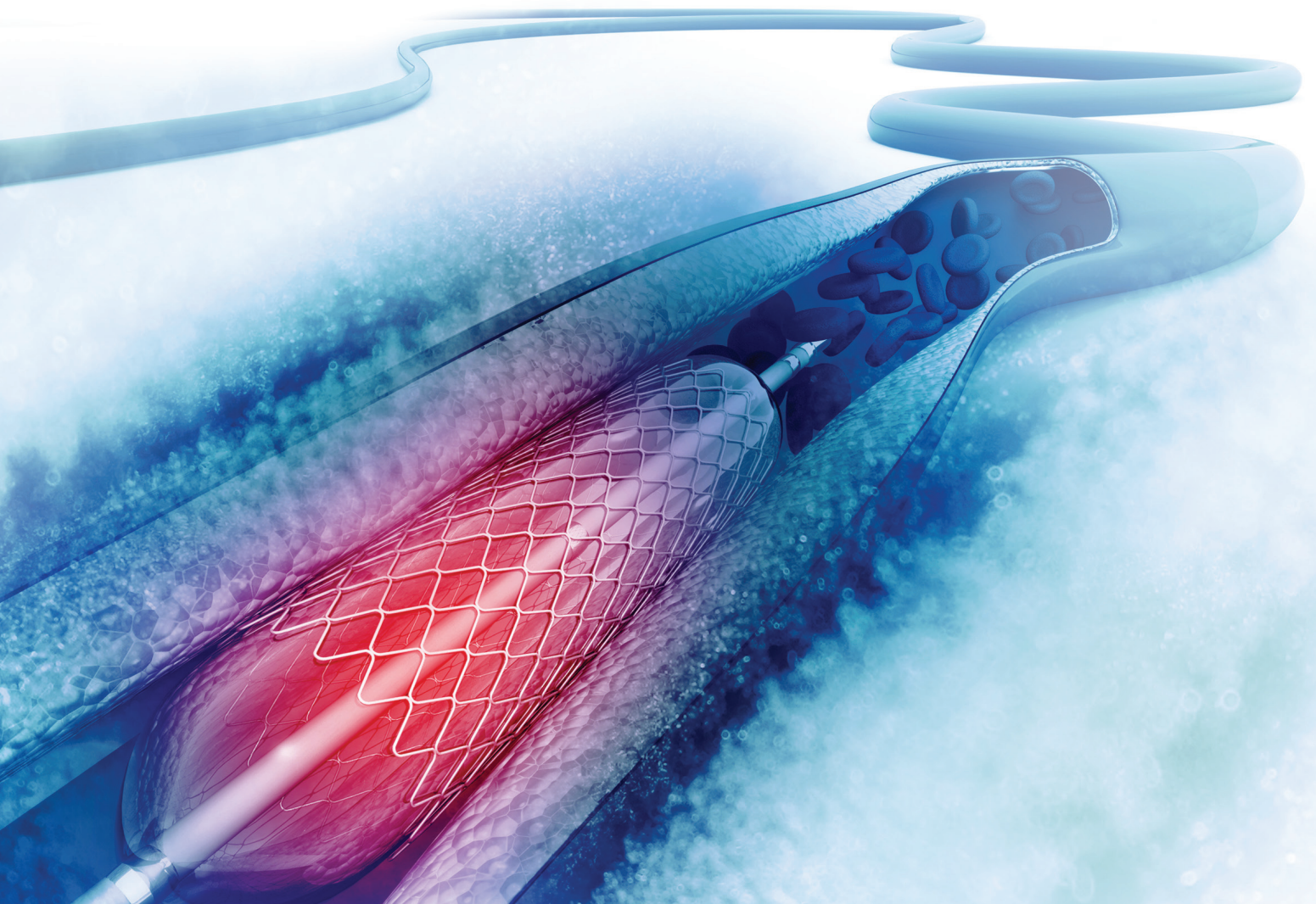


Case Profile Series 1

**Case study of a patient with triple vessel
coronary artery disease undergoing
PTCA with graft stenting**



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CLINICAL PRESENTATION

A 72-year-old male, known case of hypertension, diabetes mellitus, chronic kidney disease, ischemic heart disease, S/P CABG (2009), normal LV systolic function was admitted with complaint of typical angina. He was advised for coronary angiography.

**CORONARY ANGIOGRAPHY REPORT****RISK FACTORS**

- Hypertension
- Type 2 diabetes mellitus

ECG

- Sinus Rhythm
- T wave inversion V1 - V4
- Good LV systolic function
- AO/LVEDP/PCWP: 160/80/107

APPROACH - RIGHT FEMORAL**CATHETERS**

- 5F JL
- JR 3.5

CONTRAST MEDIA

- Contrast - Omnipaque
- Quantity - 50 ml

FLUROTOME: 7.29 MIN

- Left Main: Distal LMCA has 80 % stenosis
- Ostial LAD has 90% stenosis. Mid LAD has total occlusion

RAMUS INTERMEDIUS: NA

- LCX/ OM: Dominant Ostial LCX has 90% stenosis
- Non dominant. Diffusely diseased

LIMA/RIMA

- LIMA-LAD-> Absent
- SVG-LCX-> Patent
- SVG-LAD-> Discrete 90% stenosis in proximal half. Distally slow flow noted.

LV ANGIOGRAM - NA

- Renal/Angio/Carotid-Angio - NA
- Any other - NA

Final Diagnosis - Native triple vessel coronary artery disease. LIMA-LAD graft absent, SVG-LCX patent graft and significant disease in SVG-LAD graft.

Recommendation - PTCA with stenting to SVG-LAD graft

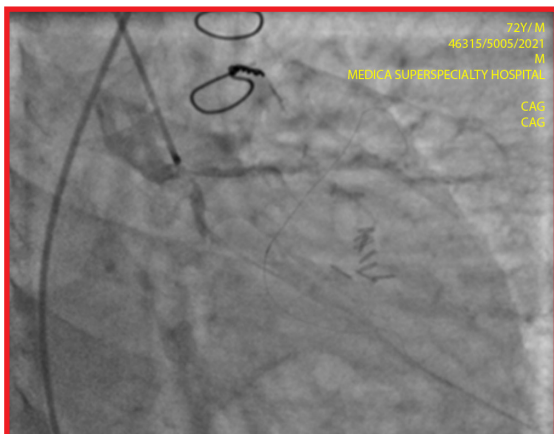
CASE PROFILE SERIES

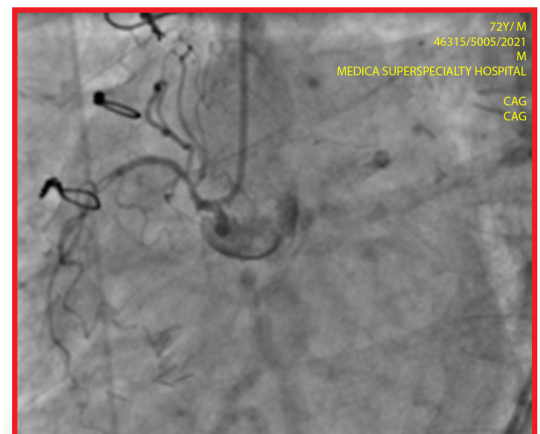
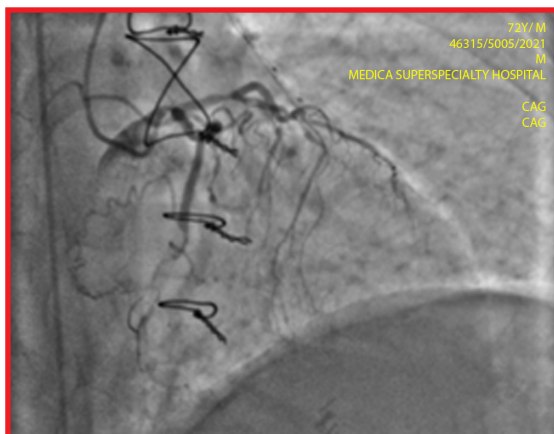
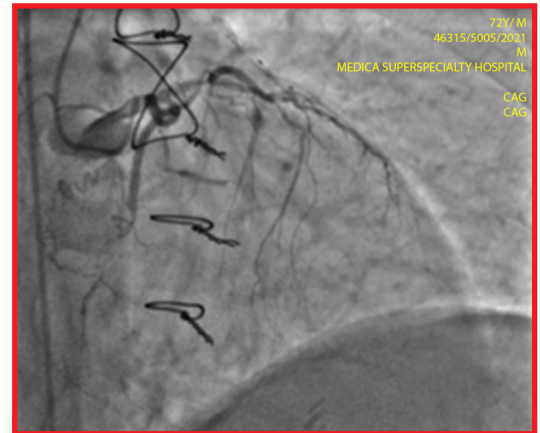
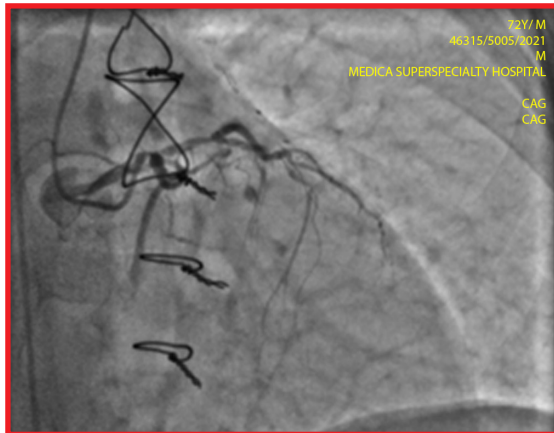
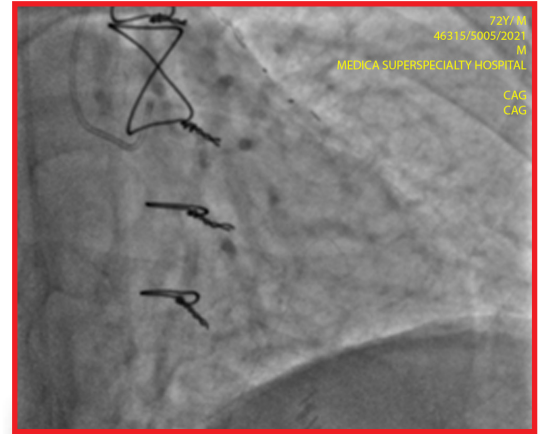
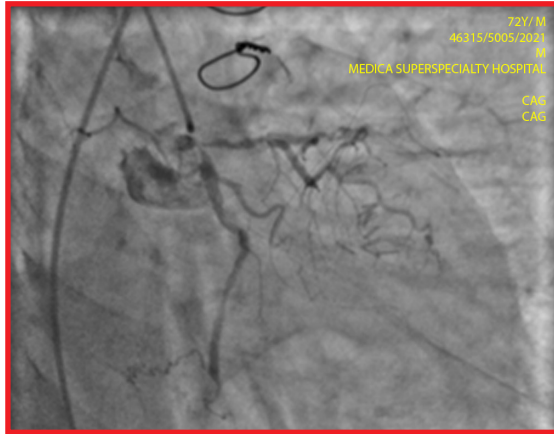
Procedure done - PTCA was done through right femoral approach and good flow was achieved in SVG-LAD graft.

Procedural Details:

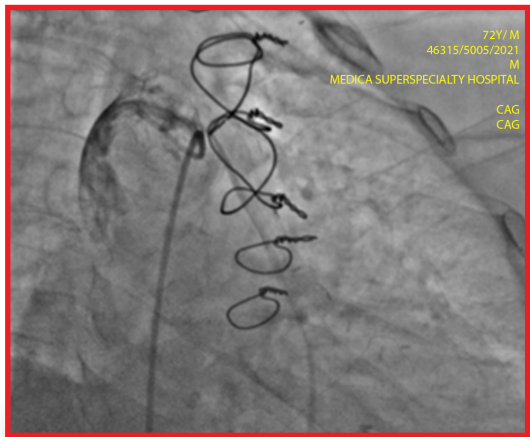
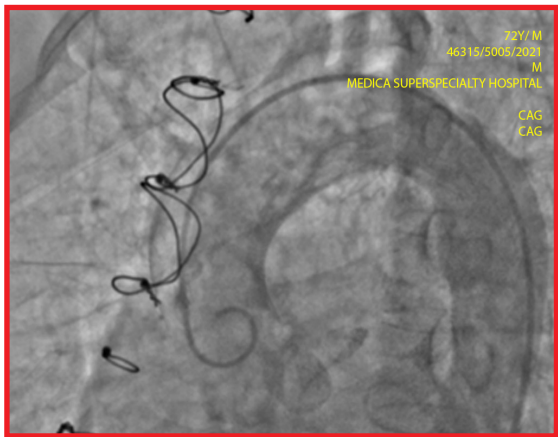
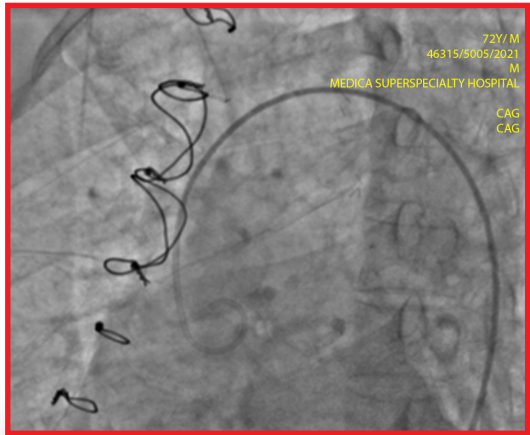
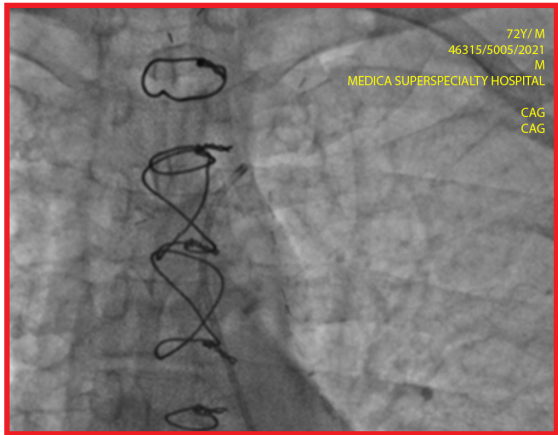
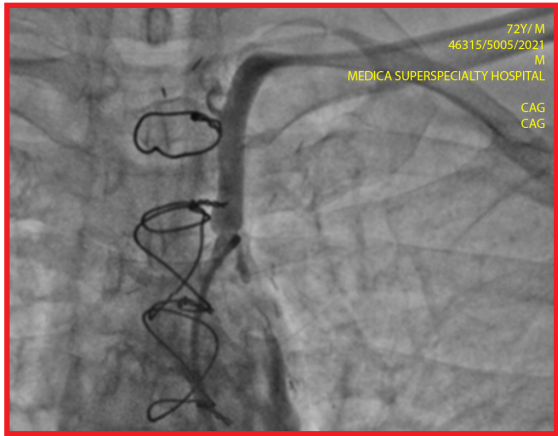
- PTCA was done through right femoral approach.
- 6F AR 1.0 guide catheter was used to engage the SVG to LAD graft.
- Asahi Sion Blue guide wire was taken to cross the lesion.
- Sequential pre dilatation was done with Ryurei 1.5 x 10 balloon at 12 atm and Ryurei 2.5 x 10 balloon at 14 atm, Yukon Choice PC 3.0 x 24 mm stent was deployed with the support of 6F Guidezilla supportive catheter at 12 atm.
- Stent boost guided sequential post dilatation was done with balloon Apollo 3.5 x 10 at 20 atm and Apollo 4.0 x 8 balloon at 22 atm.
- Post dilatation was done with high pressure balloon OPN NC 2.5 x 10 at 36 atm.
- Post stenting IVUS was done for confirming the stent apposition with 3.0F Opticross HD IVUS catheter and the measured MSA was 5.30 mm².

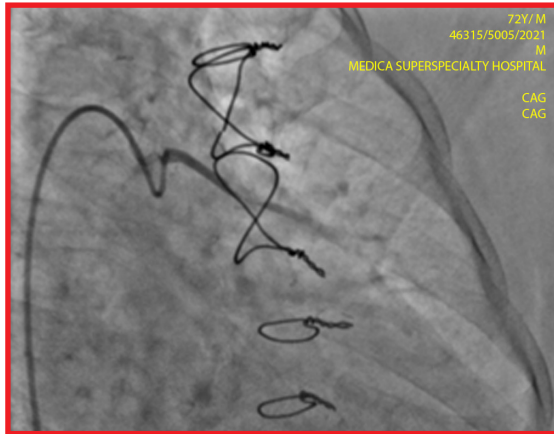
PRE-PROCEDURAL FINDINGS





CASE PROFILE SERIES





CASE PROFILE SERIES

DETAILS OF INVESTIGATION (FINDINGS) POST PROCEDURE:

ECG

- Sinus Rhythm.
- T wave inversion V1 - V4

ECHO – GOOD LV SYSTOLIC FUNCTION

Condition at the time of discharge: Stable

DISCHARGE ADVICE:

- Tab ECOSPRIN 75 mg 1 tab once daily at 10 pm (Do not stop without doctor's consultation).
- Tab CLOPITAB 75 mg tab twice daily at 10 am & 10 pm (Do not stop without doctor's consultation).
- Tab ROZAVEL 40 mg 1 tab once daily at 10 pm.
- Tab FLAVEDON MR 35 mg 1 tab twice daily at 10 am and 10 pm.
- Tab KORANDIL 5 mg 1 tab twice daily at 10 am and 10 pm.
- Tab GALVUS MET (50/1000) 1 tab once daily at 10 am.
- Tab ZORYL M (1) 1 tab once daily before breakfast to continue.
- Tab CONCOR 2.5 mg 1 tab once daily at 10 am.
- Tab ESLO 2.5 mg 1 tab once daily at 10 pm.
- Tab DYTOR 10 mg 1 tab once daily at 8 am.
- Tab MUCINAC 600 mg 1 tab twice daily at 10 am and 10 pm for 5 days.
- Cap PAN-D 1 cap once daily before breakfast.

INSTRUCTIONS TO WATCH FOR EMERGENCY:

- Chest pain/discomfort, shortness of breath, syncope, palpitation

GENERAL ADVICE:

- Proper medical management
- Oil, fat, salt restricted and diabetic diet

FOLLOW-UP

- Follow up after 30 days in Cardiology OPD with of CBC, FBS, PPBS, Na+, K+, Urea, Creatinine, ECG - 12 leads reports with prior appointment.
- In case of unwanted symptoms, visit Emergency department.

DISCUSSION

- Calcified non-dilatable lesions is a challenge for the interventional cardiologist. These lesions are developing more often in the catheterization laboratory as the total complexity of interventions are increasing. Stent under-expansion is the main risk factor for restenosis and thrombosis.¹
- The OPN NC balloon offers a new method of dilating lesions or under-expanded stents when other noncompliant balloons have failed in the catheterization process. The safety of OPN NC balloon is reasonable, even at pressures as high as 40 atm.¹

Ref: Díaz JF, Gómez-Mencheró A, Cardenal R, Sánchez-González C, Sanghvi A. Extremely high pressure dilation with a new noncompliant balloon. Tex Heart Inst J. 2012;39(5):635-638.



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