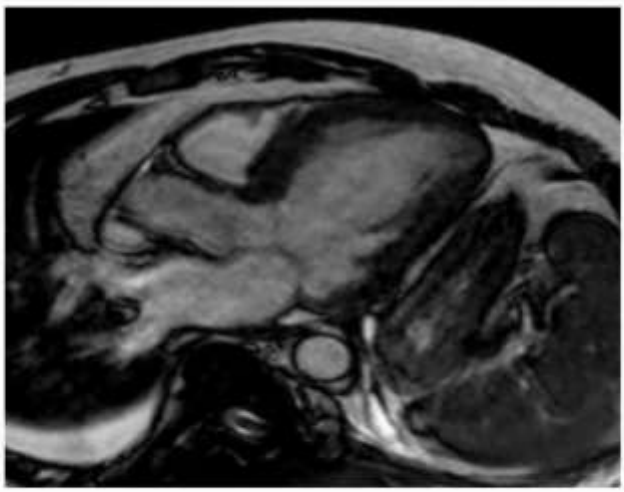


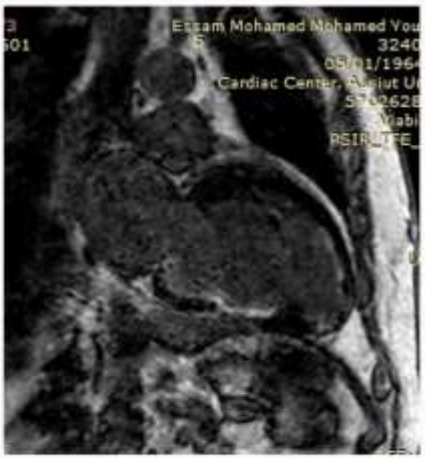
Table 14 Recommendations for percutaneous coronary intervention in ST-segment elevation myocardial infarction

PCI after fibrinolysis			
Routine urgent PCI is indicated after successful fibrinolysis (resolved chest pain/discomfort and ST-segment elevation).	Within 24 h*	I	A
Rescue PCI should be considered in patients with failed fibrinolysis.	As soon as possible	IIa	A
Elective PCI/CABG			
Is indicated after documentation of angina/positive provocative tests.	Evaluation prior to hospital discharge	I	B
Not recommended in patients with fully developed Q wave MI and no further symptoms/signs of ischaemia or evidence of viability in the infarct related territory.	Patient referred >24 h	III	B

Cine (SSFP)sequences of: 2 chamber, showing wall thickness and wall motion.

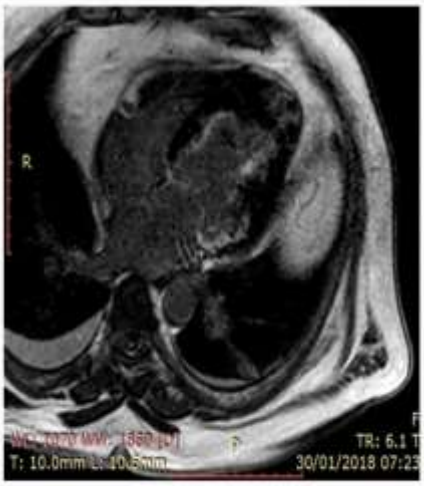


Late Gadolinium Enhancement



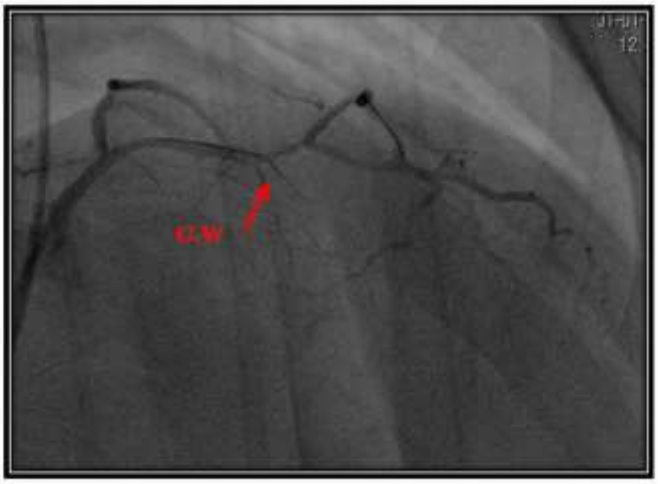
- 2 chamber view showing anterior and inferior walls, where apical anterior wall shows< 50 % subendcardial enhancement, mid and basal segments are completely viable, indicating viability of whole anterior wall.

CMR : 4 chamber view

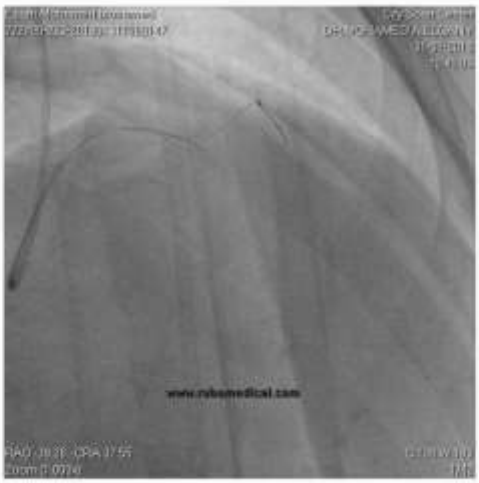


- showing<50% subendocardial ehancement of inferior IVS and lateral walls.
- Only the apical cap shows thinning and near transmural enhancement.

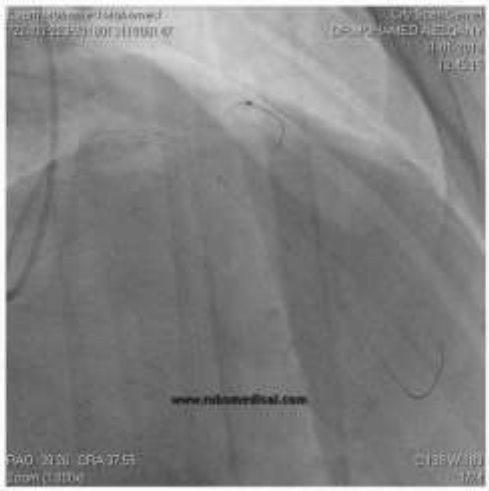
G.W
Choice PT@ MS



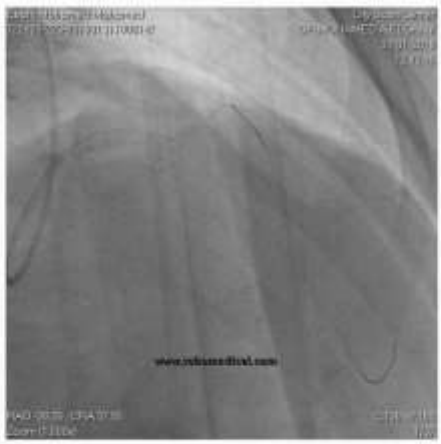
G.W Choice PT@ MS



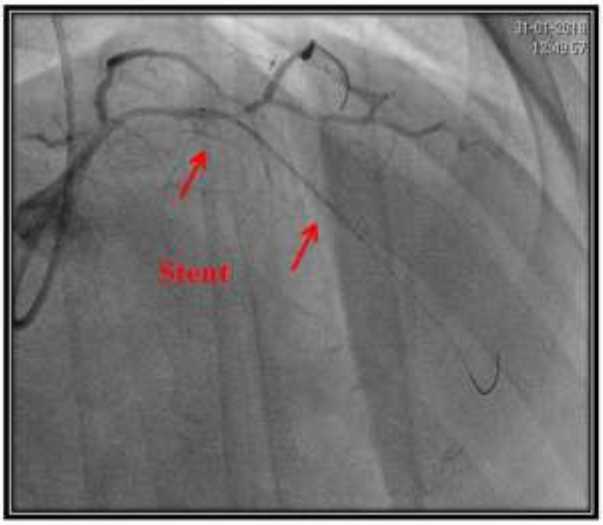
Predilatation
Maverick 1.5 &2 X 20 mm



After predilatation

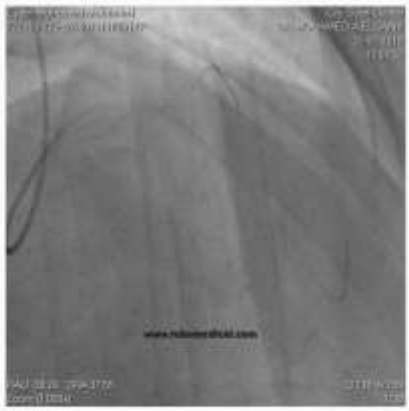


LAD stenting
Promus element Plus 2.5 X 38 mm

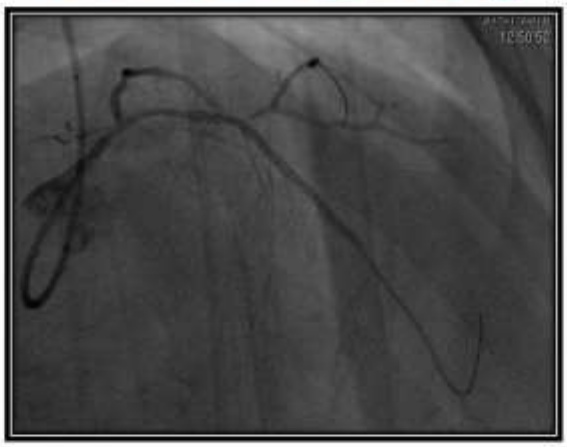


LAD stenting

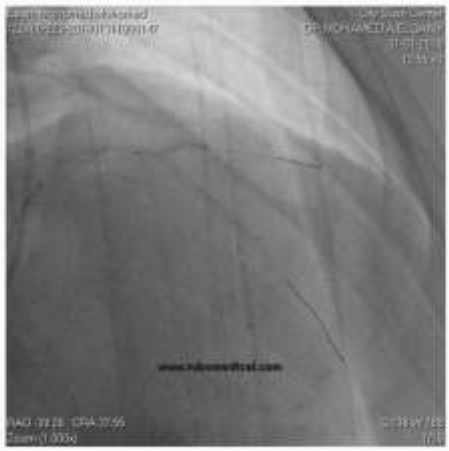
After LAD Stenting



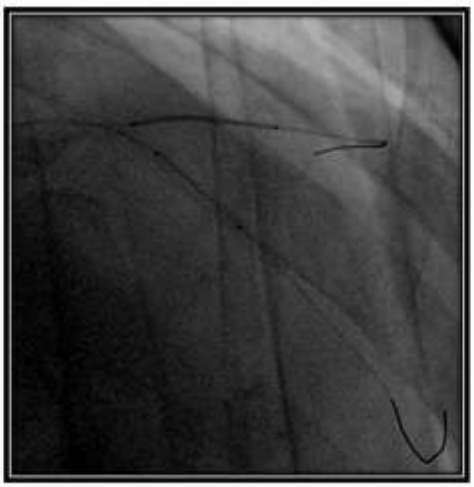
After LAD Stenting



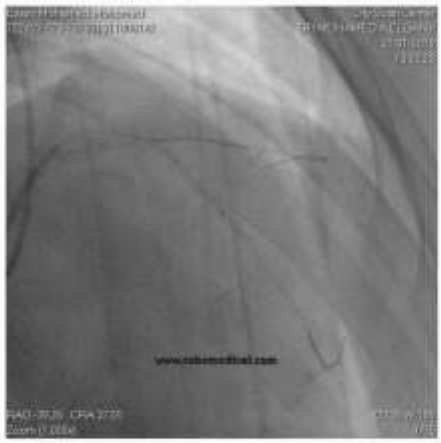
Diagonal dilatation
Maverick 2 X 20 mm



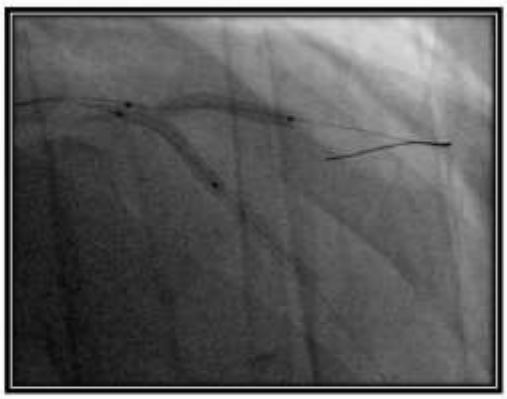
TAP
Promus element Plus 2.5 X 24mm



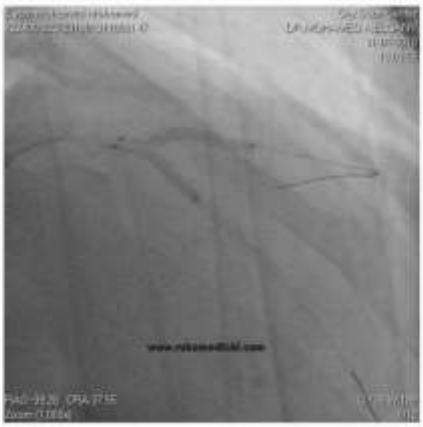
TAP



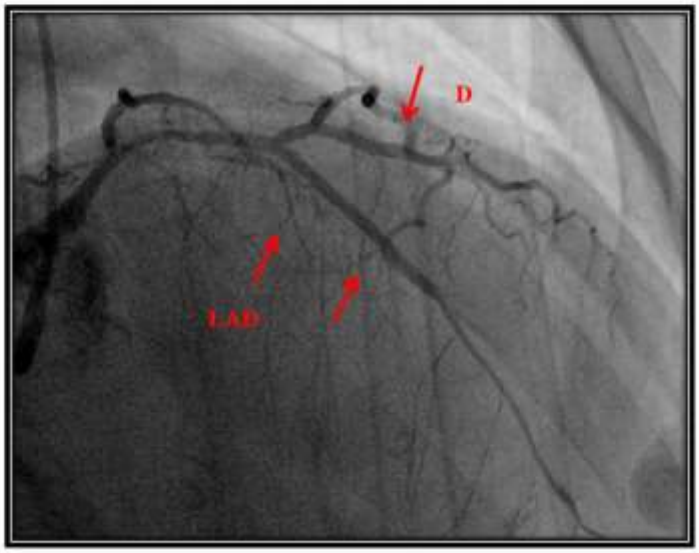
Final kissing



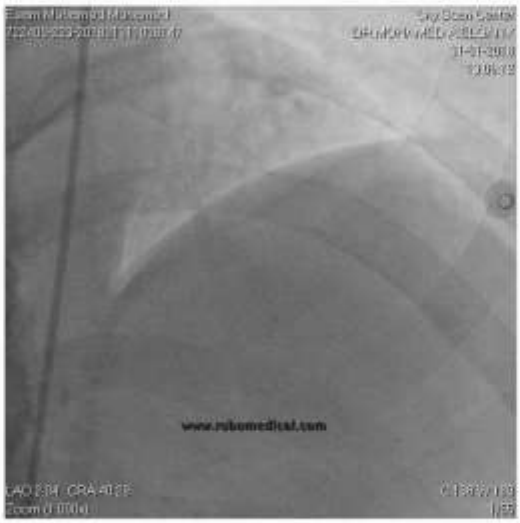
Final kissing



Final results



Final results



Conclusion

- Reopening of infraction related artery after 24 hours of MI is contraindicated unless there is an evidence of Viability or ischemia
- CMR offers the best modality for the assessment of cardiac viability.
- The TAP-stenting is a modification of the T-stenting technique which allows full coverage of bifurcated lesions and facilitates final kissing .


Thank you