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## Case Report

# Emergency stenting of unprotected left main coronary artery occlusion using bare metal stent with good long-term results – A case report



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## ARTICLE INFO

## Article history:

Received 12 June 2015

Accepted 16 June 2015

Available online 15 July 2015

## Keywords:

PTCA

LMCA

Bare metal stent

Excellent results

## ABSTRACT

Critical narrowing of the left main coronary artery (LMCA) is a high-risk condition associated with an increased mortality rate.

Currently the gold standard for treatment of LMCA occlusion is coronary artery bypass grafting, however stenting with drug-eluting stent (DES) is performed in patients who are not suited for surgery or refuse the same.

Studies that have compared bare metal stents (BMS) with DES in percutaneous stenting of the LMCA have shown results in favor of DES, however in many of these studies the rates were unadjusted thereby exposing them to the risk of confounding and selection bias.

We present a case of critical LMCA narrowing that had a complicated course in the hospital; the patient refused surgery and also was not able to afford the costs associated with stenting with a DES; he successfully underwent PTCA with stenting of the LMCA using a BMS as a life saving procedure. Long-term results over 2 years of follow up were excellent.

While uncertainty regarding use of DES or BMS in LMCA stenting does exist, stenting with DES must be preferred over BMS. In unforeseen circumstances, demanding immediate action, which may occur in emergencies when a patient is unable to opt for DES, use of BMS can be considered.

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<http://dx.doi.org/10.1016/j.jicc.2015.06.008>

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## 1. Case history

A 75-year-old male patient presented to the cardiology outpatient department with complaints of angina on exertion and exertional dyspnea since one year. Initially, the angina and dyspnea were class II but they had gradually progressed over the last year to the present status of class III-IV as per New York Heart Association (NYHA) functional classification.

The patient was a chronic smoker who had a 50 pack year smoking history; he was a non-alcoholic who chewed tobacco occasionally. He was non-diabetic and non-hypertensive.

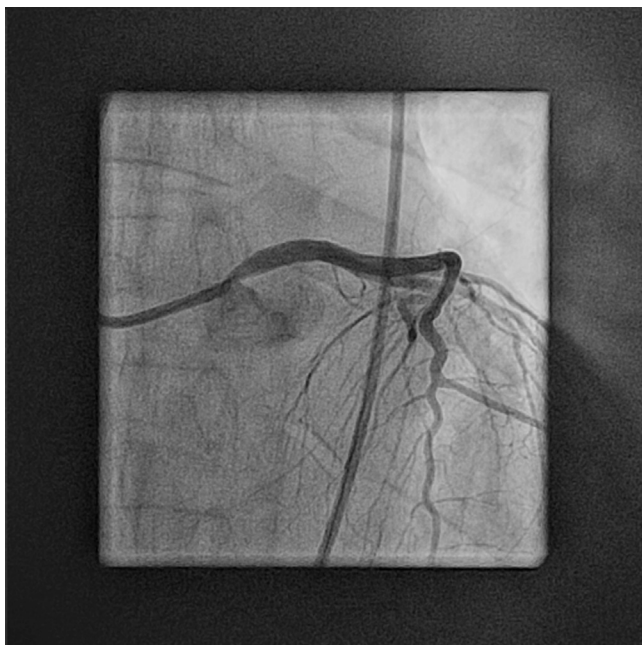
He also gave a history consistent with chronic bronchitis and used the albuterol inhaler occasionally.

An ECG done on initial evaluation revealed T wave inversions in inferior leads and slight ST segment elevation in aVR. ECHO done revealed a hypokinetic anterior wall with an ejection fraction of 35% and mild to moderate left ventricular dysfunction and there was mild TR with no chamber enlargement.

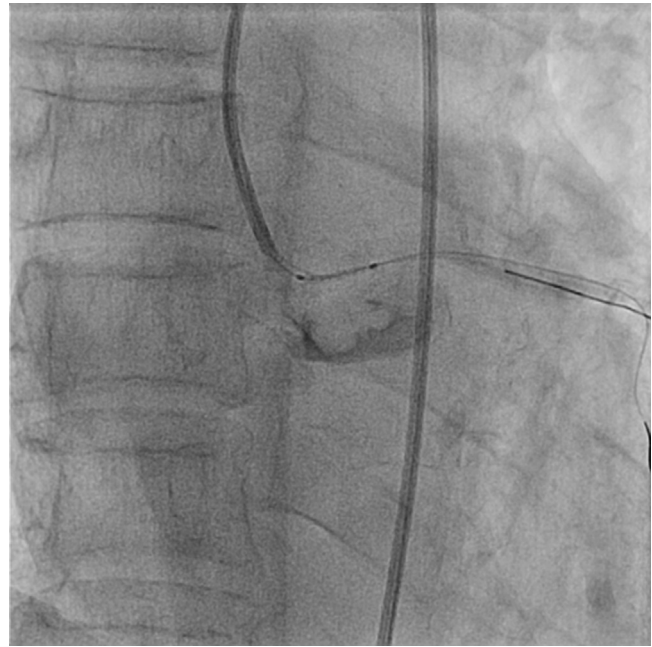
The patient was advised to undergo a coronary angiogram, which revealed 70% occlusion of the left main coronary artery (LMCA) (Fig. 1).

The patient was counseled regarding the available treatment options that included CABG, stenting with drug eluting, and bare metal stents (BMS).

The pros and cons of each treatment modality were discussed at length with the patient and his first-degree relatives. Owing to the existing co-morbidity of chronic bronchitis and a long-standing smoking history, the patient was unsuited for CABG. The patient too refused to give consent for the surgery; the patient also could not afford to manage the expenses of a drug-eluting stent (DES), as he requested a day to decide on the treatment options. We chose to keep the patient



**Fig. 1 – Coronary angiogram of the patient showing >70% narrowing of the LMCA.**



**Fig. 2 – Image showing passing of the wire and balloon across the lesion.**

in the ICU in view of the critical and unprotected quality of the LMCA occlusion.

Early next morning, the patient developed acute pulmonary edema, became severely breathless and also complained of severe chest pains. There were no fresh ECG changes but ECHO revealed severe LV dysfunction with an EF below 30%.

The patient and his close relatives continued to refuse emergency surgery and requested us to perform a PTCA using a BMS instead of a DES again citing economic reasons. The patient was taken up from emergency PTCA and the LMCA was stented using a BMS (Figs. 2-4).

The patient showed prompt recovery from the pulmonary edema, which resolved over the next 48 h; also, his LV function progressively improved during his stay in the hospital to an EF of 40% at the time of discharge.

The patient was put on long-term aspirin and clopidogrel prophylaxis as per guidelines and discharged after a week.

The patient remained asymptomatic during each of the monthly follow-up visits. There were no major adverse cardiac events, ECG changes, etc. and a coronary angiogram done after a year of PTCA showed TIMI III flow with no evidence of restenosis.

## 2. Discussion

It has been observed that around 4% of patient's undergoing angiography have unprotected left main coronary artery (ULMCA) disease.<sup>1</sup> Since the mortality rate in patients with ULMCA is higher in those managed medically, it is recommended that such patients undergo revascularization.<sup>2</sup>

Although CABG continues to be the preferred mode of treatment in patients with ULMCA, there is a considerable

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