

1009 Case; Two different interventions to the same post-CABG patient with ostial LM calcified lesion

A 74-year-old male was admitted to our hospital for acute heart failure (HF) with reduced ejection fraction (EF 36.8%). He had diabetes mellitus, kidney dysfunction (estimated glomerular filtration rate was 38.7 ml/min/1.73m<sup>2</sup>), and past history of F-F bypass surgery. HF was exacerbated in spite of the medical management during admission. CAG revealed 90% narrowing at ostial left main (LM), accompanied with severe calcification, and he was referred to urgent CABG. LITA was anastomosed to LAD, but LCx could not be bypassed due to the hemodynamic instability.

Because of insufficient improvement of HF after CABG, we underwent CAG again. LITA patency and no stenosis at LM bifurcation were confirmed (CD-ROM No.1). In this situation, PCI to ostial LM would increase the blood flow to LCx, but might cause LITA failure. At this time, we could find the stenosis of left subclavian artery (LSCA) with 20mmHg pressure gradient. We performed EVT to LSCA, resulted in the dramatic improvement of HF (CD-ROM No.2).

Fifteen month later, he admitted for the re-exacerbation of HF. Angiogram demonstrated LITA patency without LSCA restenosis and the progression of the stenosis and calcification at ostial LM (CD-ROM No.3). Stress scintigram revealed the significant ischemia in LCx region. So, we determined to perform PCI with rotational atherectomy to calcified LM ostial lesion.

Because of the pulse weakness of left radial artery after CAG, PCI was performed via right transradial approach with 7Fr JL3.5SH. IABP was only stand-by, due to limited access site. XT-R could cross the lesion, but Caravel MC could not pass because of poor back-up force and tight stenosis. Fortunately, Rota floppy wire barely cross the lesion. So, we performed rotational atherectomy with 1.25mm burr, and then increased the burr size to 1.75mm. After the rotational atherectomy, we performed pre-dilation with scoring balloon, following by the DES implantation (CD-ROM No.4). After the PCI, HF was improved again.

Herein, we report a case with ostial LM lesion after CABG who underwent two different interventions to residual myocardial ischemia.