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A 80 years female underwent percutaneous coronary intervention (PCI) for acute inferior myocardial infarction in the prior hospital and, a stent was successfully implanted in the right coronary artery (RCA). However, she had severe stenosis of the left main trunk(LMT), the proximal segment of the left anterior descending artery(LAD) and left circumflex artery(LCx) with heavily calcified plaque and, she was transferred to our hospital for the treatment to residual lesions. The SYNTAX score was 27. The echocardiography showed akinesis of the antero-septal and apex wall , and low ejection fraction(EF:18%). Her past medical history included mitral annuloplasty. Additionally, she required intra-aortic balloon pumping(IABP) and hemodialysis(HD). She underwent a elective IVUS-guided PCI, because she was surgical high-risk patient with a Society of Thoracic Surgeons (STS) score of 58% and the Japan score of 50%. After the crossing wire, rotational atherectomy for LMT to LAD and LCx with 1.75-mm burr and predilatation for LCx with 3.0 mm non-compliant balloon was performed. Synergy stent 3.5 x 24 mm was implanted in the LMT to proximal LCx. Postdilatation using 2.5 mm compliant balloon and 3.0 mm non-compliant balloon was performed at the bifurcation of LAD-LCx to attempt a kissing balloon inflation at the end of the procedure. As her hemodynamic status was improved, IABP was removed on the next day, and she got off HD 7 days after the PCI. She was discharged 30 days after the procedure without complication.