

Presentazione del caso

Uomo, 67 aa
173 cm x 88 kg

FRCV: ex-fumo, familiarità per CAD, dislipidemia, diabete mellito di tipo II.
COMORBIDITA': pregressa gotta.

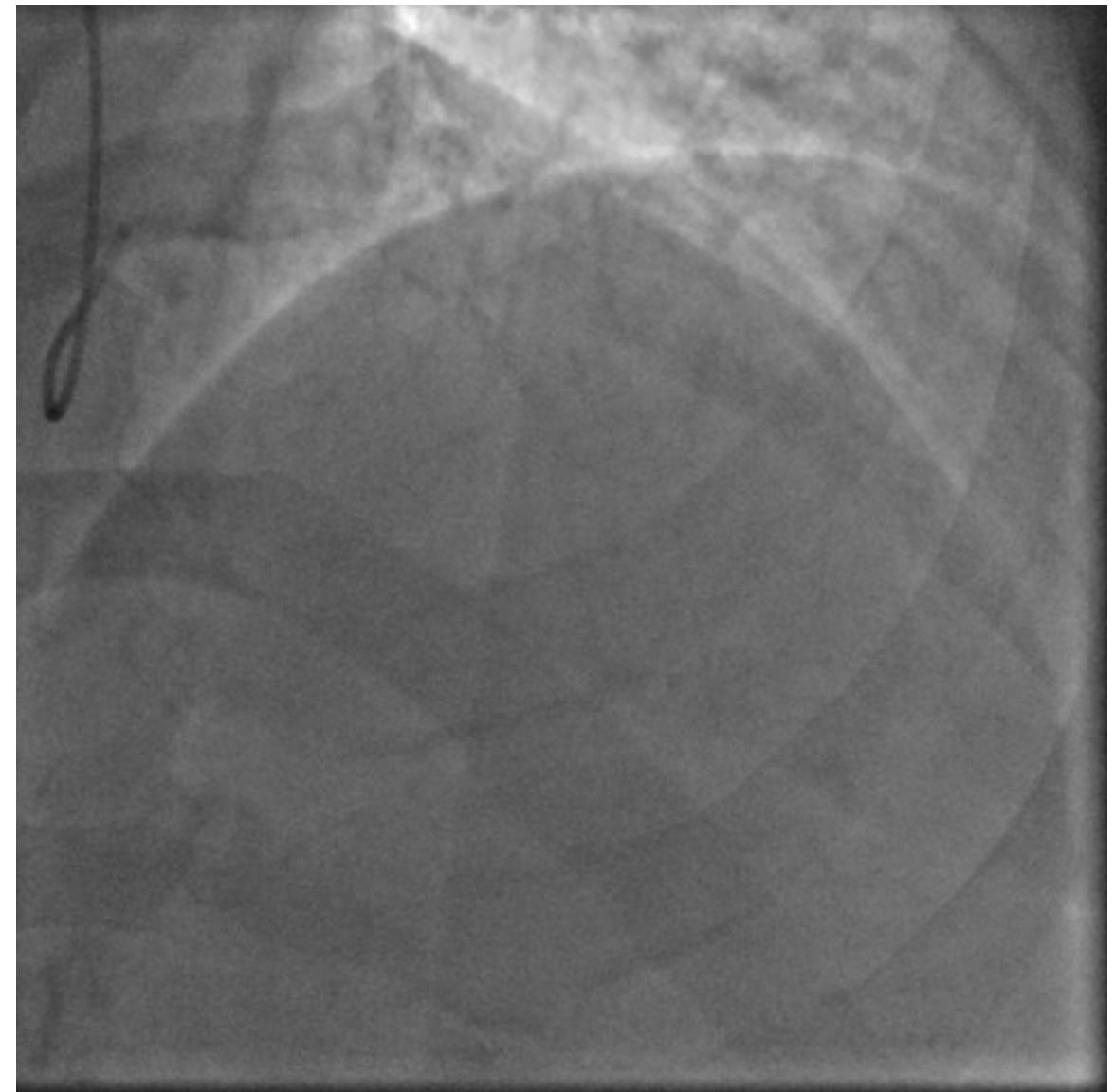
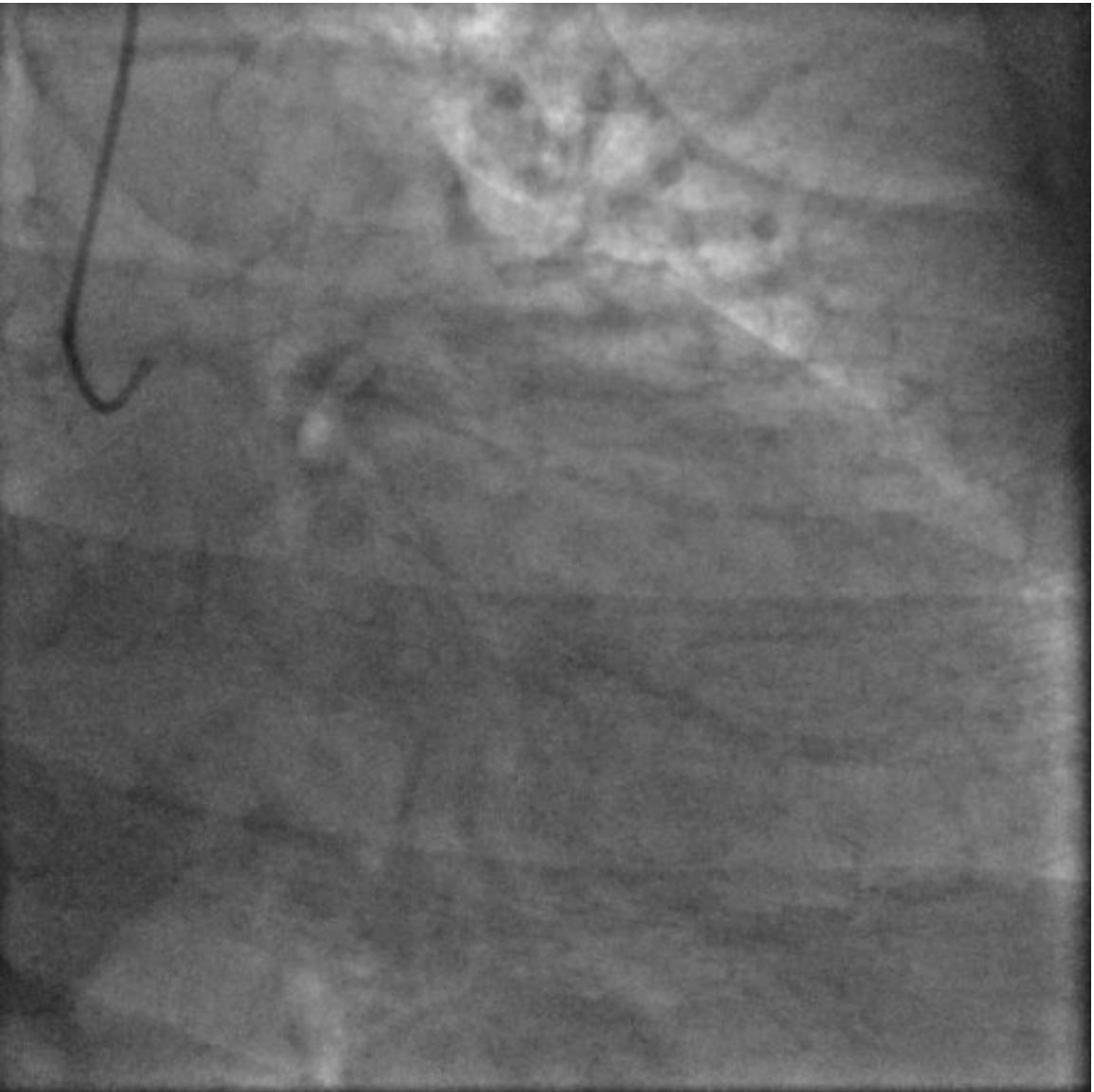
ECG (06/2022): RS 68 bpm, normale conduzione AV, BBD e DAS. Alterazioni aspecifiche della ripolarizzazione ventricolare

- **Ecocolordoppler grafia cardiaca (06/2022):** rimodellamento concentrico ventricolare sinistro (SIV 11 mm). Non alterazioni della cinesi (FE 54%). Normali dimensioni batriali e della radice aortica. Ventricolo destro nei limiti per dimensioni e funzione sistolica longitudinale (TAPSE 33 mm). Lieve IM. Lieve IT con PAPs stimata di 28 mmHg. Pattern transmitralico da alterato rilasciamento

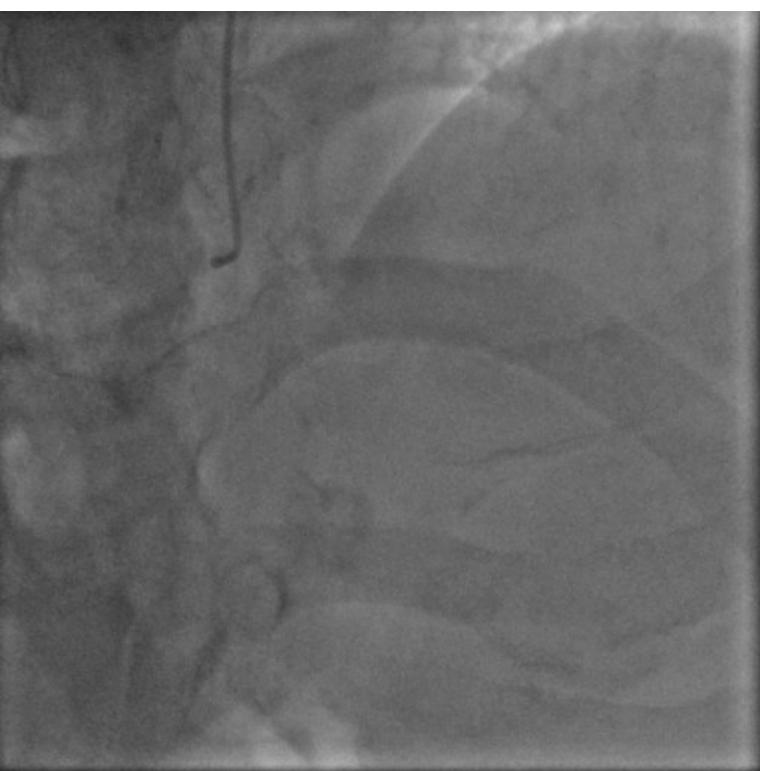
Anamnesi cardiologica

A maggio 2022 è stato eseguito TDS dubbio per ischemia inducibile, 150W con DP 21760 e sfumato sottoST in laterale in assenza di sintomi. E' stato quindi consigliato un approfondimento diagnostico mediante TC coronarica, eseguita c/o il nostro centro il 29/06/2022, con riscontro di ateromasia coronarica calcifica critica trivasale (subocclusione di IVA medio-distale, D1 ostio-prossimale e CX-MO al tratto medio).

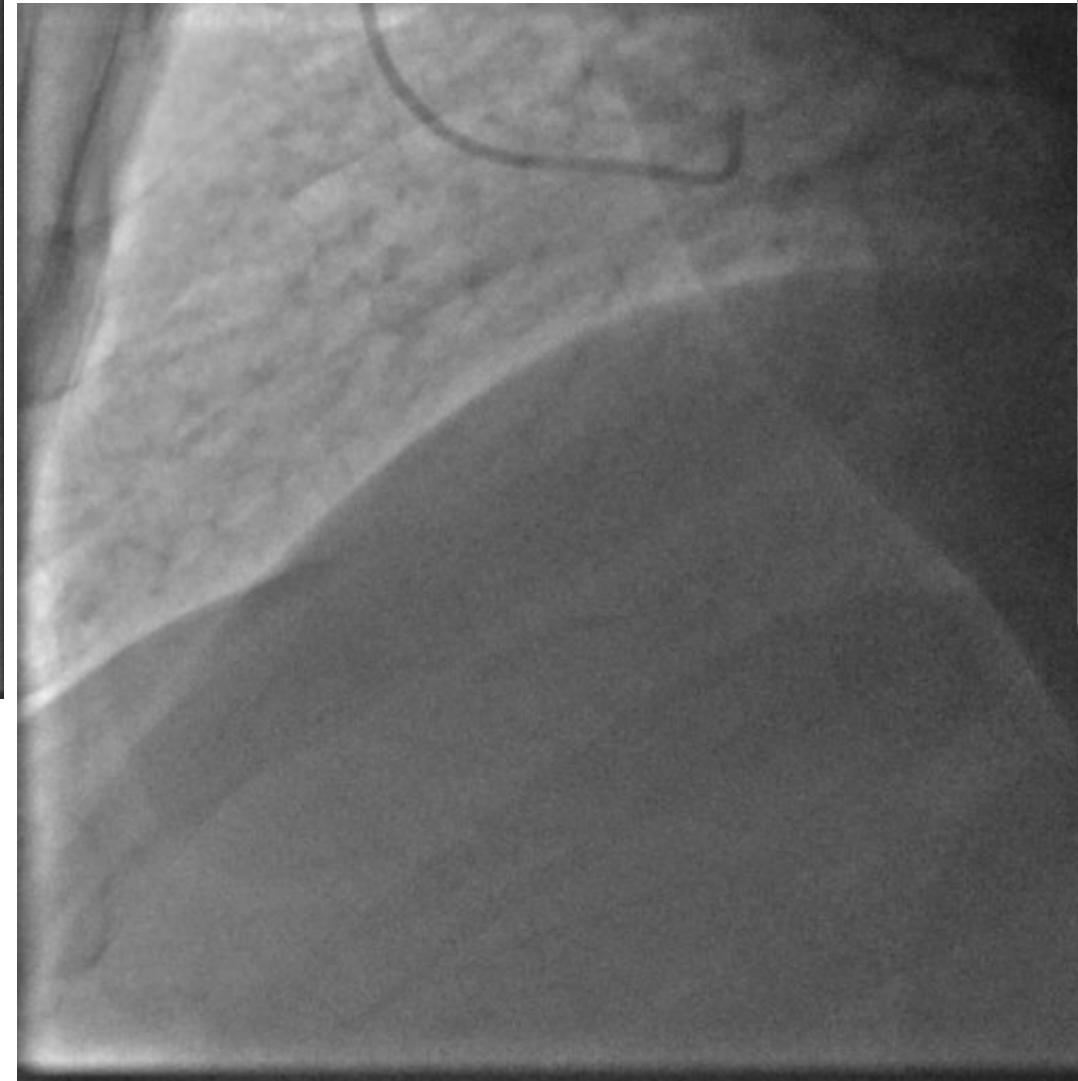
posta indicazione a ricovero elettivo per esecuzione di coronarografia



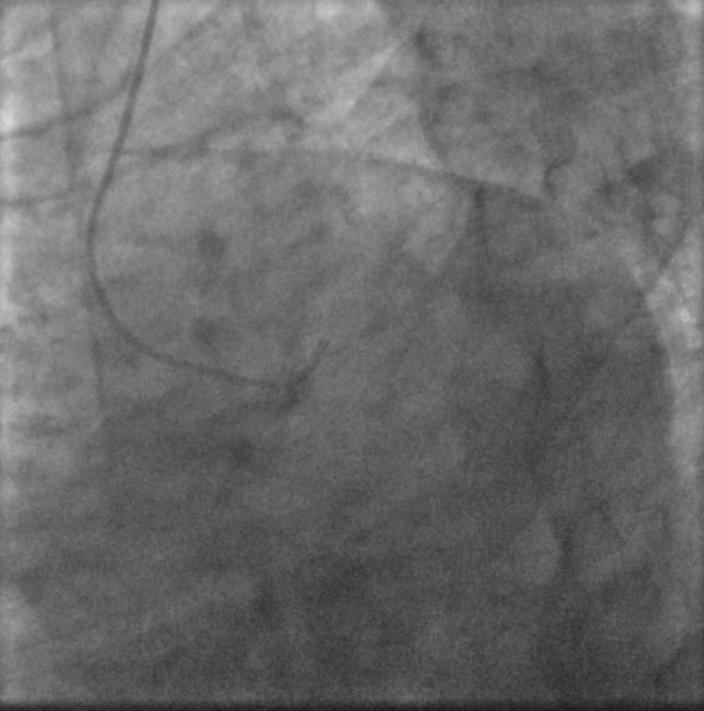
Stenosi significativa TC, malattia critica/subocclusiva calcifica plurifocale su IVA, subocclusione di D1 ostiale
Stenosi critica Cx ostiale e tratto medio dopo emergenza di MO1. Collaterali per PL di CD occluso



Stenosi critica di IVP ostiale



Infiltrazione diffusa della distalità dell'IVA



Malattia trivasale calcifica con coinvolgimento del TC e CTO di PL di CD in paziente con DM II

Syntax score 40

VP CCH (27/7/2022):

Presa visione delle immagini dell'angiografia coronarica: malattia trivasale severa con lesioni diffuse a carico dell'IVA media e distale e stenosi subcritica del TCCS. Discusso il caso con l'emodinamista, dr. Soriano: è fattibile la rivascolarizzazione percutanea dal pdv tecnico.
- Si ritiene sfavorevole il rapporto rischio/beneficio di un intervento chirurgico di bypass coronarico a causa dell'anatomia dell'IVA. Cordialità,

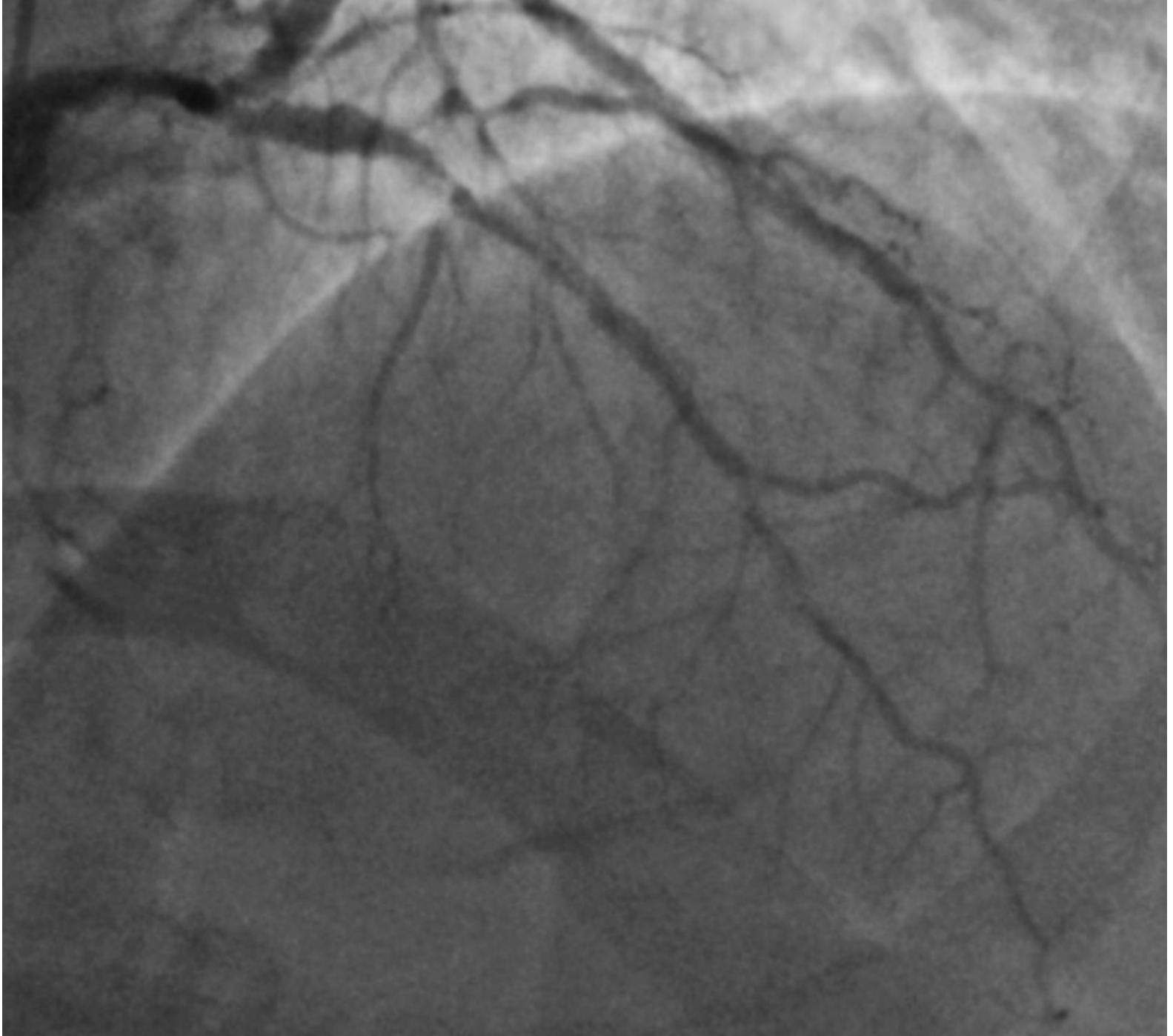
27/7/2022

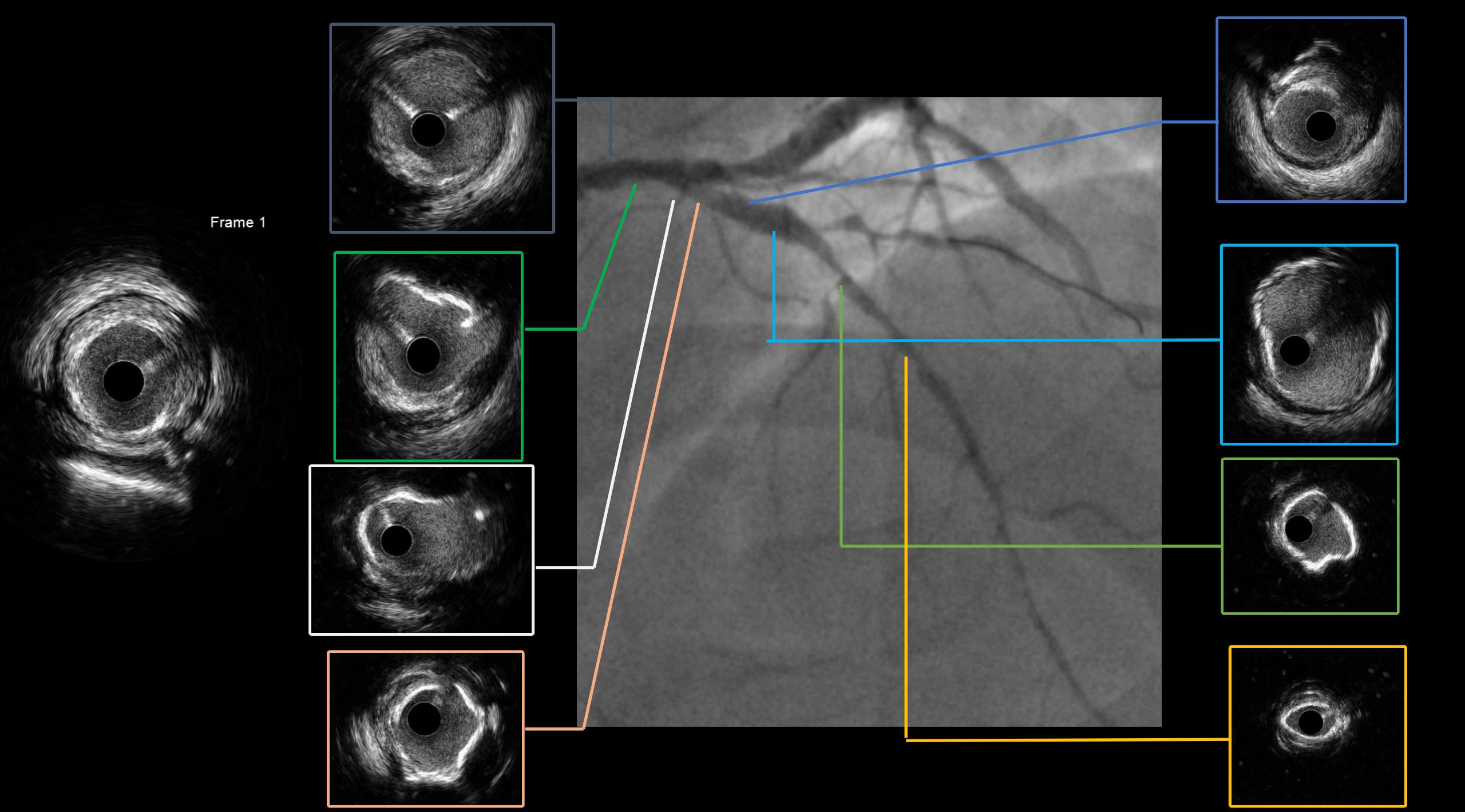
Arruolato nello Studio Optimal
Randomizzato nel braccio IVUS

28/7/2022

PCI TC-IVA-CX

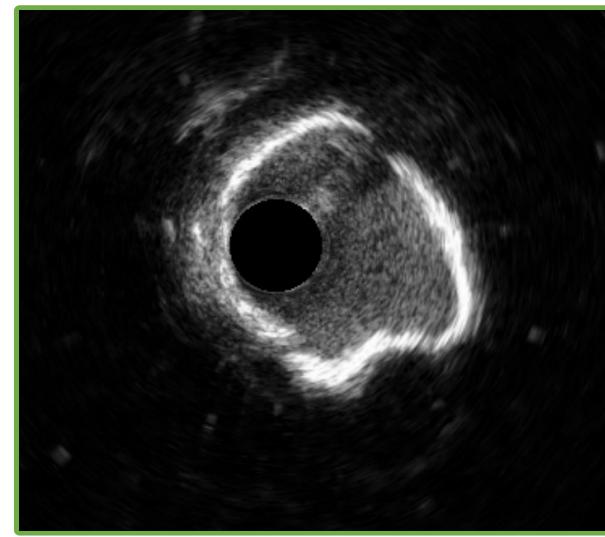
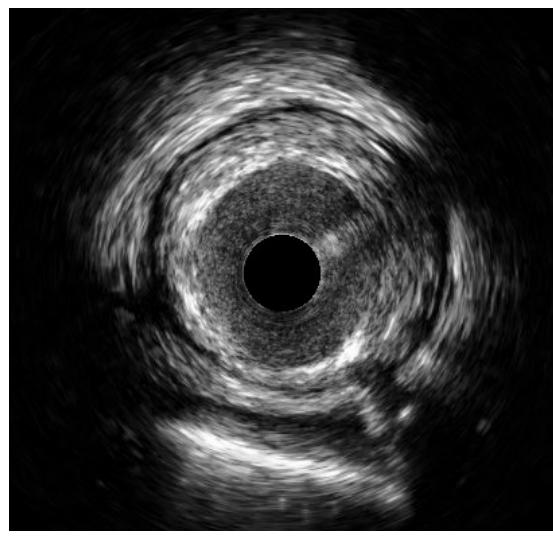
Accesso radiale destro 7F





Frame 1

Quale metodica di Plaque modification?



Cutting/scoring balloon
Intravascular lithotripsy
Aterectomy rotazionale
Aterectomy orbitale



ROTATIONALATHERECTOMY

ORBITALATHERECTOMY

The luminal gain with RA is related to the burr size, and if a larger lumen is needed, more devices are required, which can be costly and time-consuming. Larger burrs (1.75 mm) require 7F guiding catheters



Burr is always in contact with the plaque, not allowing blood and debris to flow beyond the burr, increasing the risk of thermal injury, platelet activation, distal ischemia, no-reflow phenomenon, and periprocedural MI

Increasing the speed of rotation and slowing advancement can help achieve larger luminal gains without the need to exchange the device, and it can be done through a 6F guiding catheter.



risk of burr entrapment, as the RA only ablates in an antegrade way



1.25mm Crown allows blood and particulates to flow during and between activations, reducing the risk of ischemia, distal embolization, and complete heart block.

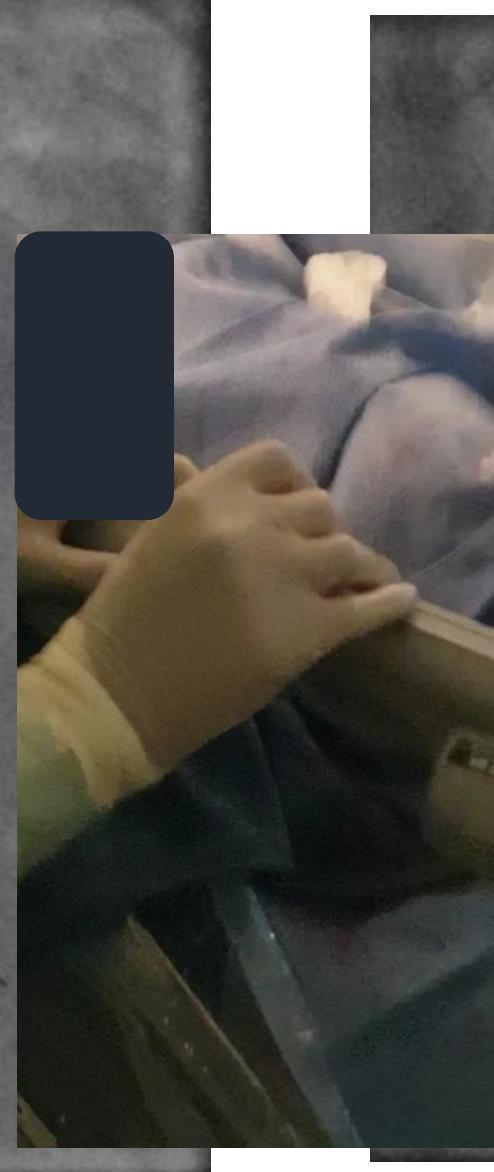
OA associated with a lower risk of MI, ischemic stroke, ventricular tachycardia, and complete heart block.

The bidirectional ablation ability with the OA, combined with the small crown size, minimizes the risk of crown entrapment

OA results in more modification of the plaque with longer cuts and deeper dissections compared with RA
OA was associated with a higher risk of coronary perforation and pericardial tamponade

unclear data regarding use in small (≤ 5 mm) or large (> 10 mm)

Aterectomia Orbitale



80.000 rpm IVA media - 120.000 rpm TC-IVA prossimale

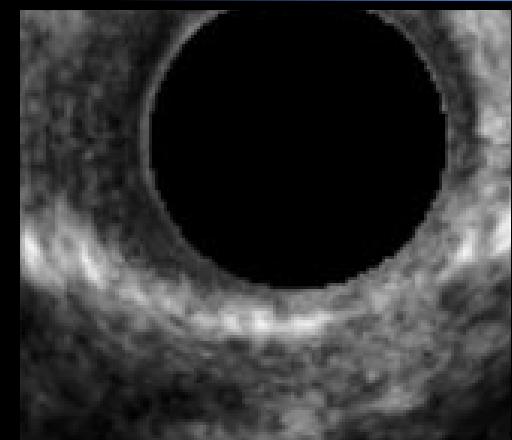
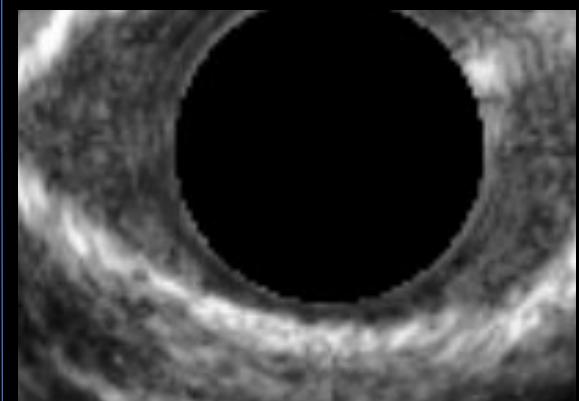
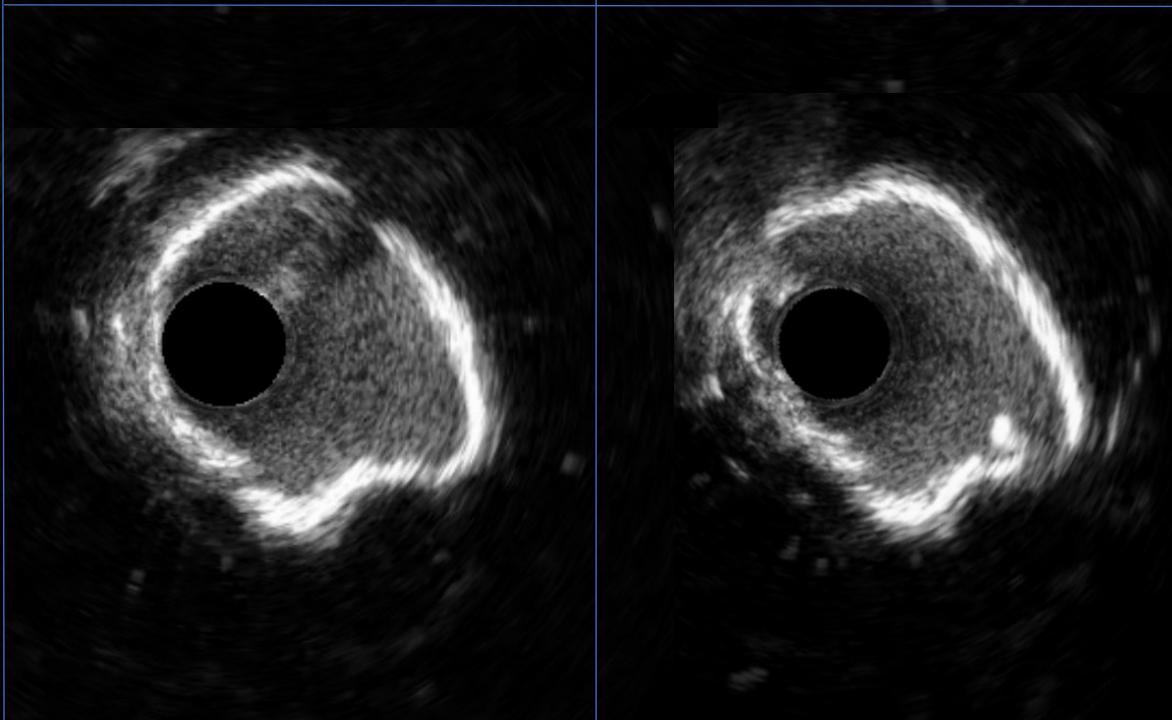
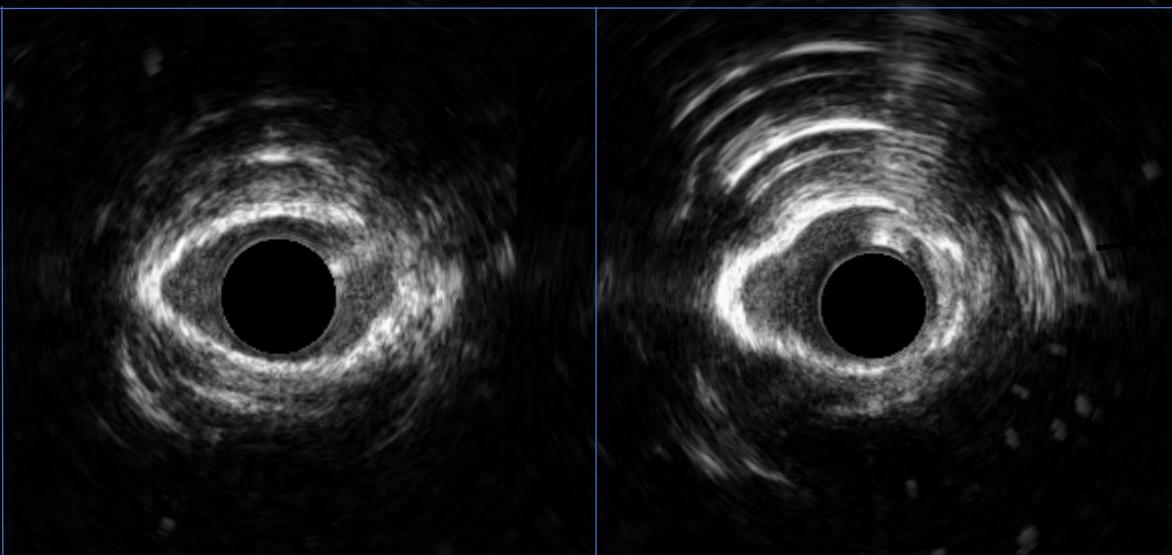
ORBITAL ATHERECTOMY
IVUS FINDINGS

PRE

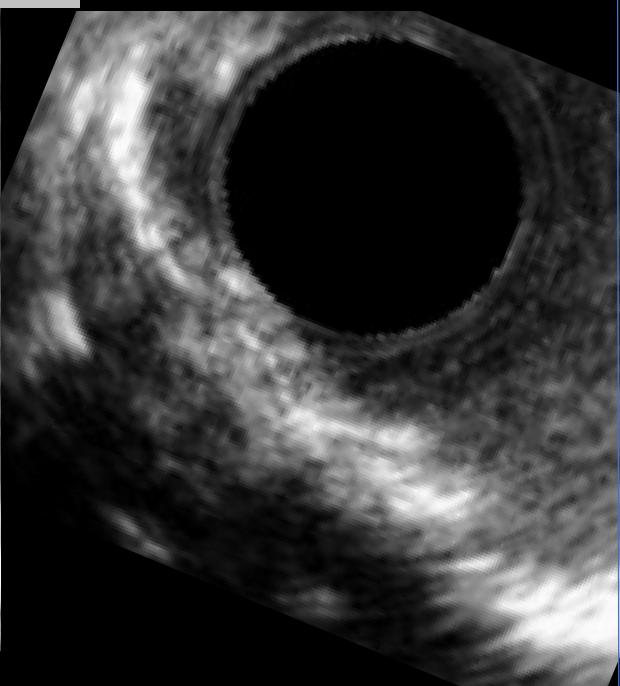
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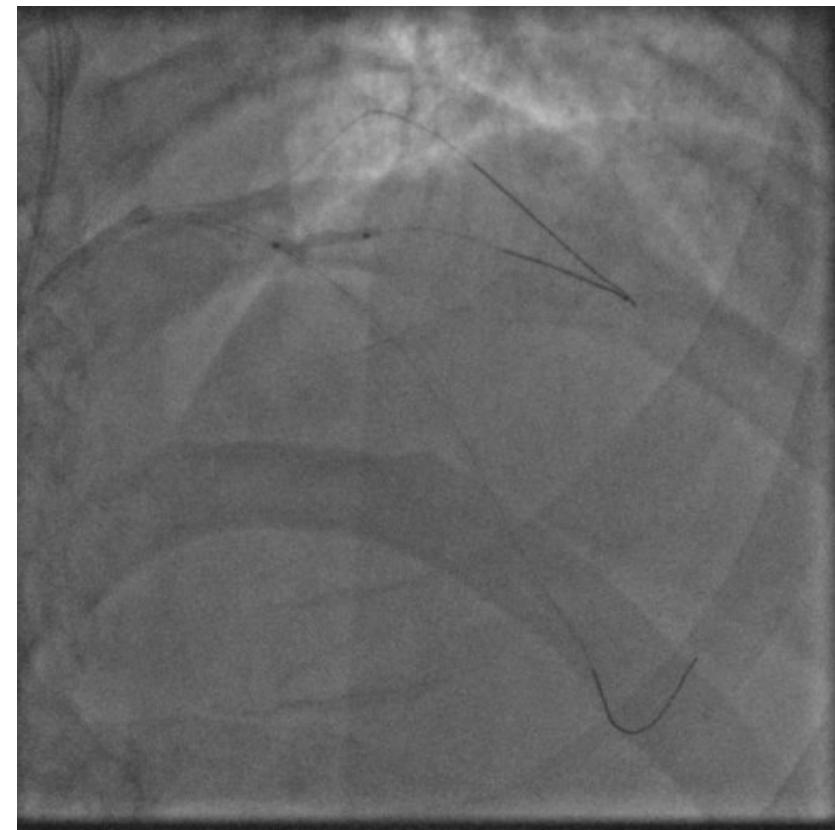
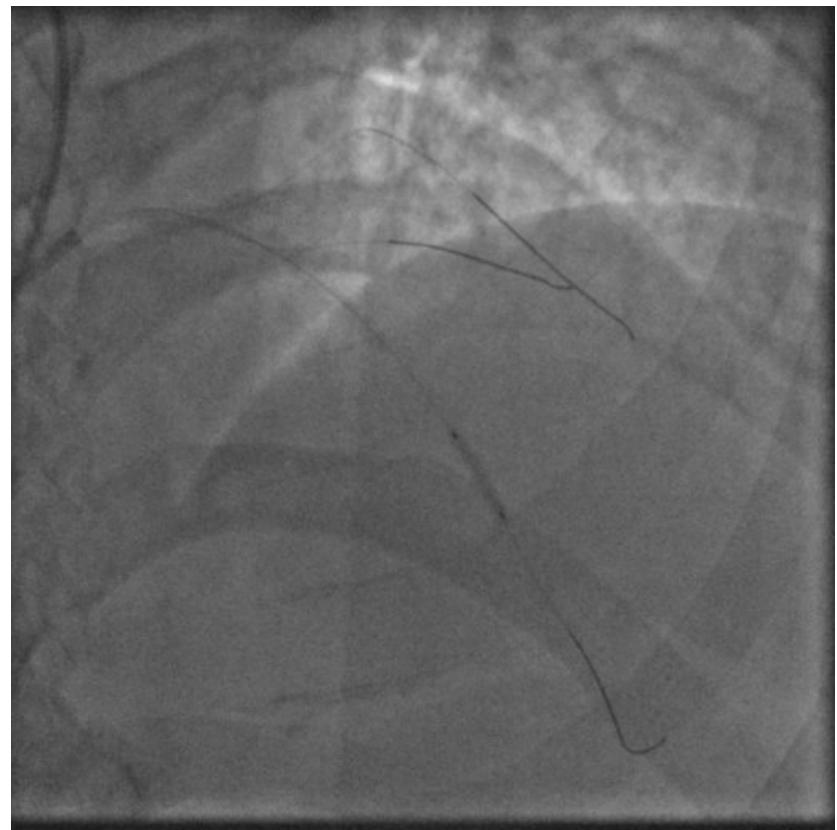
PRE

POST

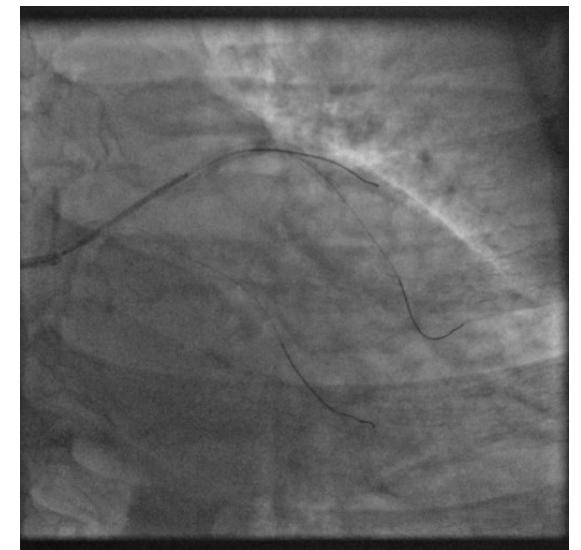
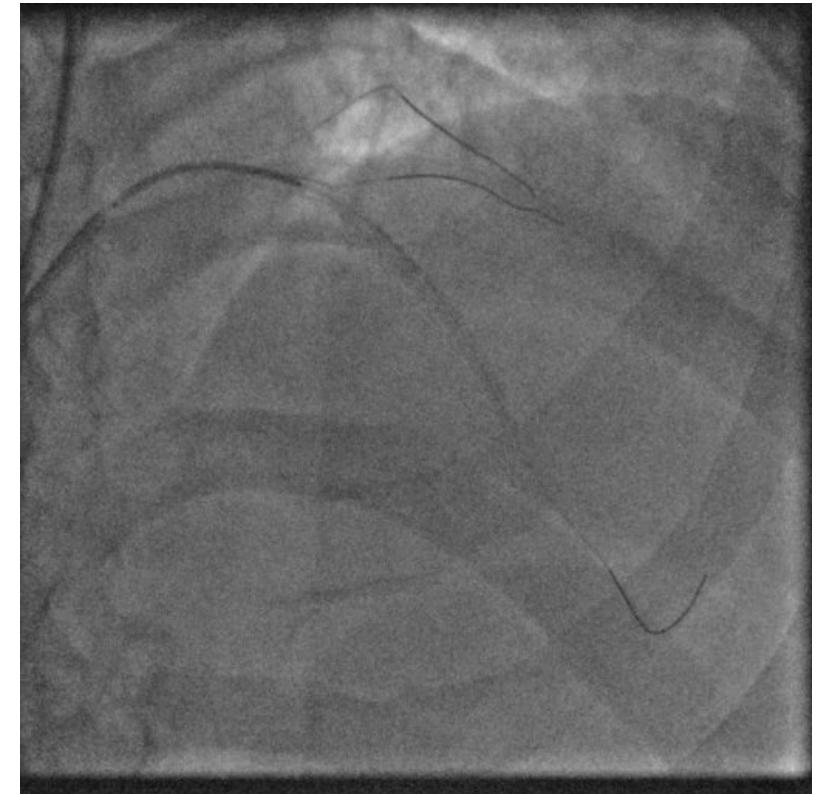
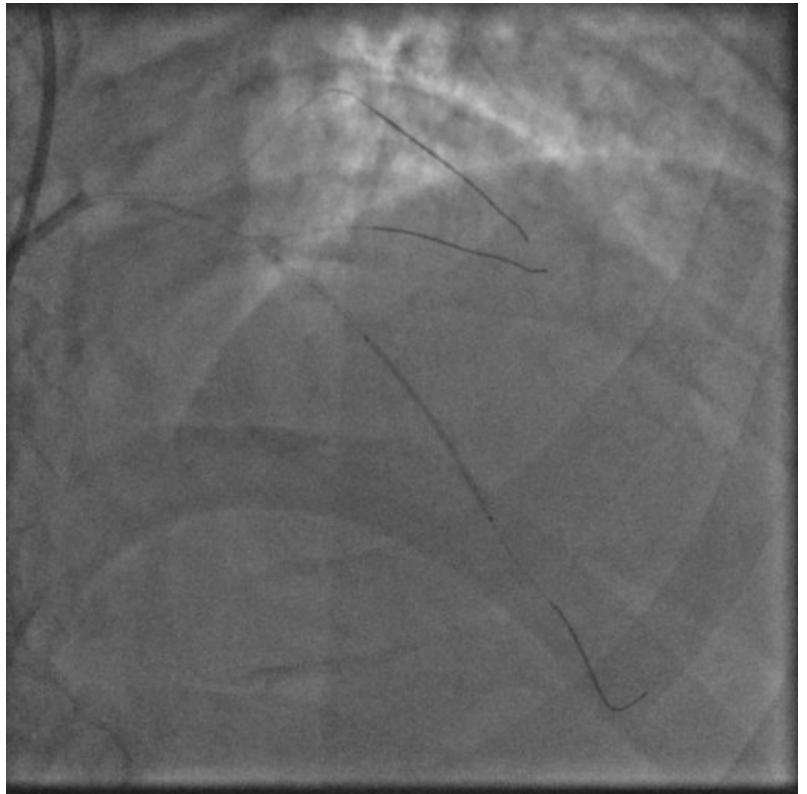


Zoom in

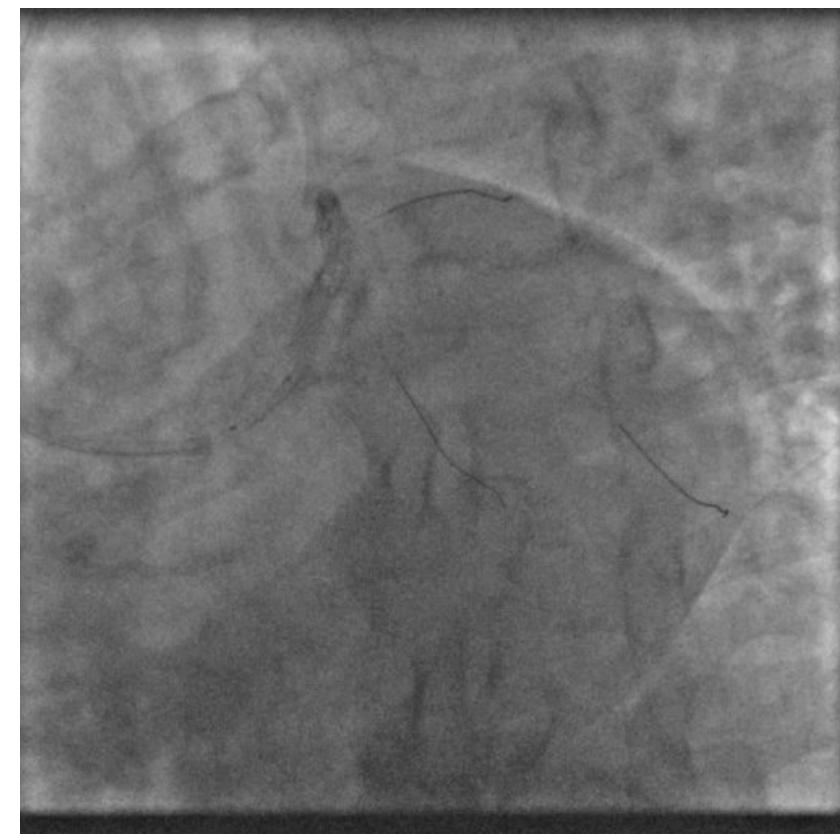
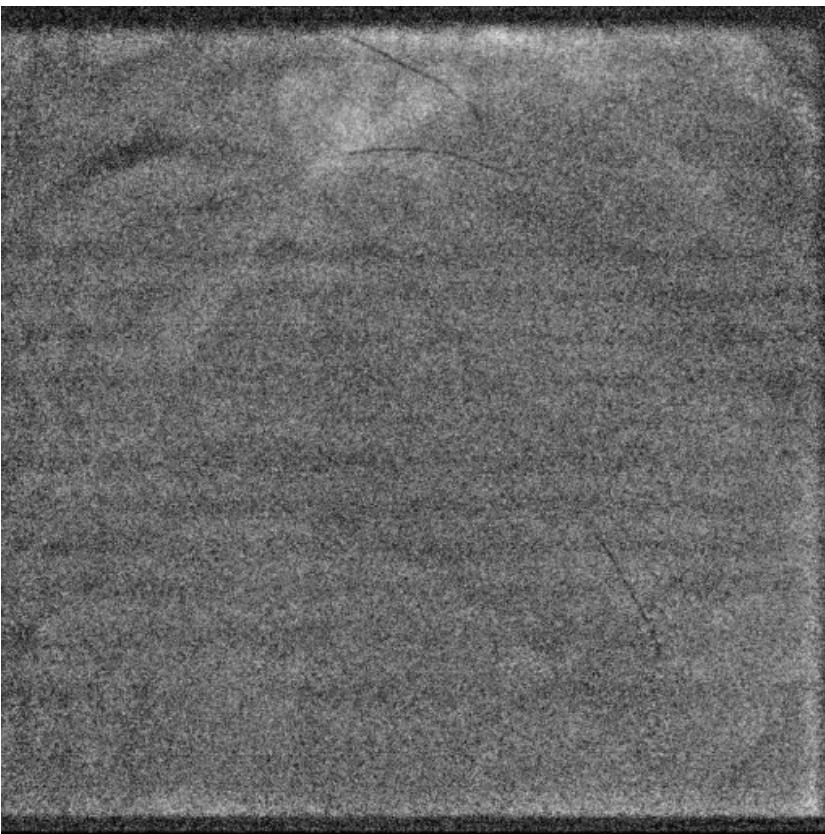
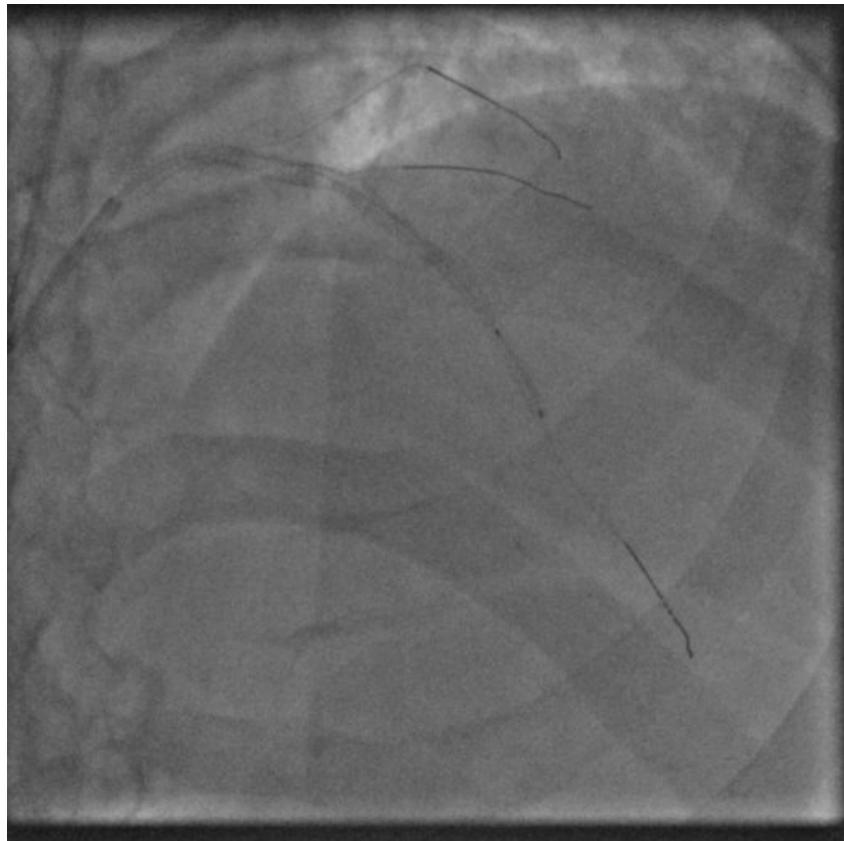




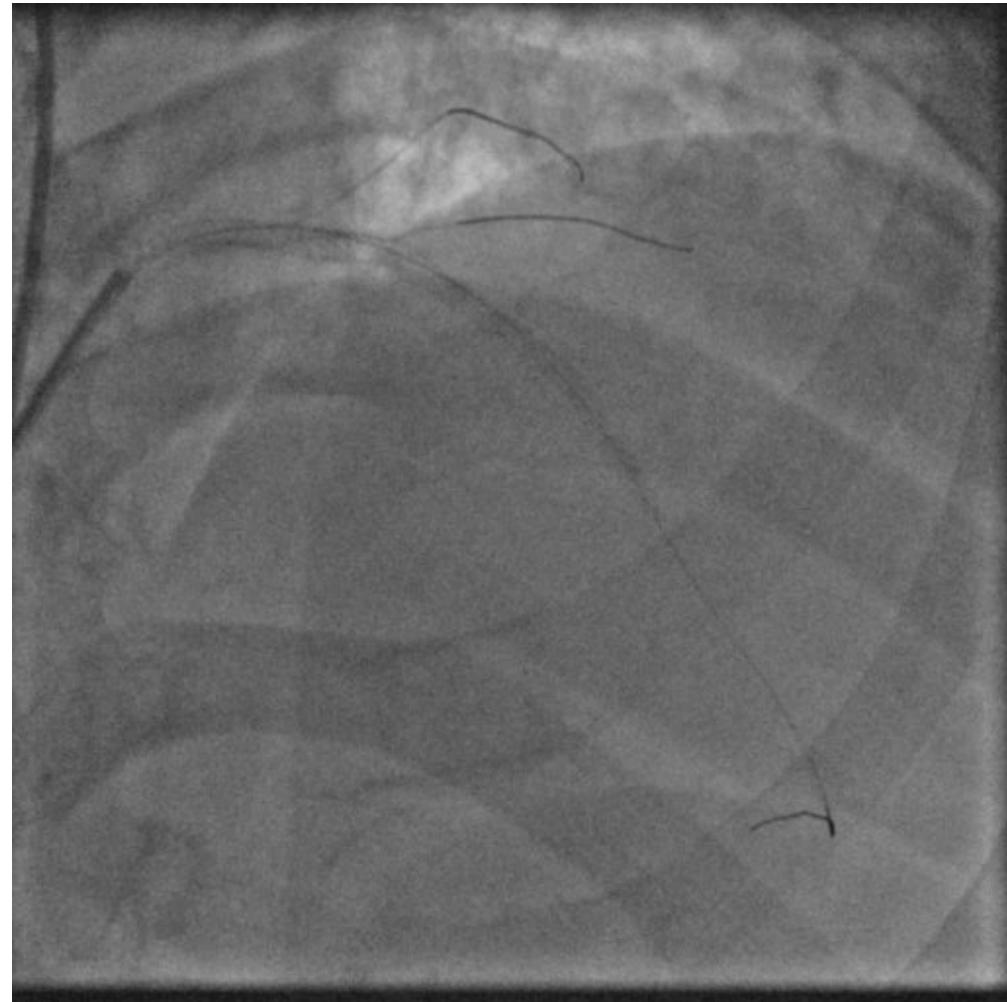
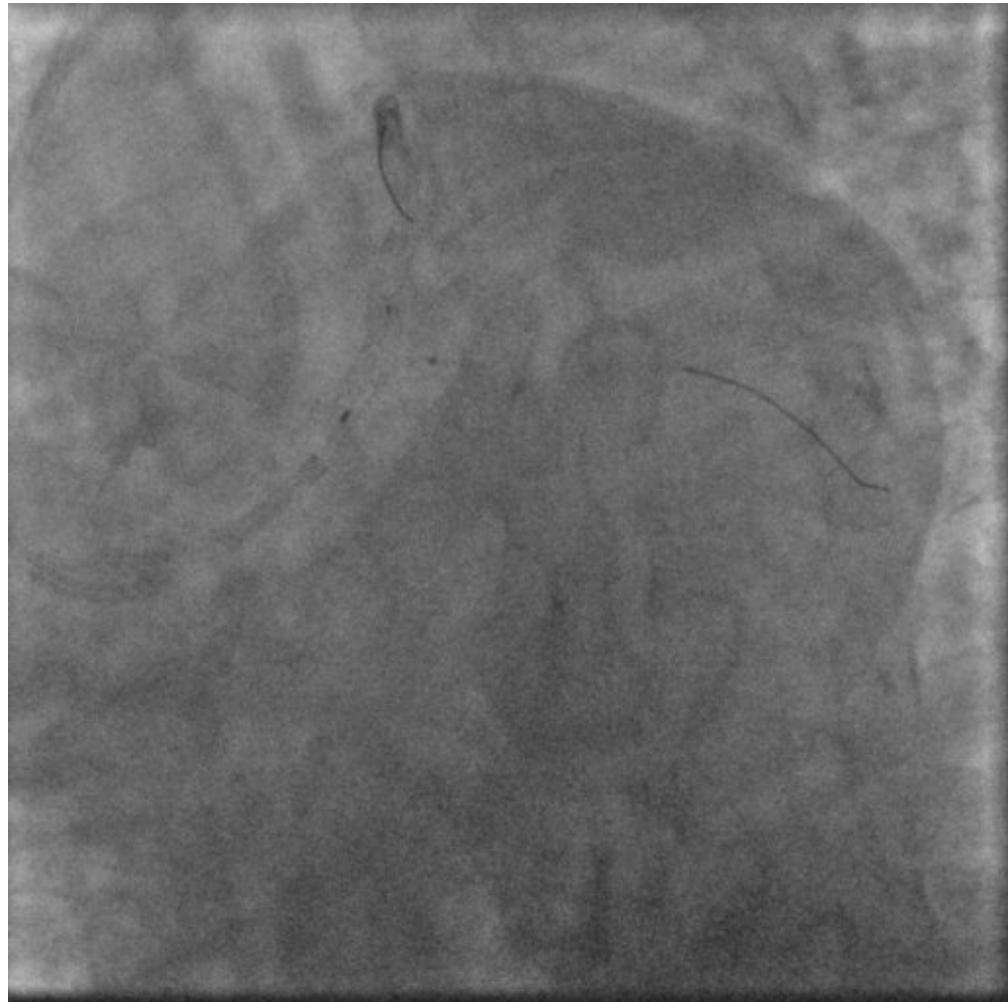
Predilatazione di IVA con NC 2.5 mm e 3.0mm
POBA con SC 2.0mm di D1



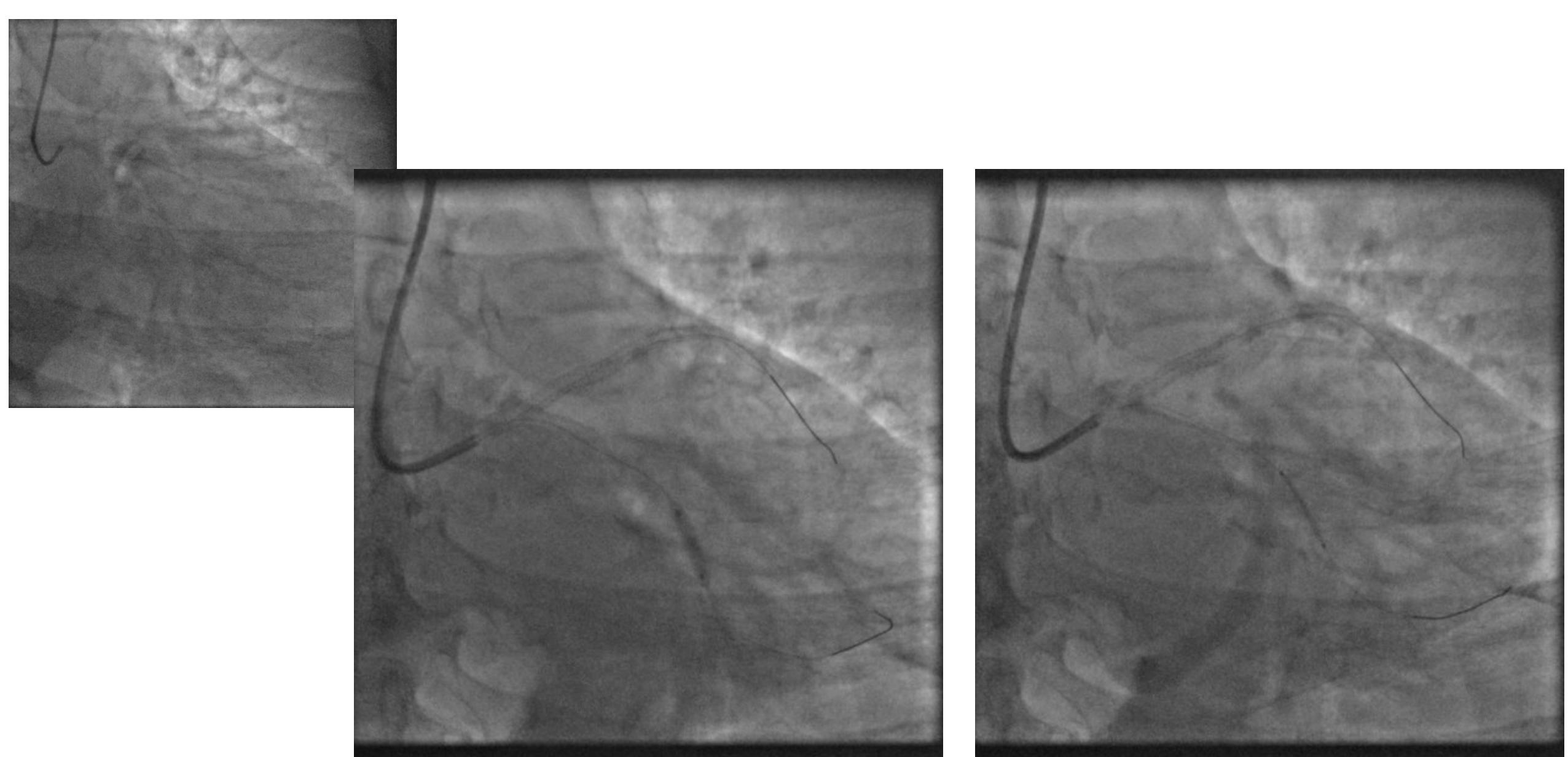
Impianto in overlap di Synergy 2.5x32mm,
Synergy 3.0x32mm e Megatron 3.5x32mm



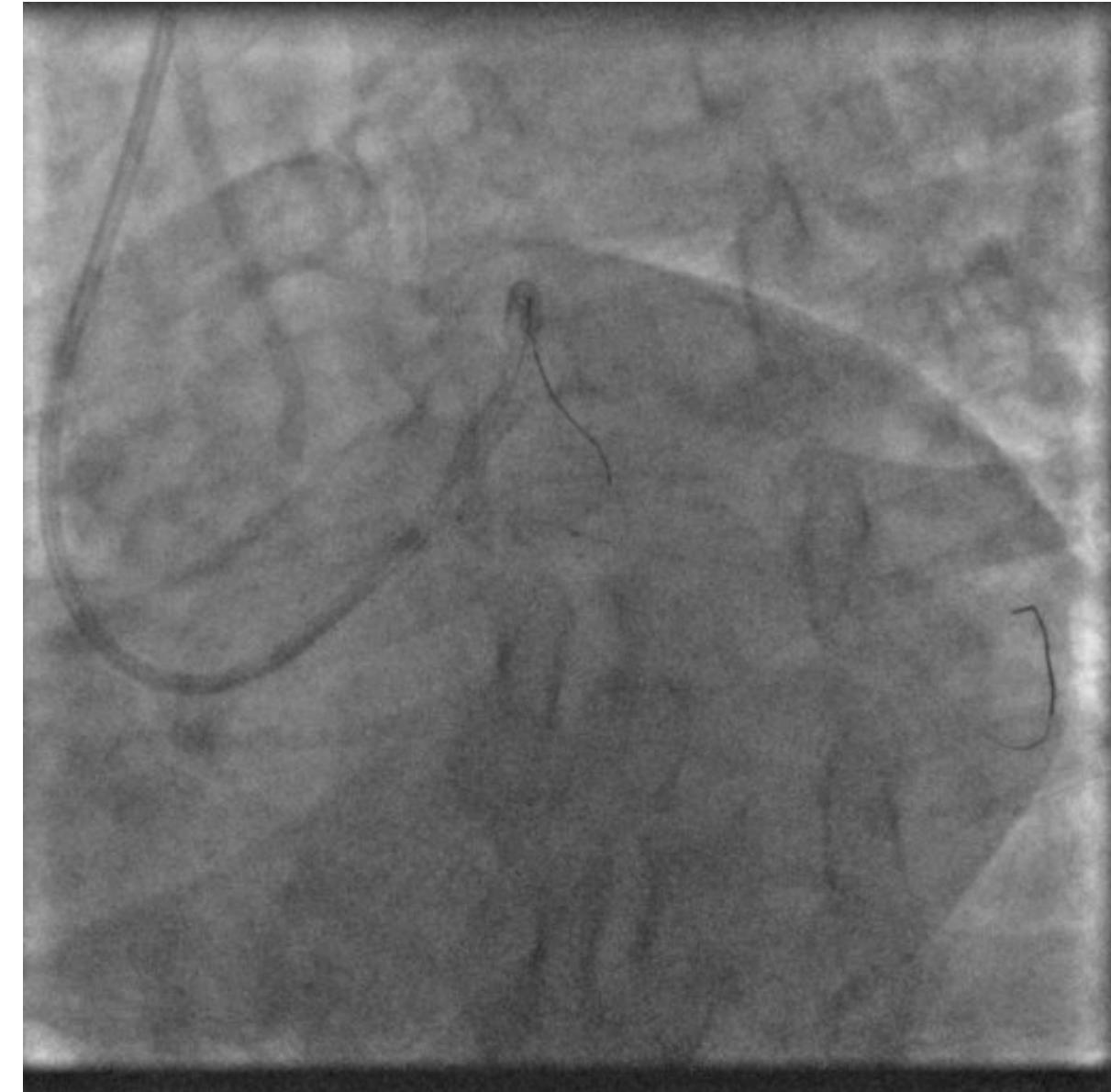
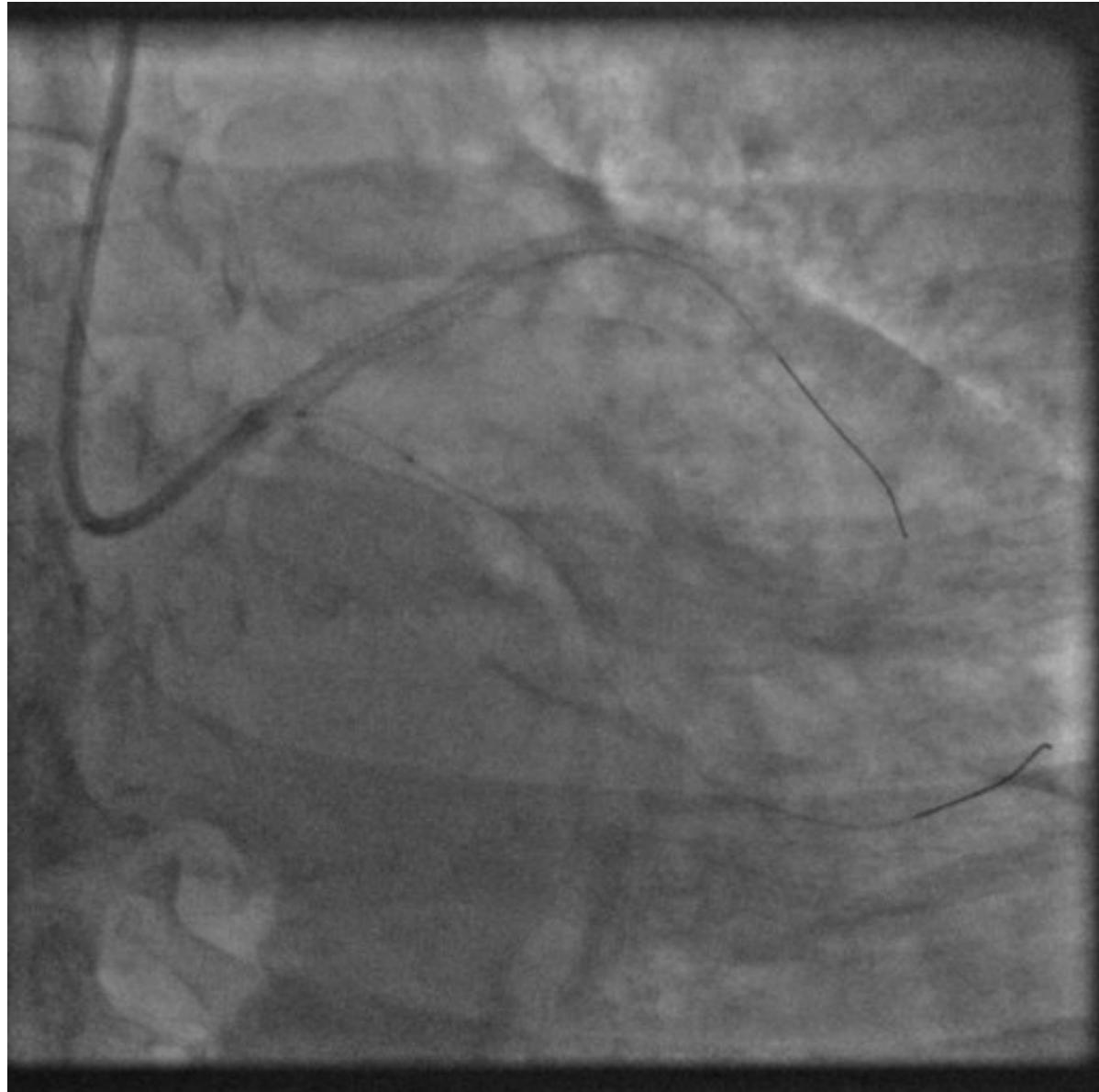
Postdilatazione con NC 2.5mm, 3.0mm, 3.5mm,
4.0mm, POT sul TC con 5.0mm

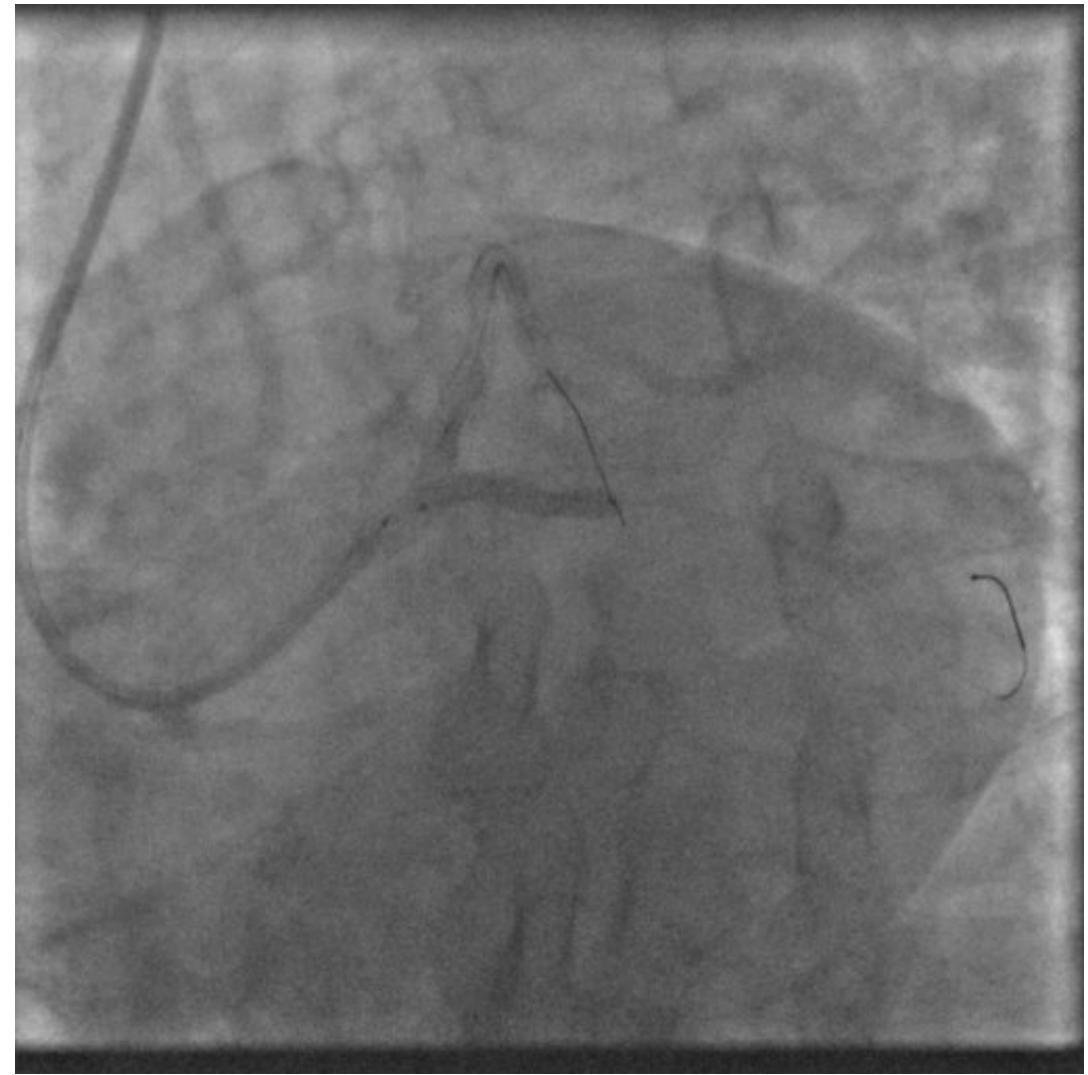


Risondaggio di CX e Kissing ballon TC-IVA-Cx (NC 3.5mm e NC 3.0mm)

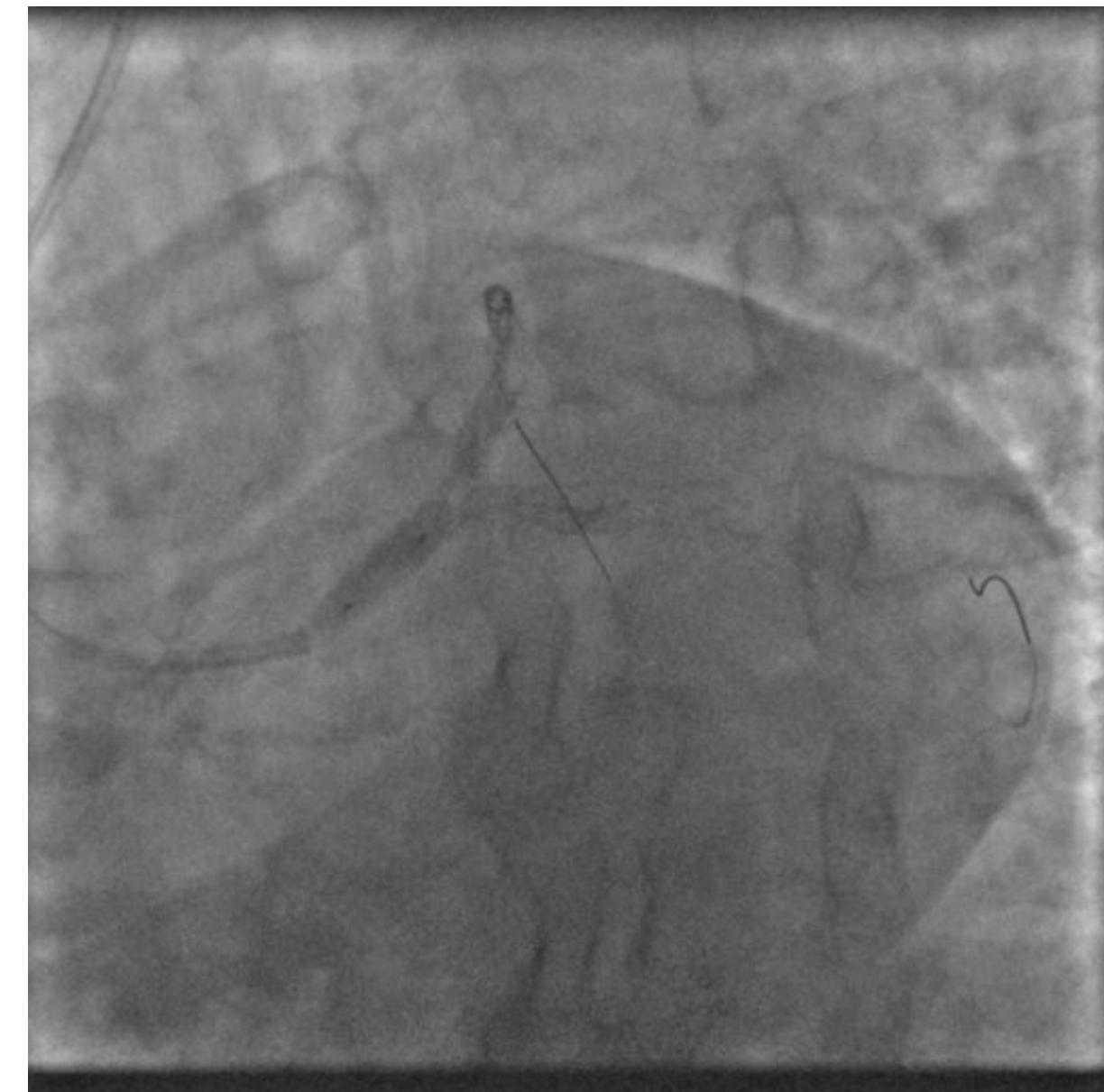
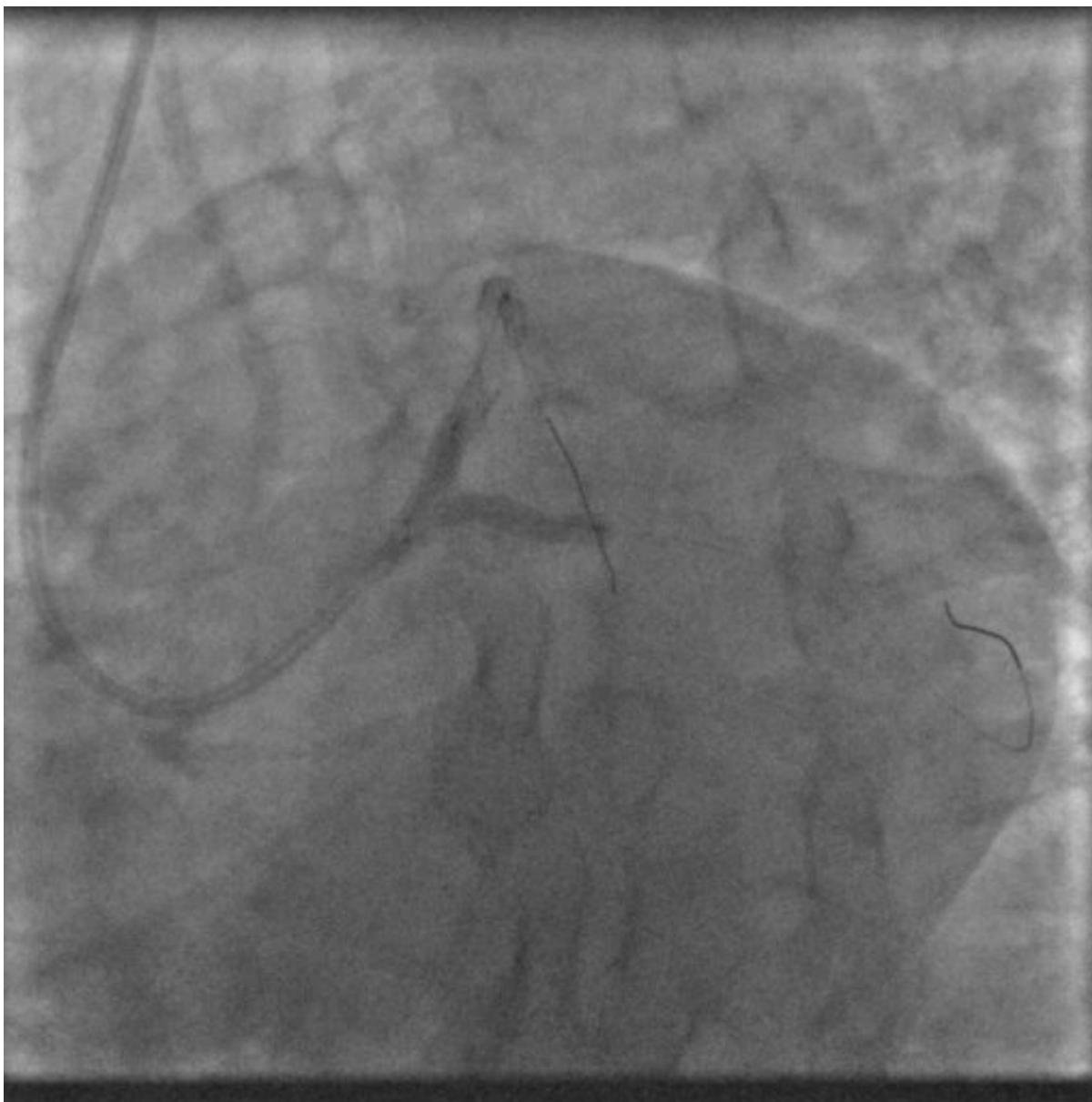


Synergy 3.0x16mm



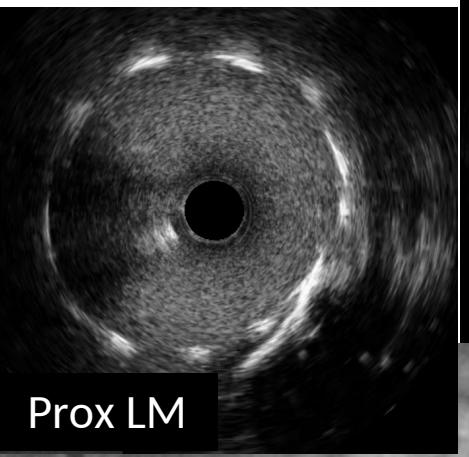


TAP con Megatron 3.5x20mm



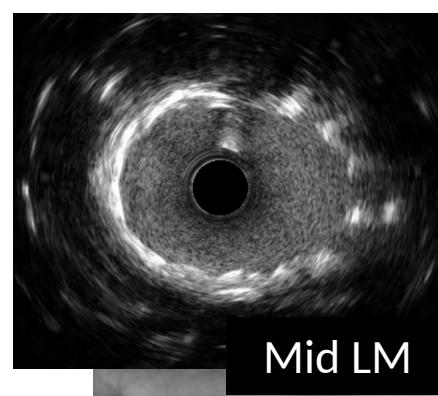
Kissing Ballon NC 3.5 e NC 3,5mm, Final POT NC 5.0mm

IVUS TC-IVA



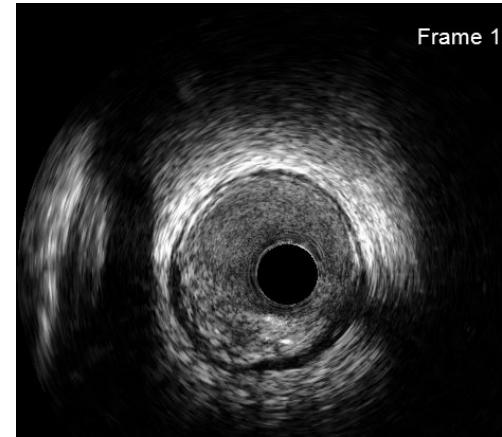
Prox LM

IVUS TC-Cx

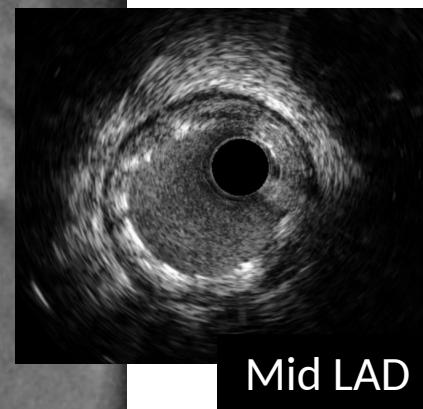


Mid LM

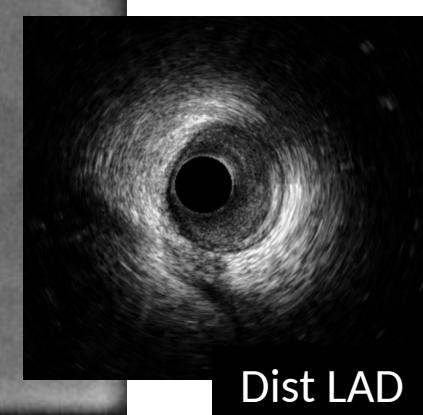
Frame 1



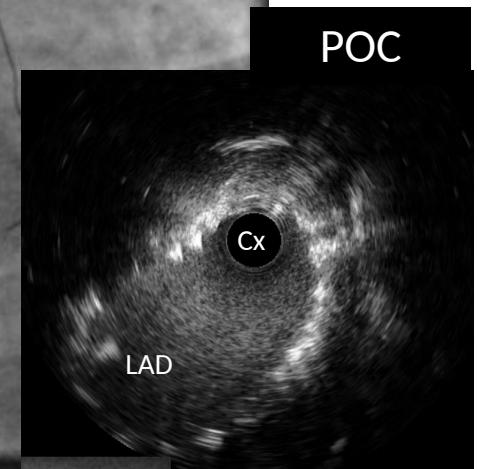
POC



Mid LAD

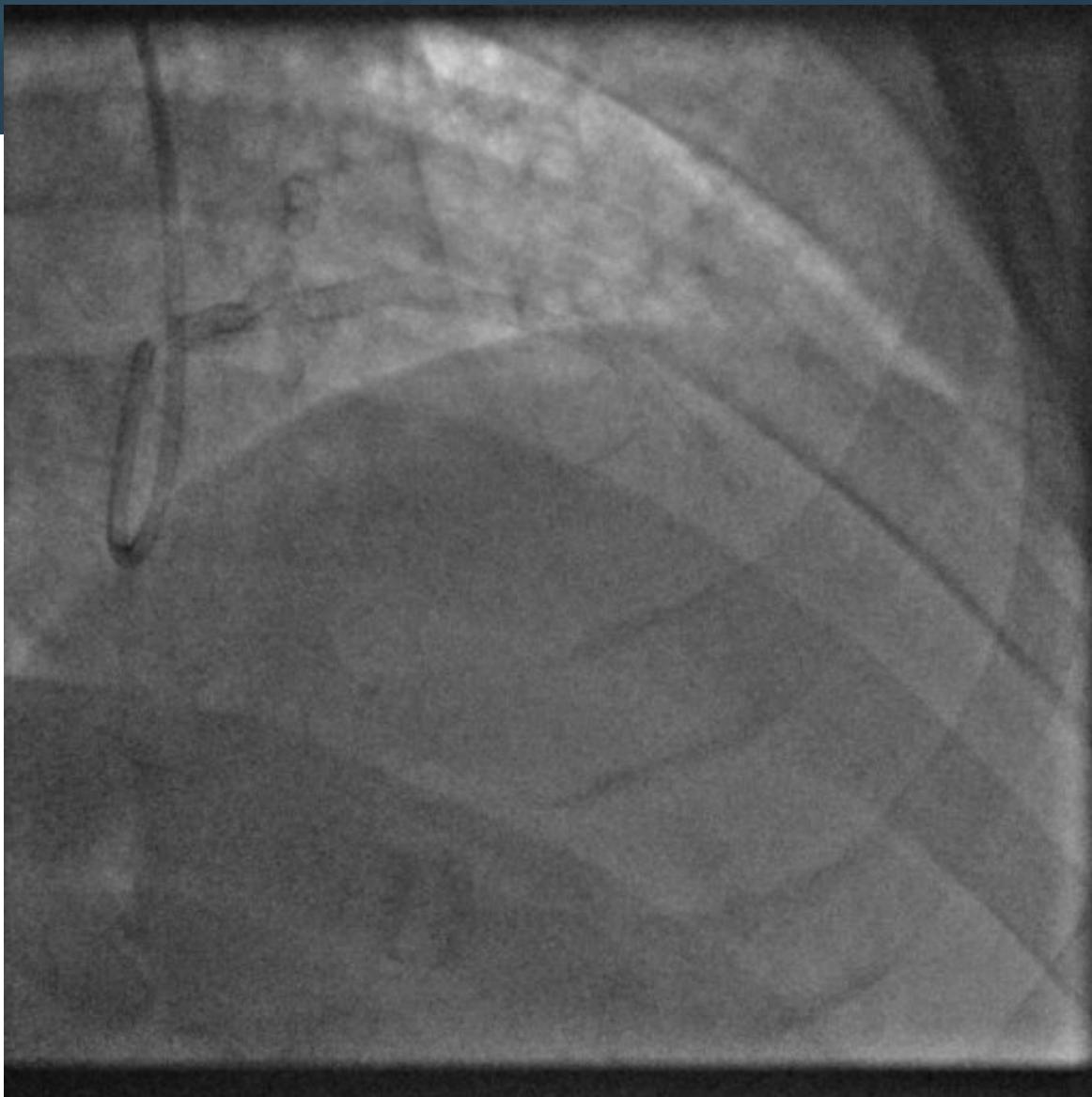


Dist LAD



LAD

Cx



Decorso postprocedurale regolare

Dimissione in seconda giornata

Terapia domiciliare:

- Pantoprazolo 40 mg 1 cp prima di colazione**
- Clopidogrel 75 mg 1 cp ore 12 PER ALMENO 6 MESI (fino a visita di controllo)**
- Bisoprololo 1.25 mg 1 compressa ore 8**
- Cardioaspirina 100 mg 1 compressa ore 12**
- Metformina 1000 mg 1 compressa ore 20**
- Forxiga 10 mg 1 compressa ore 8**
- Rosuvastatina/ezetimibe 5/10 mg 1 compressa ore 20**
- Trulicity 0.75 mg 1 fiala sc il martedì**