

1161 **Rotational atherectomy at LM-ostial LAD enhanced wiring to a reverse angle of ostial LCX in LM true bifurcation.**

Osit Bambat¹

¹ Department of Internal Medicine, Chiangrai Prachanukroh Hospital, Thailand

[Case]

A 81 years old woman with underlying T2DM, HT, DLP, NASH and cirrhosis. She presented with dyspnea on exertion and had limited daily activity. ECG 12 leads were normal. The echo showed normal LV systolic function. Dobutamine stress echo revealed stress induced myocardial ischemia at anterior wall. She was scheduled for coronary angiography in the OPD case. But she was admitted due to NSTEMI before the appointment.

[Coronary angiogram]

There was LM bifurcation lesion with Medina 1-1-1. The distal LM was 90% stenosis and ostial LAD was 99% stenosis. The ostial of LCX was 99% stenosis and was arising from the bottom of ostial LAD which made a reversing angle from LM.

[Strategy]

LM bifurcation using 2-stent techniques (Culotte) under IVUS guidance. EBU3.5 7Fr guiding catheter. Using rotablator 1.75 burr to ablate LM-ostial LAD lesion rather than balloon because avoid dissection and for opening more space to wiring to ostial LCX. Use a dual lumen microcatheter with a large curve of polymer coated wire and try to get into the reverse angle LCX. Then using rotablator 1.75 burr to ablate LM-ostial LCX lesion then study IVUS in both vessels. Using a cutting balloon in both LAD and LCX. Do the 2-stent Culotte techniques as usual (DES#1 3.5x29 mm at LM-LAD, DES#2 3.5x26 mm at LM-LCX, POT at LM with NC 4.5x8 mm with kissing balloon inflation). Final check IVUS and final angiogram was done.

[Final result]

The final IVUS showed good stent expansion about 85% in both LAD & LCX without distal edge of stent dissection. MSA at ostial LAD was 9.14 mm², at ostial LCX was 10.10 mm² and at LM was 15.11 mm².

The final angiogram showed TIMI 3 flow in both LAD and LCX. No distal edge of stent dissection.