

Rotablator preparation for distal LM stenting

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Case presentation

Medical history

- 68 years old male
- NSTEMI (~24 h)
- Hypertension
- Hyperlipidaemia
- LM distal critical lesion with heavily calcified plaque

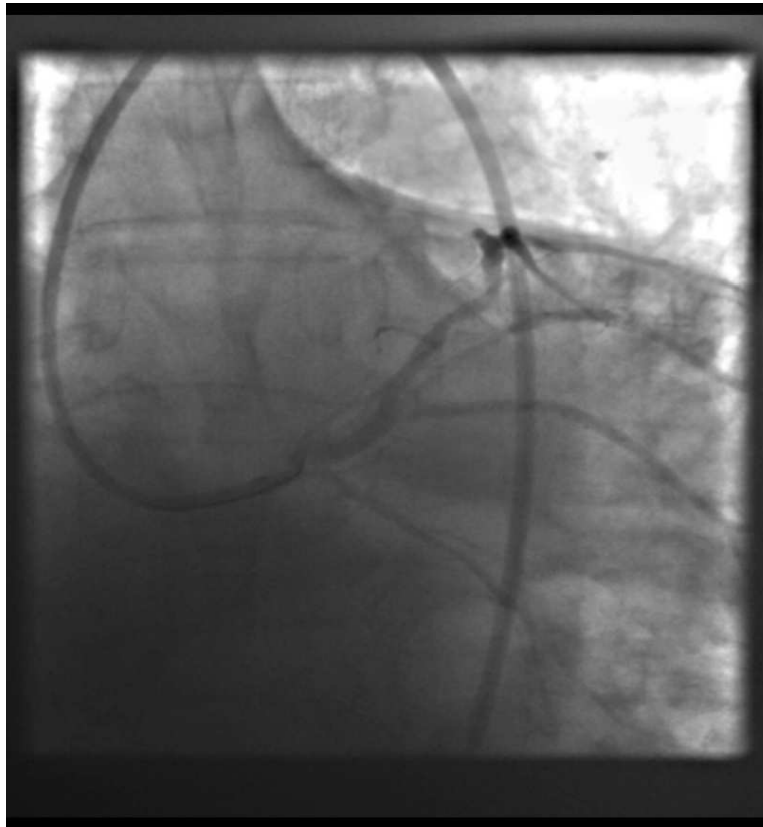
Referred to our hospital after an unsuccess PCI

- Femoral approach (because of weak pulse) 6Fr
- EBU 3,5 guide
- Wire to LAD but impossible to CX because of plaque and angulation
- Predilatation with 1.5, but unsuccessful predilatation with 2.5 Apex quantum NC
- TIMI-3 flow remain
- Procedure interrupted (contrast 240 cc)
- Trop-T: 2.1
- Echo: EF-40%, no akinetic wall

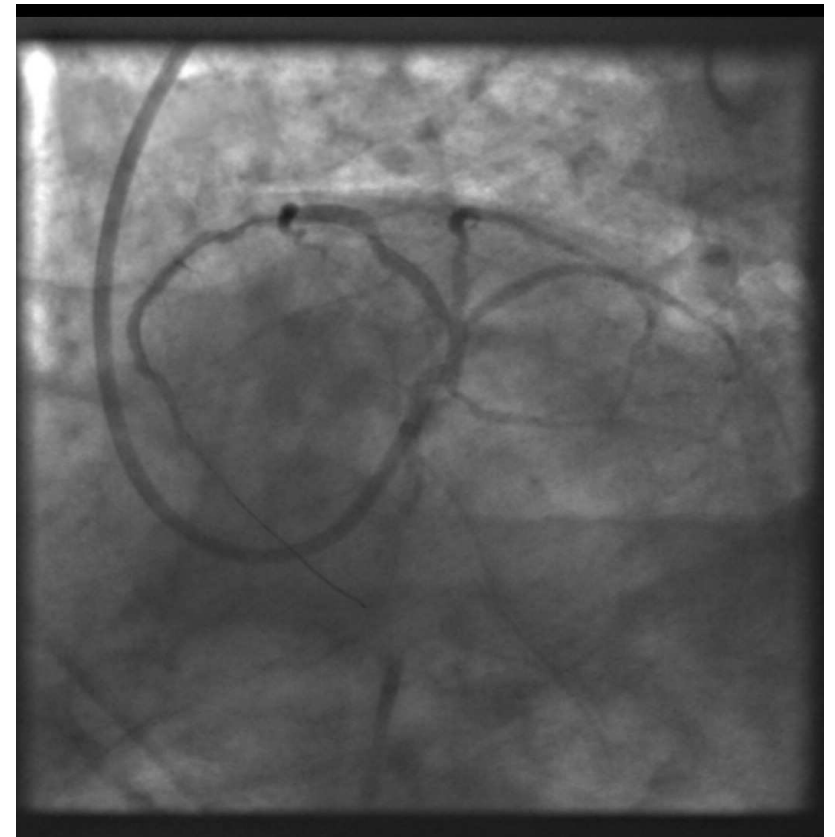
2nd Intervention (plan)

- 7 Fr EBU-4 guide, femoral (US prove that the other side is better)
- Marker wire (Pilot 150 and after RW (contrast))
- RA 2.0 burr
- Additional preparation, if necessary ?????
- CX protection, occlusion????
- Stent (LM-LAD)
- Post dilatation LM, Kissing, IVUS ?????

Basic Coron. angios

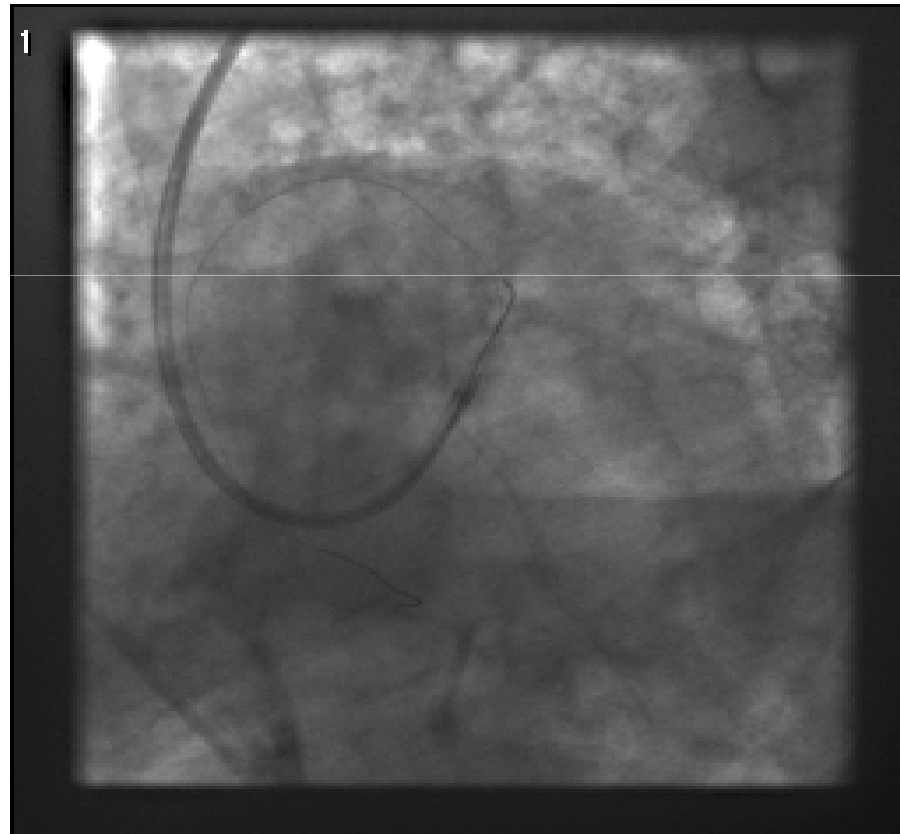


AP-cranial -20

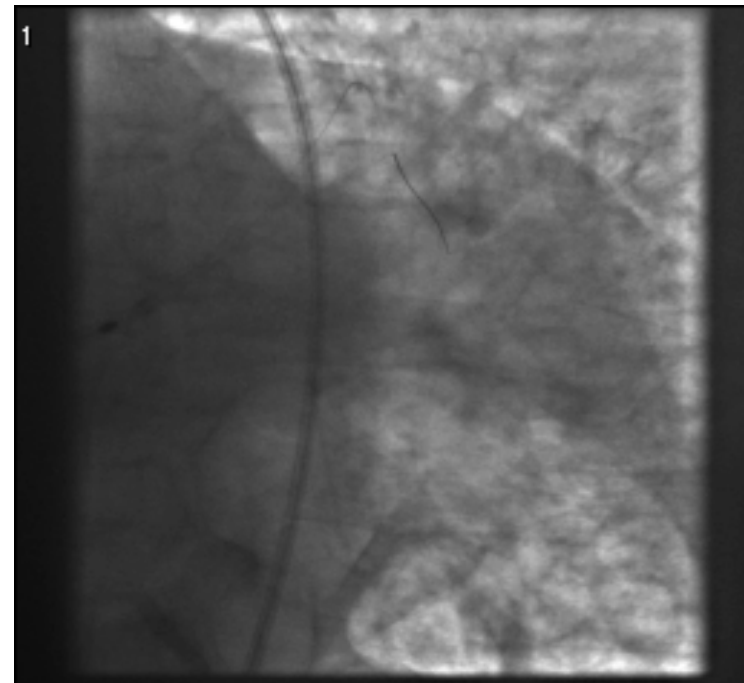
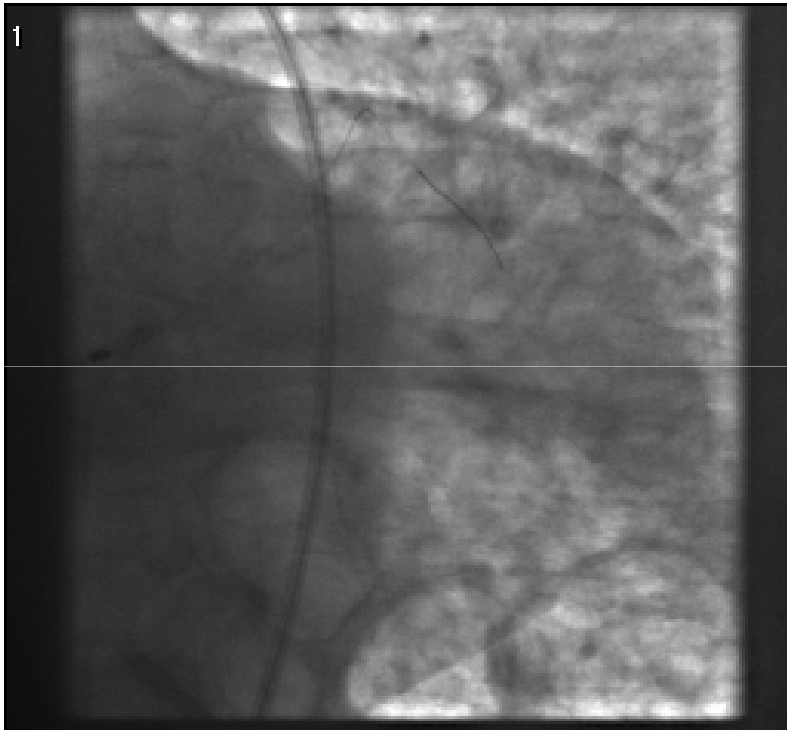


Spider

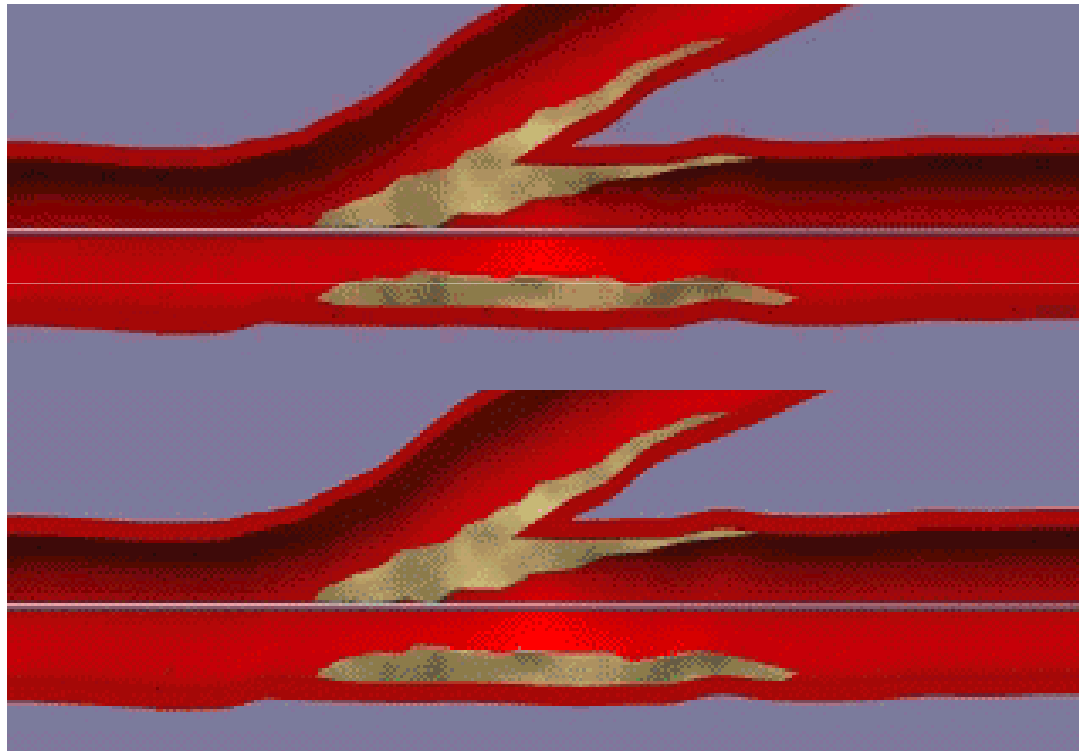
Wireing of LAD with help of marker wire



RA of LM-LAD



What is a benefit in RA in case of bifurcation

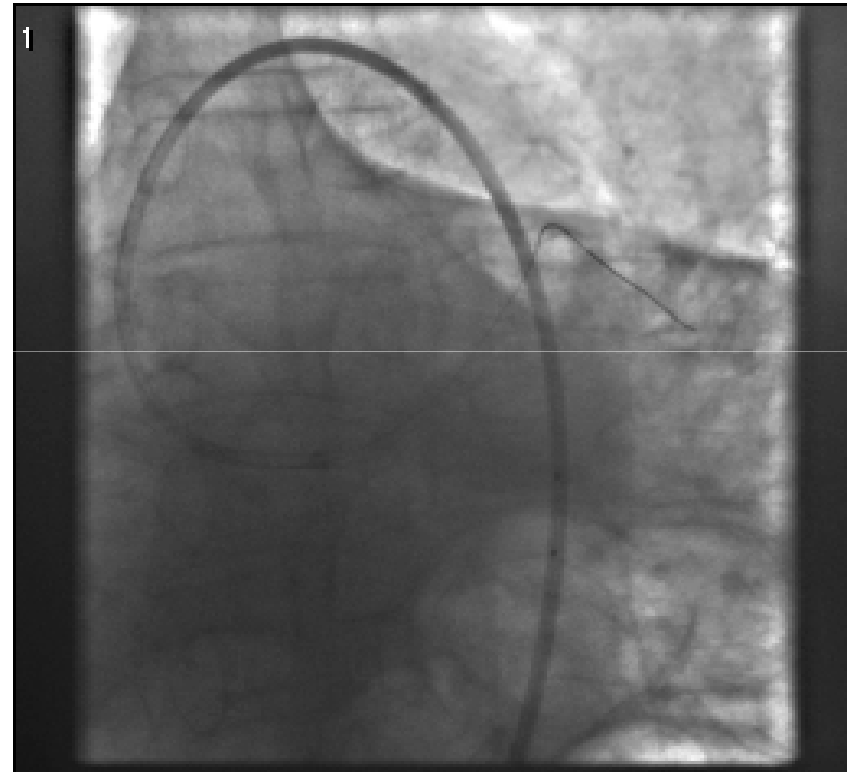
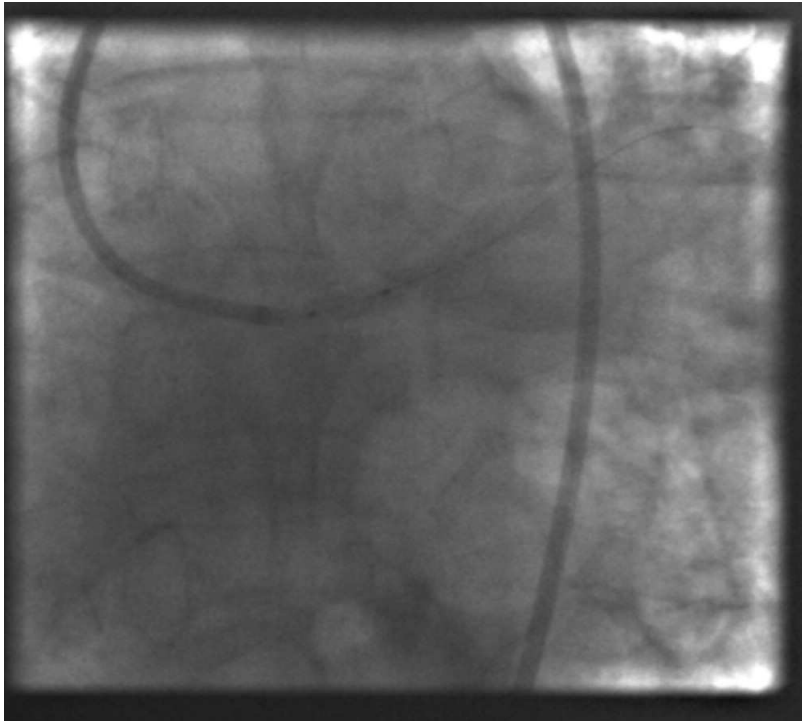


Advantages and disadvantages

- RA
- + If the wire pass RA pass
- + Angulation makes no problem
- - 6-8 Fr compatibility
- - Debris embolization
- - Share the concentration
- Cutting
- + Size is bigger and 6Fr
- + No debris
- - Angulation makes problem (Flextone is better)
- - If the balloon can't pass cutting never will

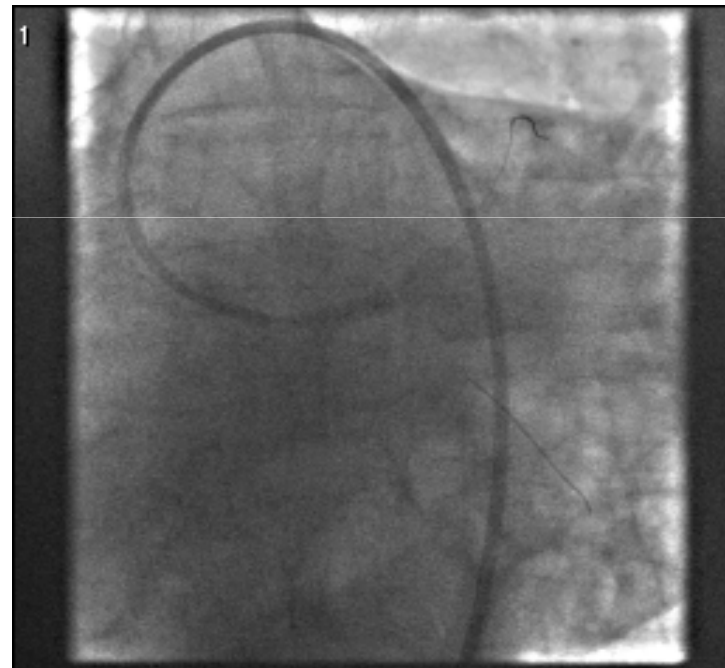
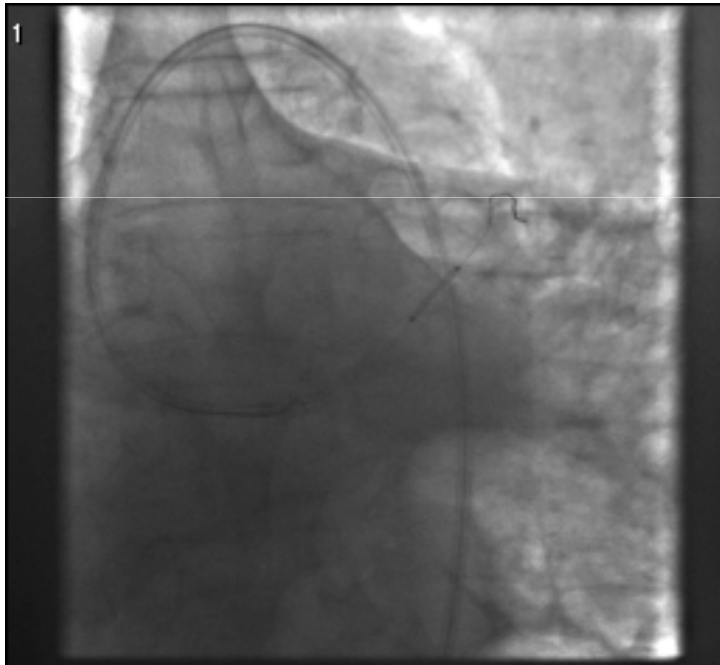
But what about a combination of this
two plaque modification technics???

Cutting predilatation LM-LAD (result after cutting)



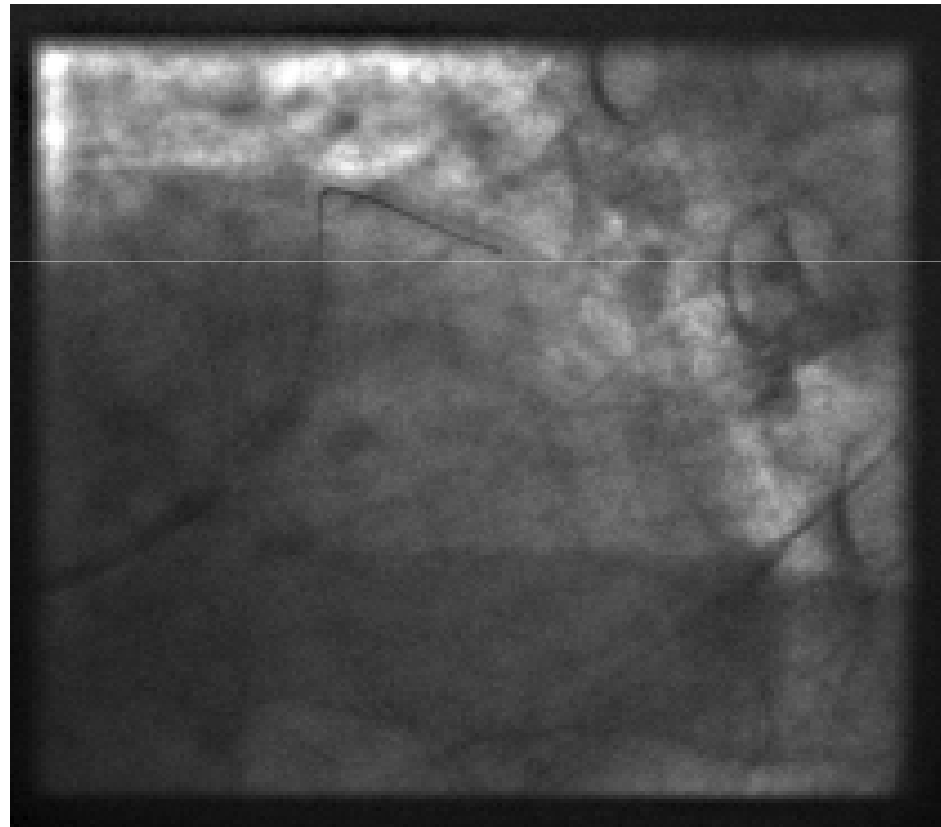
Flextone 3x10

CX protecting wire and LM-LAD stenting (3.5x15 Xience Prime)



Final result after IVUS guided post dilatation LM (4.0 Apex Quantum NC)

Contrast: 200 cc
EF: 40% (the same)
Trop-T max 3.1
CK-MB: 24-21-19
LDH: 502-447
Kreat: 113-96
**6 m. later the patient
is still free of angina**



Thank you for attension!

(good result with a moderate compromize)

