1029 OCT GUIDED STENT OPTIMISATION

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65 years old female

ACS ? NSTEMI

K/C/O Carcinoma right breast (T4bN1M0) ? modified radical mastectomy done on Chemotherapy

Lymphedema on right upper limb with Morbid obesity (98 kgs)

Left Trans radial CAG showed significant OM ostial lesion with normal LMCA, LAD And non-dominant RCA.

Underwent sequential predilatation of OM with 2mm NC balloon followed by 2.5 mm NC balloon. OCT run was made and then stented from mid LCX into OM with 2.75x33 mm Xience Xpedition at nominal atmospheres followed by post stent dilatation with 2.75x10mm NC balloon up to 16 atm.

Post stent OCT done which showed severe malapposition with floating proximal stent in the LCX.

High pressure post dilatation again done in proximal LCX part of stent with 4mm x 8mm NC balloon up to 18 atm.

Repeat OCT continued to show severe malapposition with floating proximal stent in the LCX.

Another 4x12mm Xience Xpedition stent was deployed proximally into the previous stent and then post dilated with 5x8 mm NC balloon up to 18 atm.

Final OCT run showed good proximal stent expansion without significant malapposition

LEARNING POINTS

1.WHENEVER THER IS A SIZE DISCREPANCY ALWAYS PLAN 2 STENTS (OVERLAPPING STRATEGY)

2.IMAGING IS A MUST IN OPTIMIZING PCI IN SUCH PATIENTS

3.STENT SELECTION BASED ON STENT MODEL DESIGN AND MAXIMUM EXPANSION CAPACITY IS CRUCIAL IN TREATMENT OF LARGE ARTERIES WHERE OVEREXPASION IS NEEDED.