



The only surviving vessel is at risk!

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Disclosure

I do not have any conflict of interest

Case



- 60 year old man
- Risk factors: chronic smoker, DM
- LVEF 30%

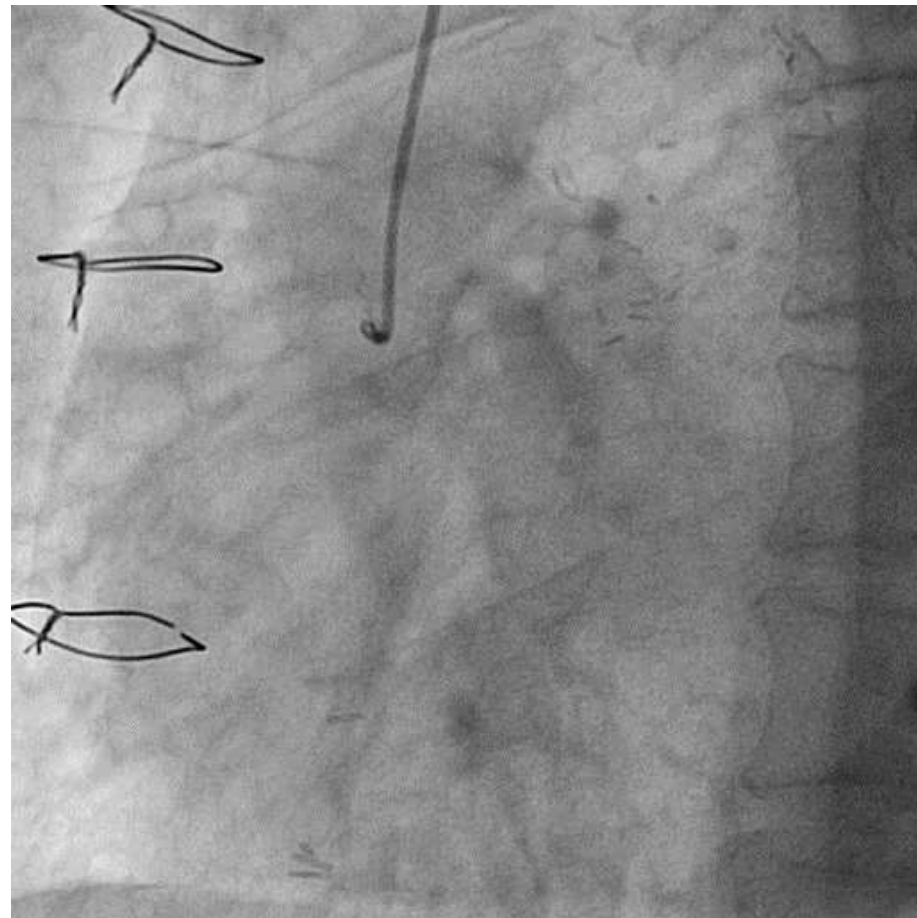
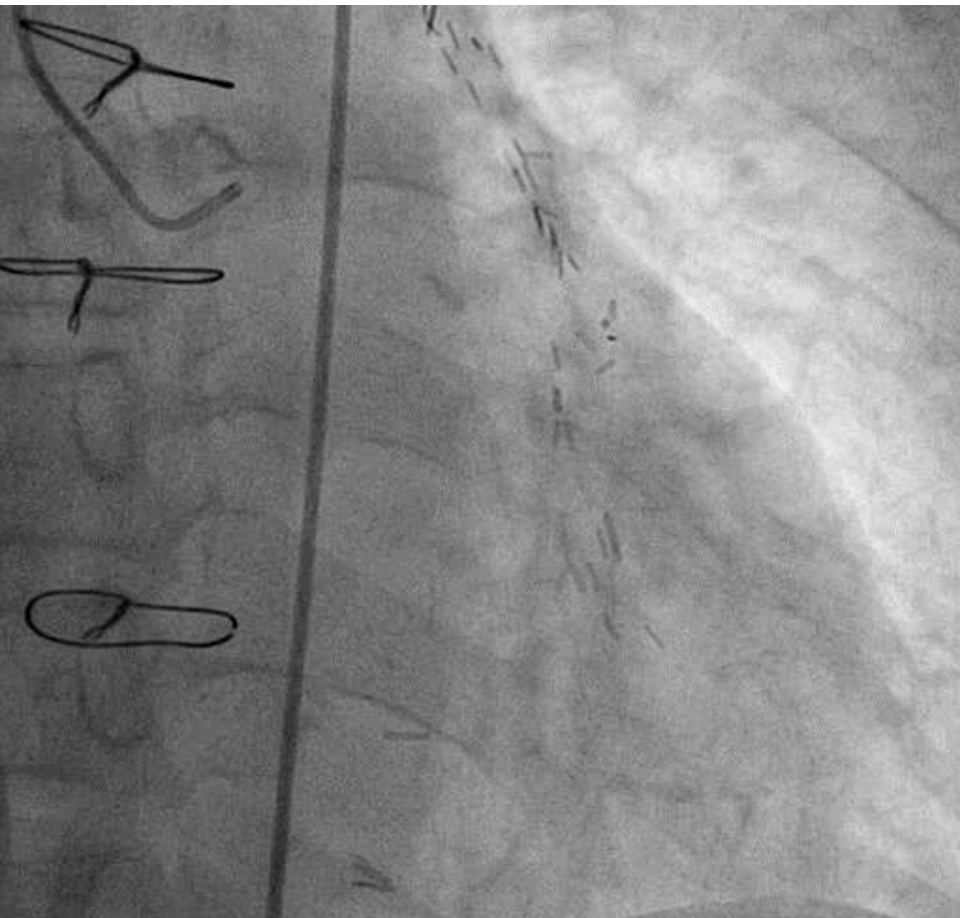
- 10 year ago CABG
 - LIMA-LAD, grafts to OM and PDA

- Recurred angina

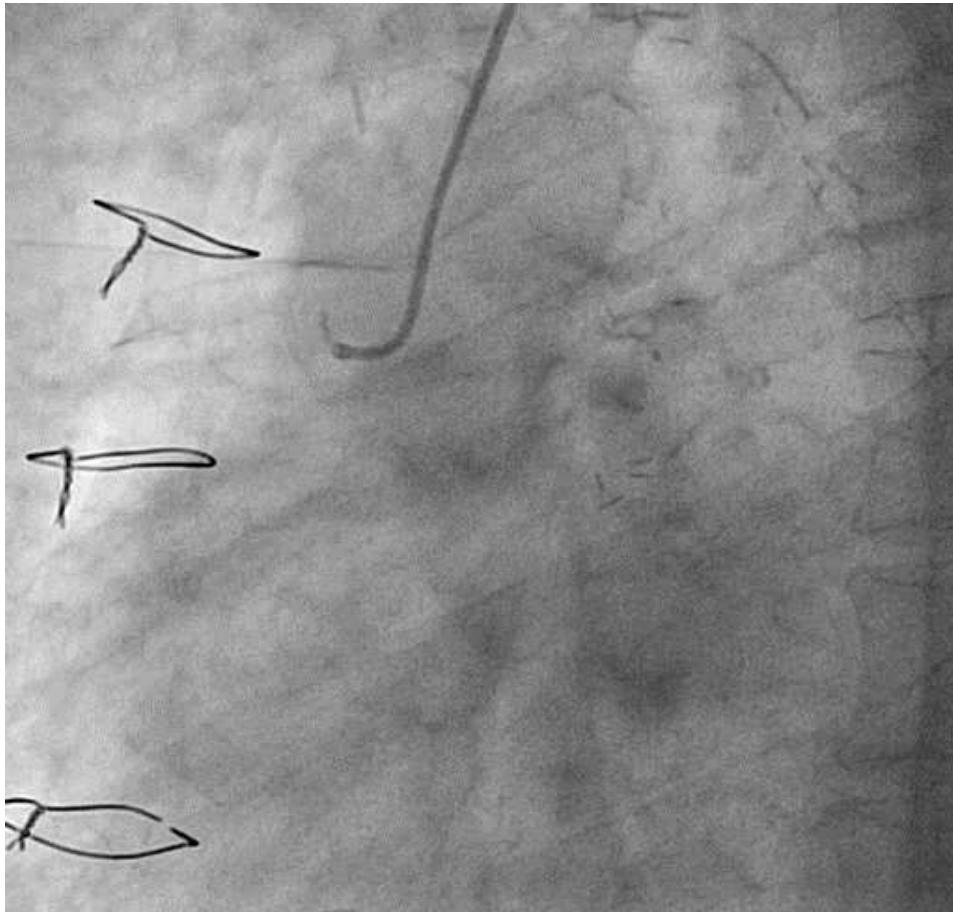
Native LM / TVD

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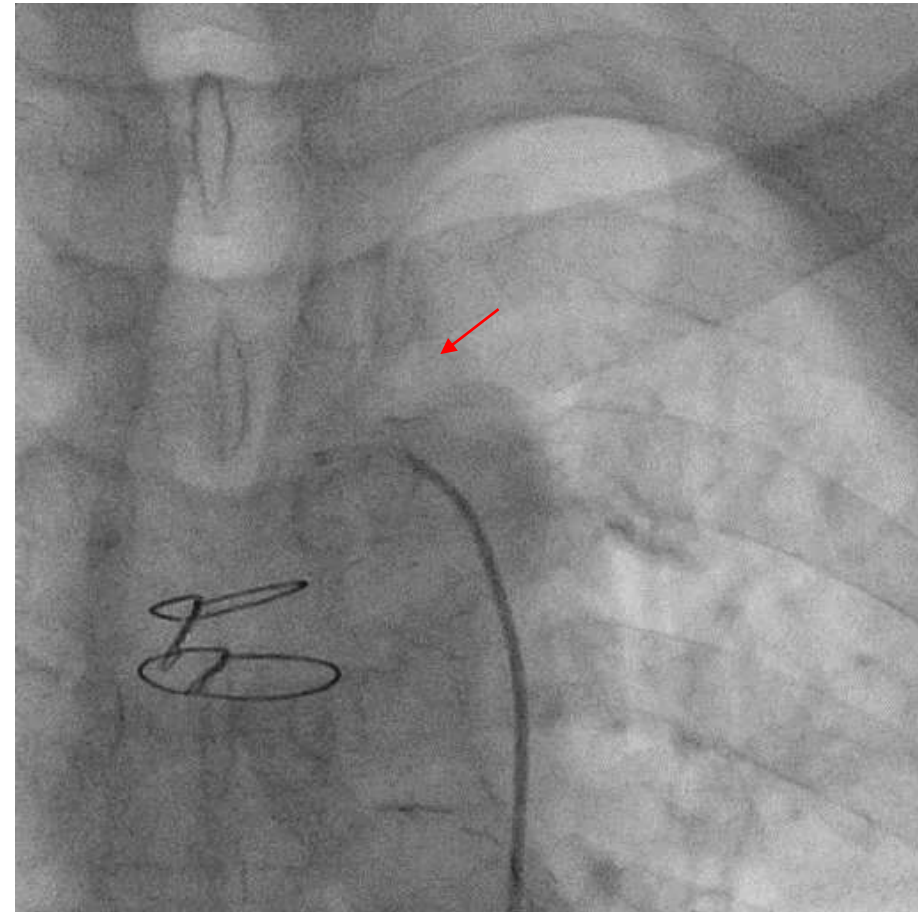
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Grafts



Blocked PDA and OM grafts

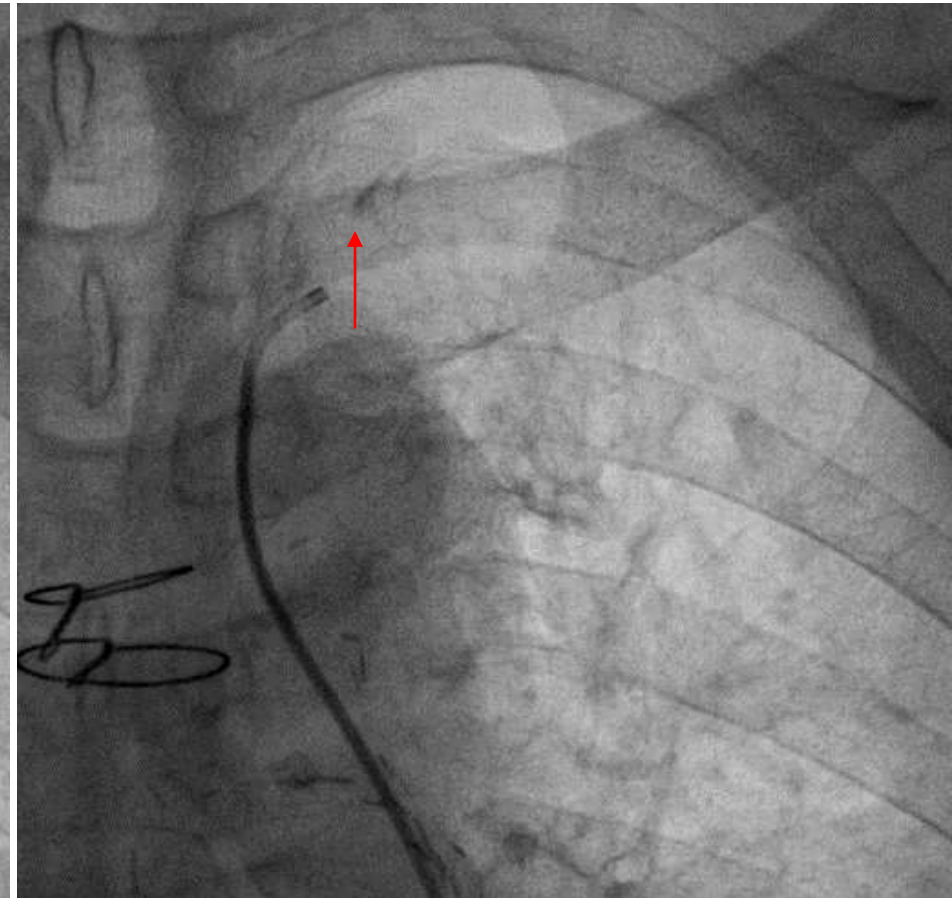
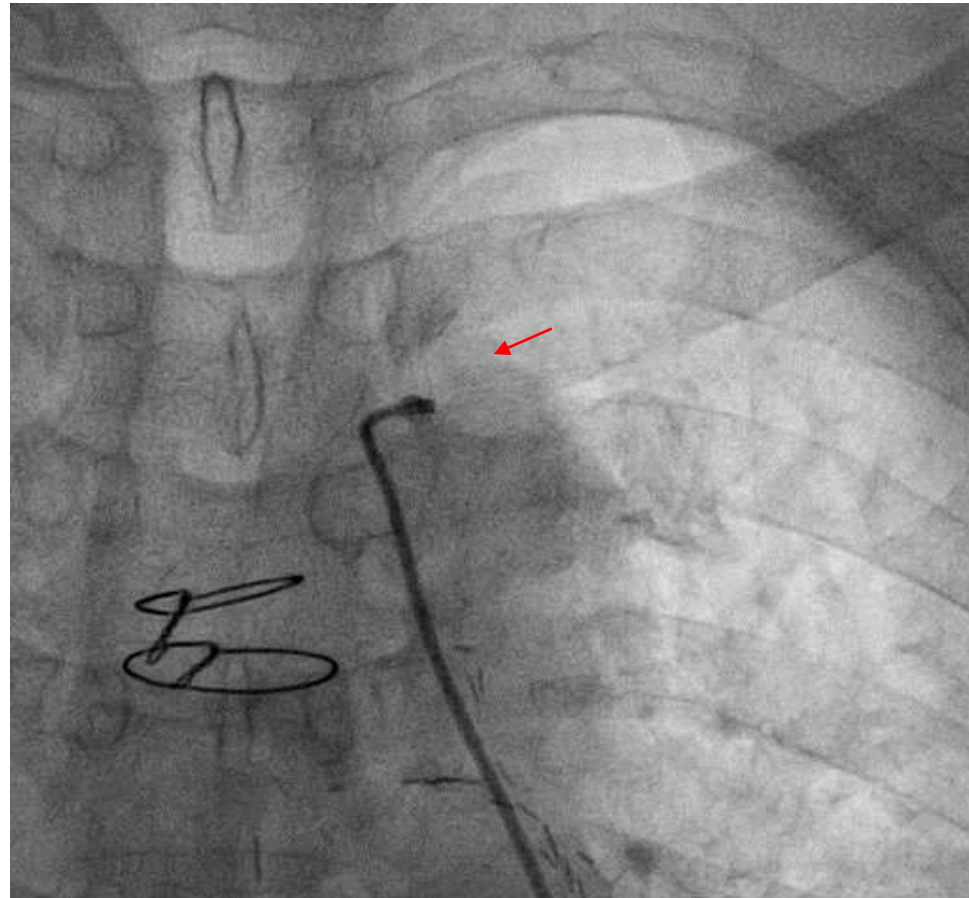


RFA, 5Fr JR4
Try to locate LIMA

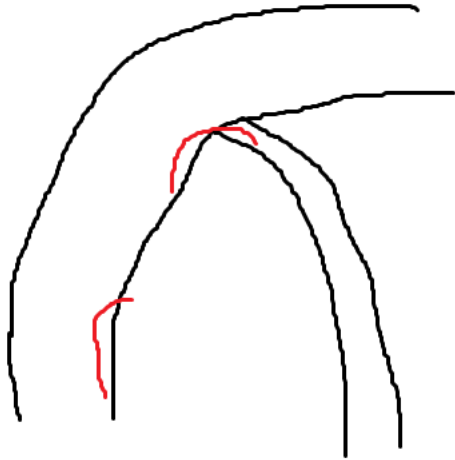
LIMA

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Subclavian dissection extending to LIMA



- Confirmed with CT thorax
- Stable
- What should we do?
 - Wait and see
 - Intervene: CABG vs PCI

Progress



• What should we do?

• Medical

Patient stable
Good flow to LIMA

• CABG

Very high SYNTAX
Ostial PCI

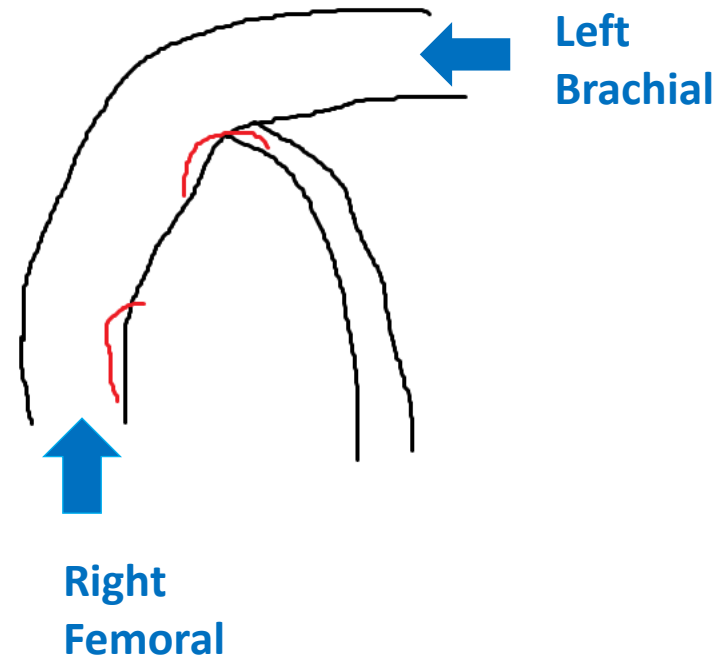
• PCI

Risks of redo-CABG
LIMA acute closure
(single surviving vessel)

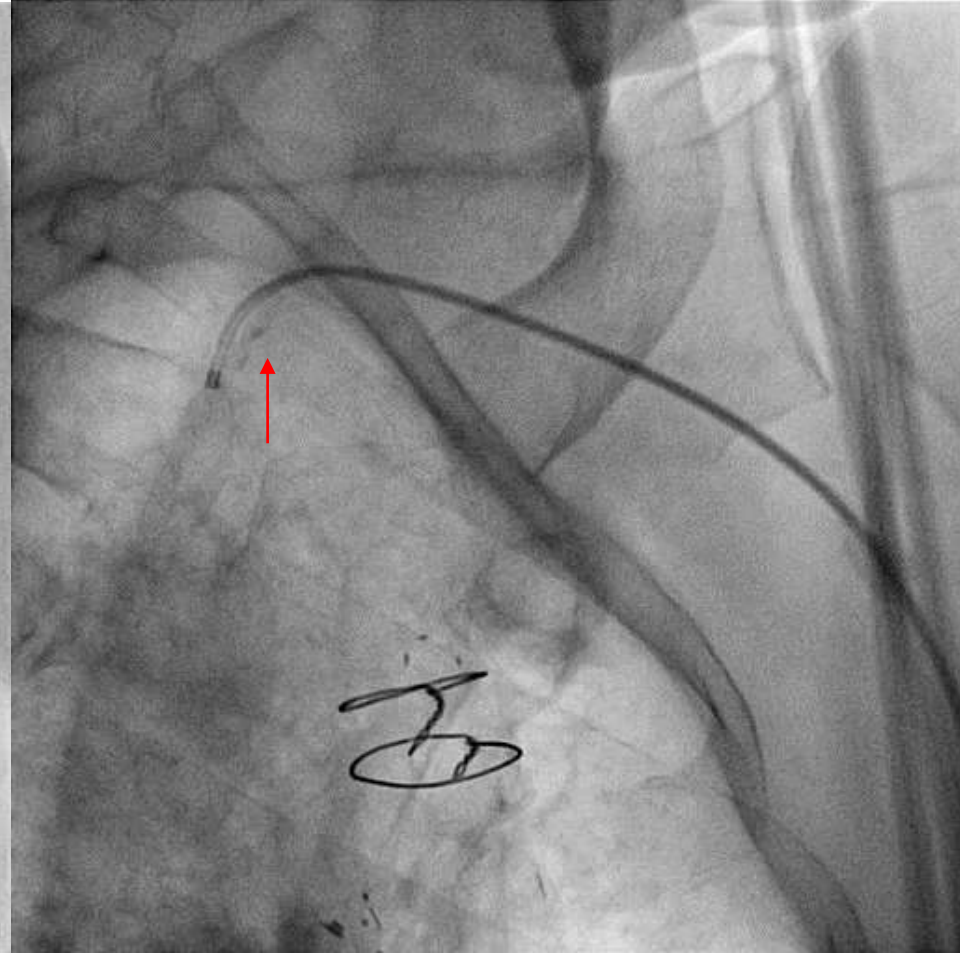
Progress



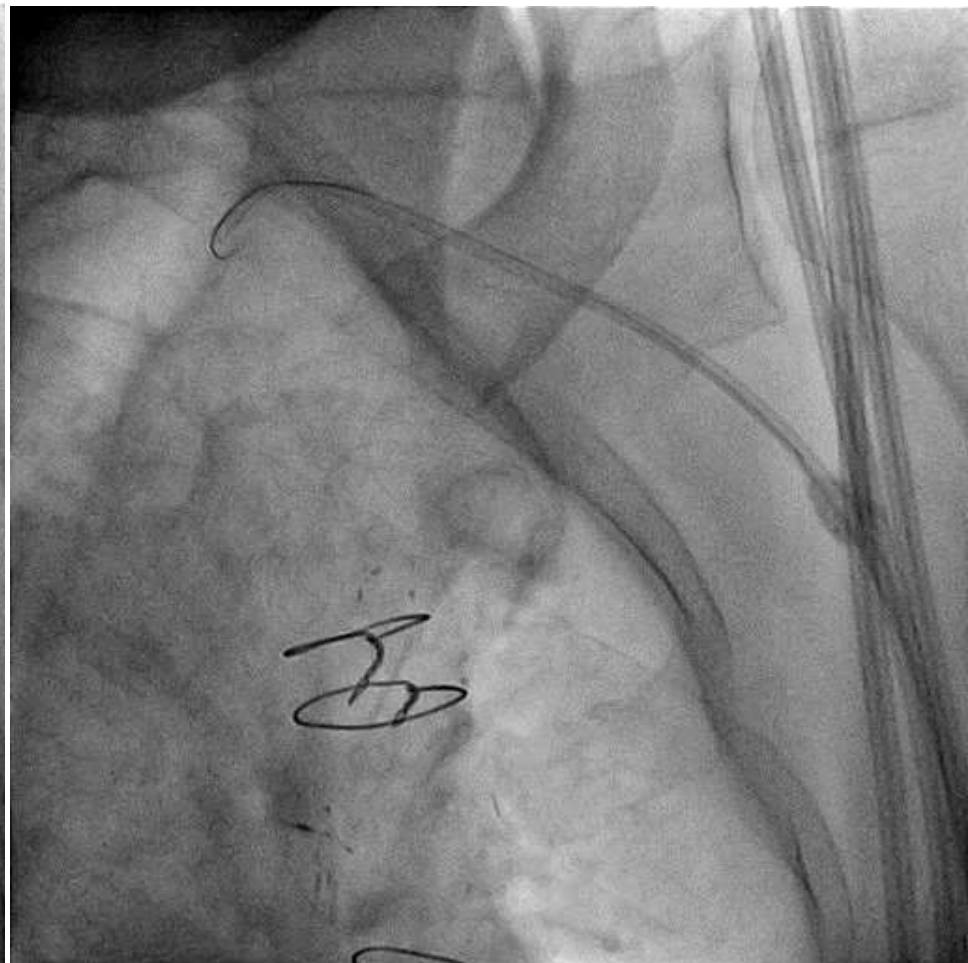
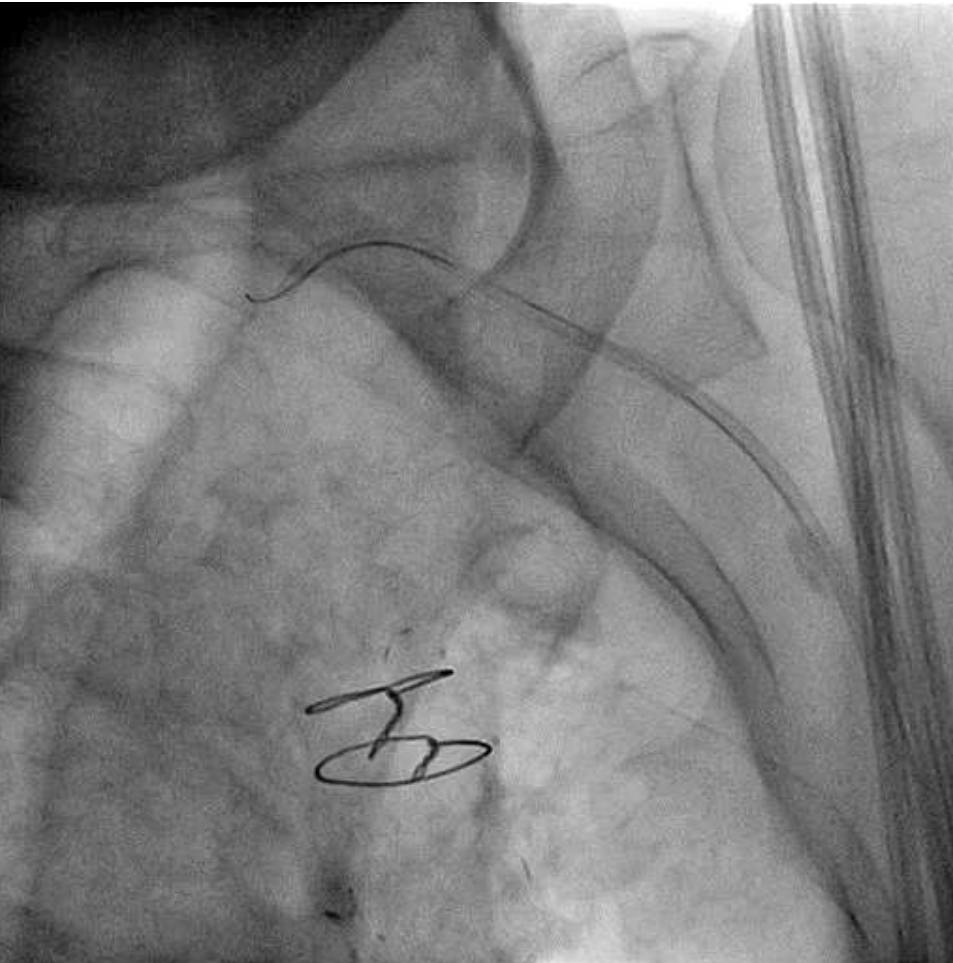
- Pros and cons discussed
- Opt emergency PCI
- Left brachial approach
 - Leave subclavian
 - Further extend subclavian dissection into LIMA



Difficulty negotiating

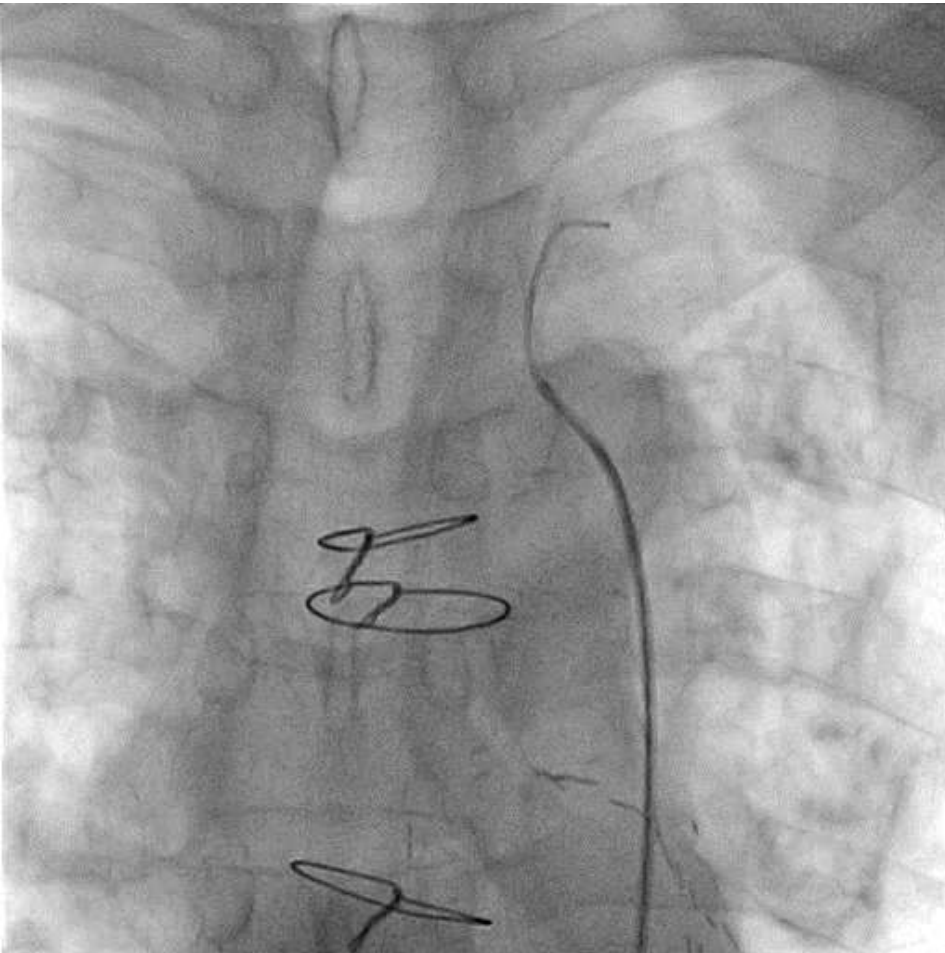


Fail to wire due to acute bend

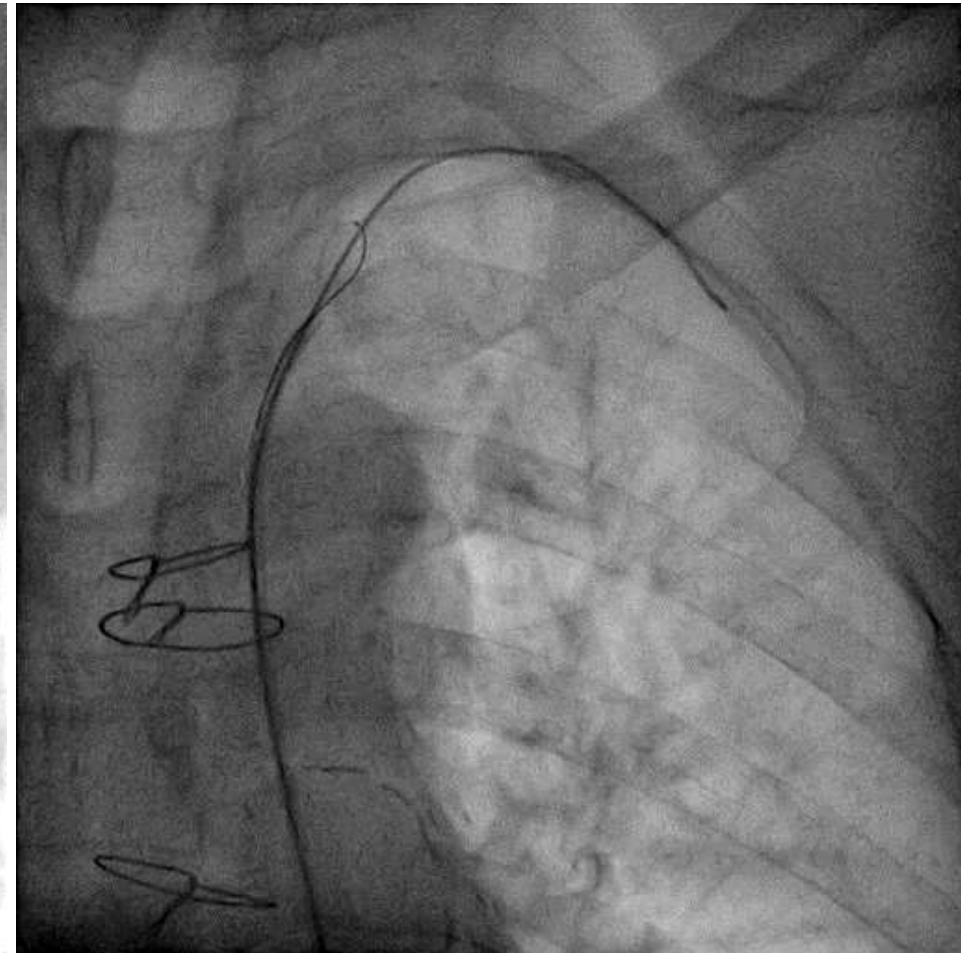


Multiple guidewires attempted:
BMW, Fielder FC, Sion Blue, with Crusade microcatheter

Switched to right femoral approach

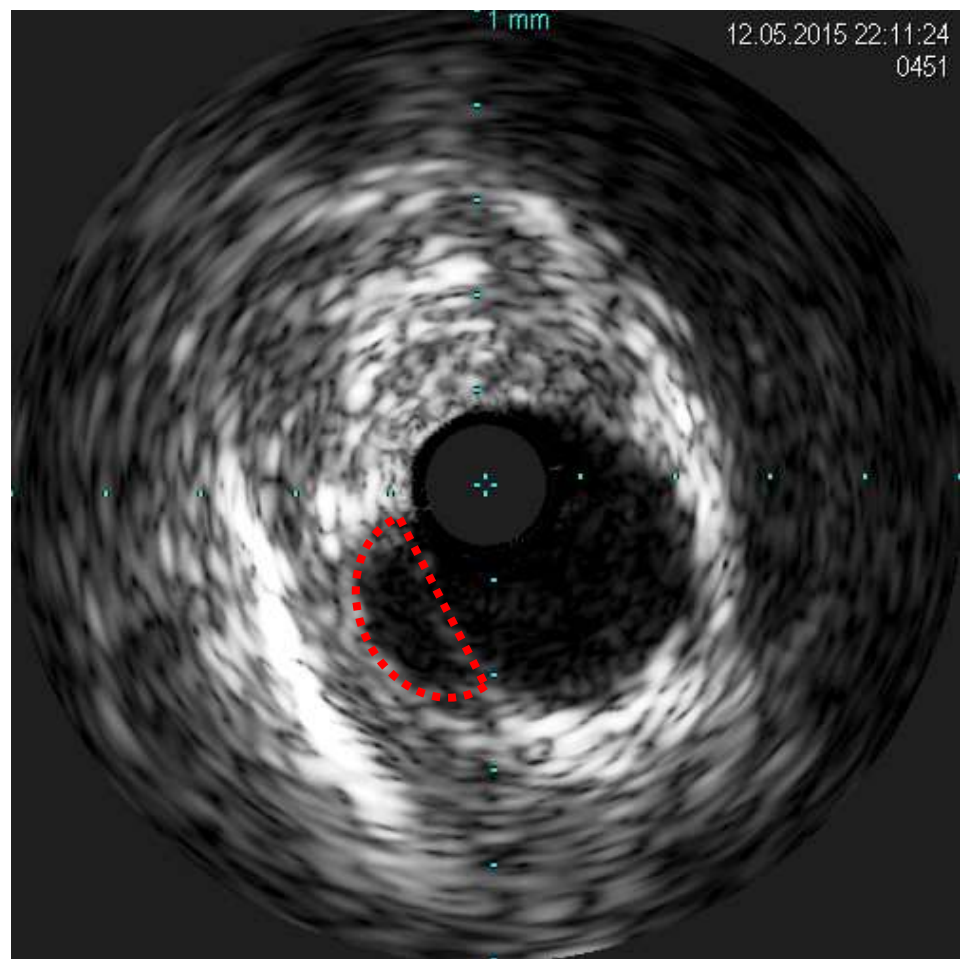
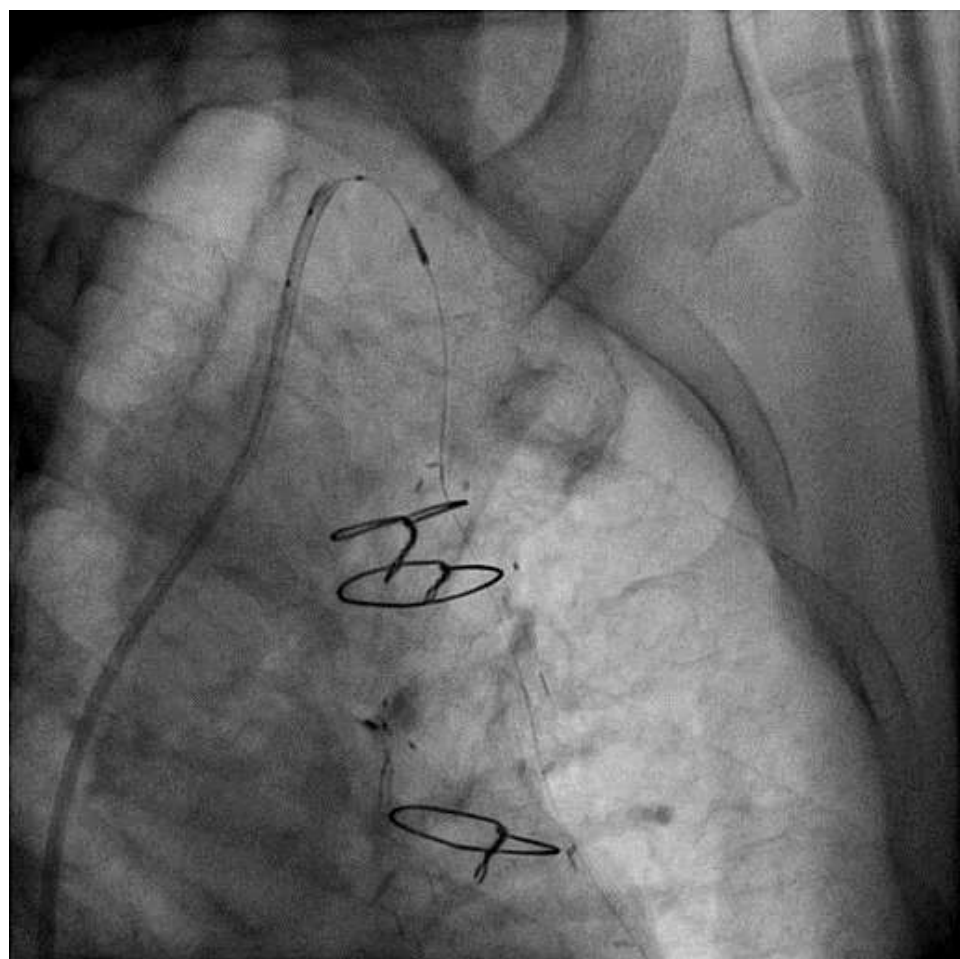


Diagnostic catheter first



Then exchanged with 6Fr IMA guiding supported by GW

IVUS

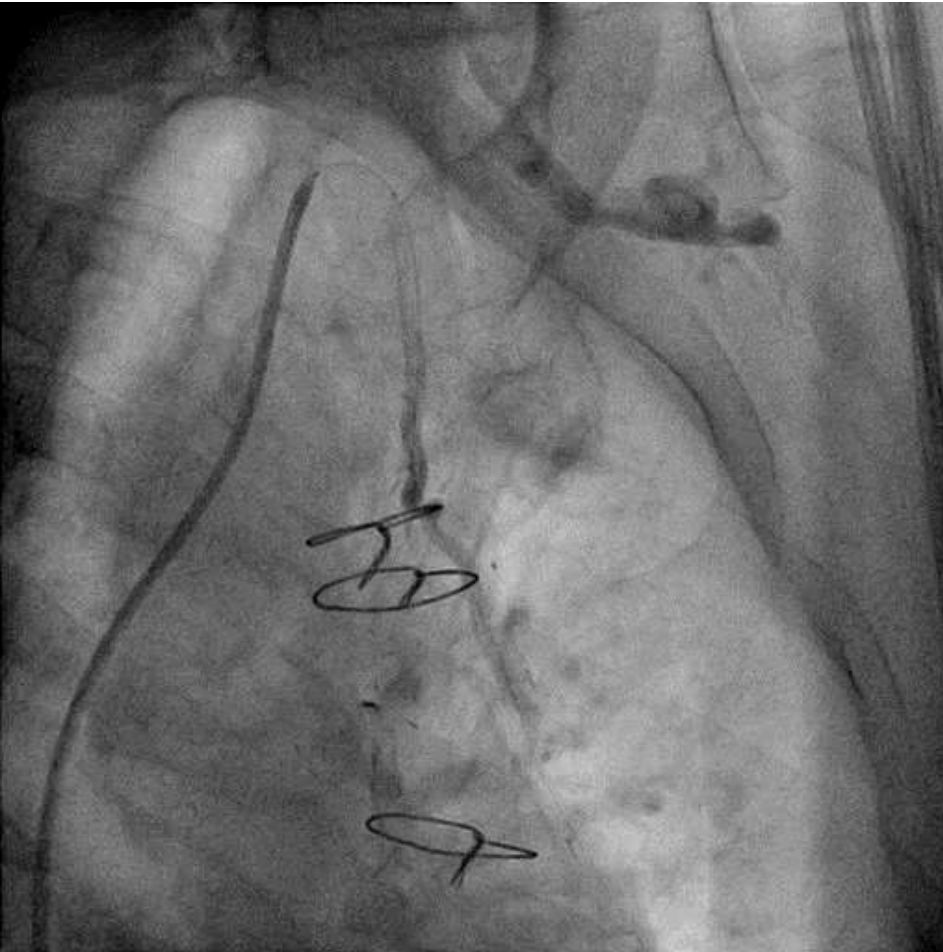


IVUS: confirm LIMA dissection, vessel size 2.75-3.0mm

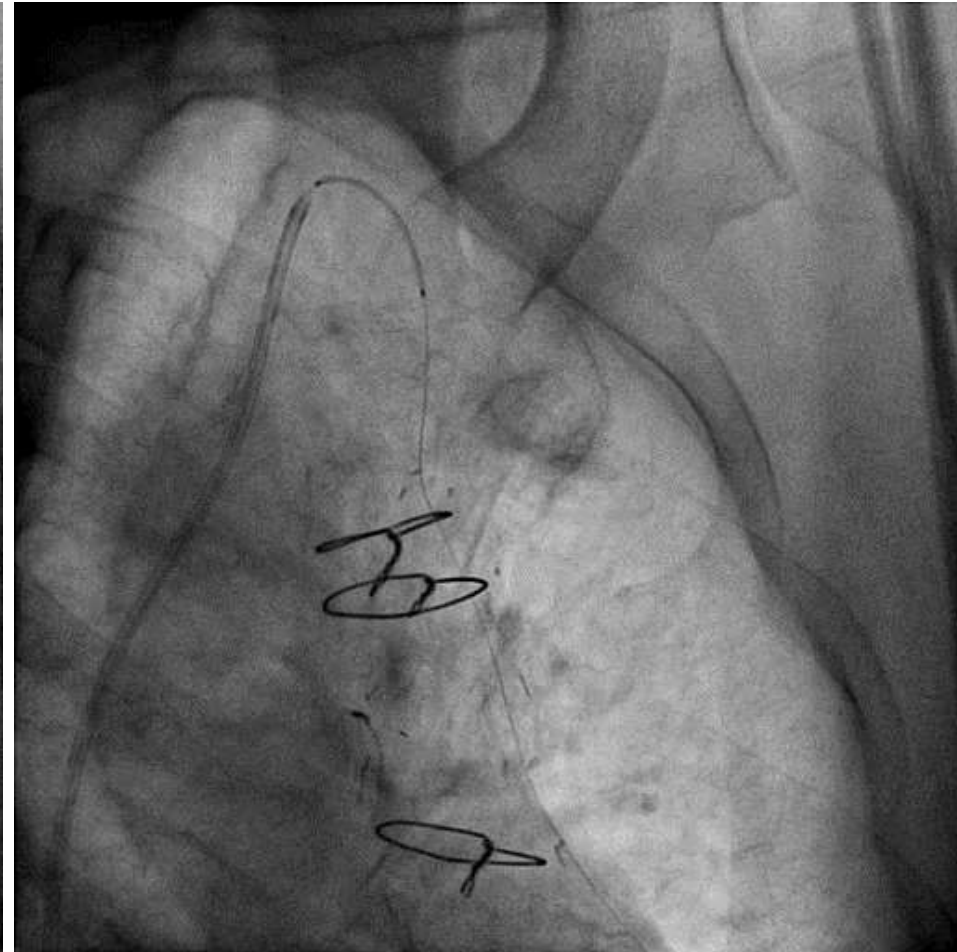
PCI

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Predilate 2.5 balloon (ostial PCI)
2.75 DES

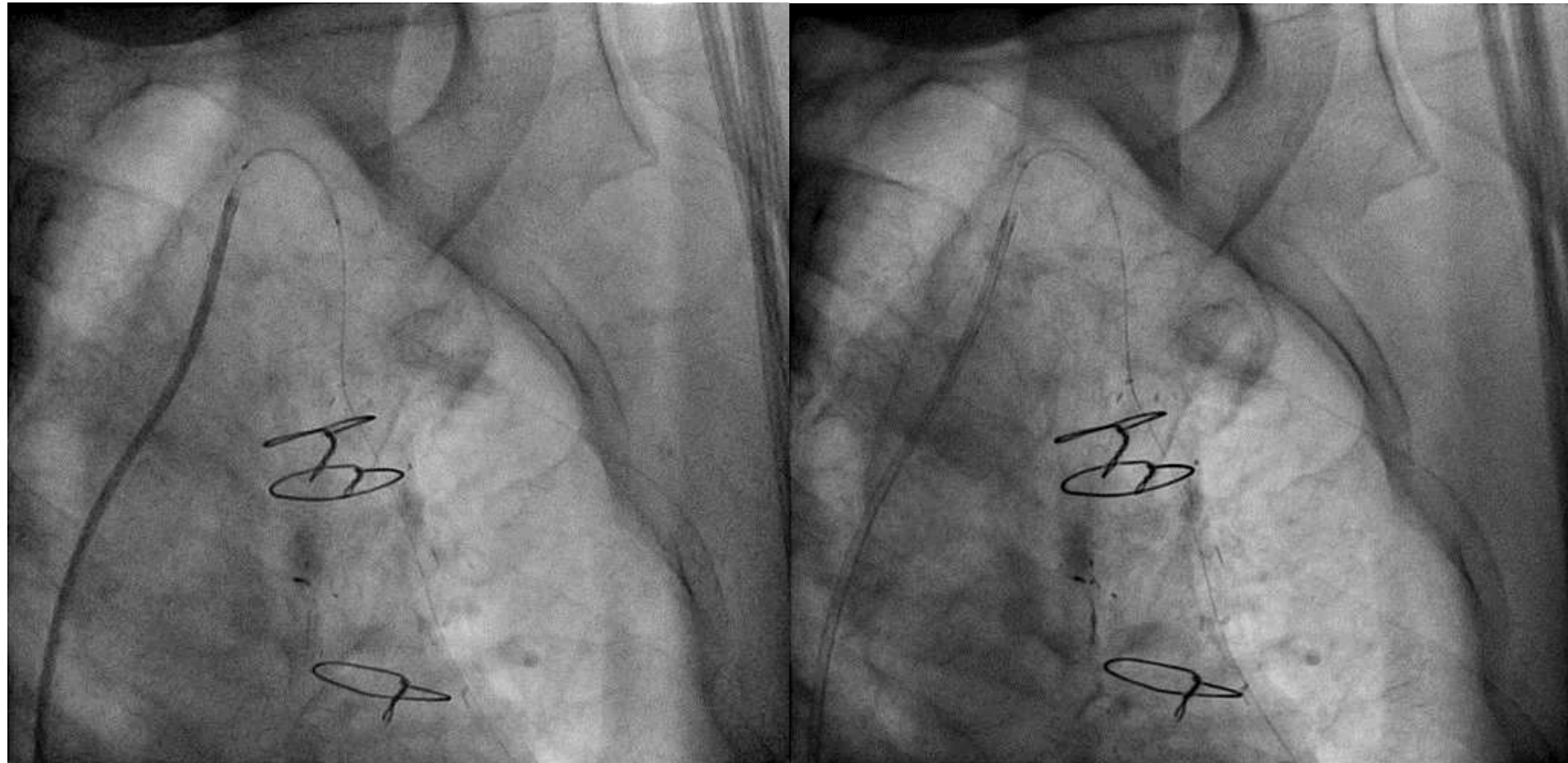


Careful stent positioning
Partial protrusion to subclavian
(not to miss ostium), avoid stent slipping

PCI

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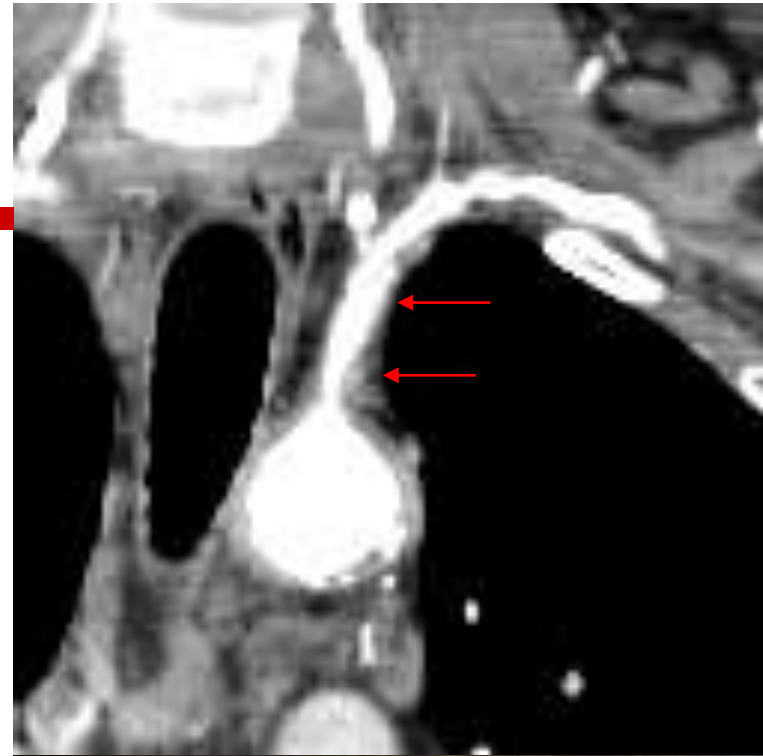


2.75 DES deploy
Post dilate 2.75

Satisfactory result

Progress

- Post-PCI well
- CT 24 hours later
 - No extension of dissection
- Surgical plan
 - Conservative management
 - No limb ischemia
 - Follow up scan



Learning points

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- Don't inject contrast while manipulating catheter
- Watch out for pressure damping
- If dissection occurred -> minimize contrast injection

Learning points

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- LIMA takeoff orientation poses great challenge for wiring
- Diagnostic catheter first, then exchange with guiding catheter
- Ostial PCI
 - Always predilate
 - Stent hangout rather than missing ostium, avoid slipping out during deployment

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Thank you!
