

The Efficacy of Angioscopy to Determine How to Treat ACS Patients with Coronary Dissection.

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Case1; A 82-year old man presented with acute heart failure and STEMI. Emergency coronary angiography revealed 90% stenosis at the distal LAD. IVUS study showed circumferential plaque formation at the distal LAD and coronary dissection with flap formation at the more proximal site. Although the intravascular lumen area was maintained, it was highly possible that the dissected site was the true culprit lesion. The angioscopy was performed to verify vulnerability of the dissected site. Angioscopic findings showed localized coronary artery dissection, but there was no red thrombus formation. Furthermore, vulnerable plaque that looked yellow color was seen at the more distal site only. Hence we implanted the DES at the distal site.

Case2; A 86-year old woman presented with UAP. Emergency coronary angiography revealed 90% stenosis at the mid RCA with spontaneous coronary dissection. IVUS study showed partially attenuated plaque, and thrombus formation was suspected. The angioscopy was performed to determine the need for distal protection. Because angioscopic findings showed only localized yellow plaque, and no red thrombus, we decided not to use distal protection device. DES was directly implanted at the lesion, without distal embolization. Angioscopy is the only modality that can provide the direct view of the lesion, detailed assessment of the lesion characteristics or vulnerability. Direct intravascular view from angioscopy was effective in deciding how to treat ACS patients with coronary dissection.