• 85 years old Sudanese, hypertensive
• ACS 3 years ago, had PCI, stent of LAD
• Recently angina FC III/IV, SOB
• Vital signs normal
• ECG T wave inversion diffuse
• S Creatinine 1.8 mg
• Echo EF 40% antero-lateral, septal hypokinesia
• ASA, Bisoprolol, Nitrates statin
• Angio:
  • Heavily calcified distal LM, osteal and proximal LAD, Osteal and proximal CX
  • Left main distal subtotal occlusion, LAD osteal tight lesion, instent restenosis, distorted stent
  • Cx osteal tight lesion, proximal 90% lesion

• Advised for CABG: very old age general condition
• PCI? Challenges
  1. Heavy calcification
  2. Tiny track in LM
  3. Multiple lesions
  4. Kidney function impaired
  5. Family wanted non- Surgical, non-intervention treatment!!
Intervention Plan

• Wiring: which wire?
• Deal with calcification: Balloon, cutting balloon small or big
• Left main only or complete revascularization
• Sequential or TAP
• Wiring LAD, CX PT2 MS, Run through
• Cutting balloon 3.25x10 mm
• To LM, LAD, CX
• Try to stent LAD instent, BioMatrix 3.0 x 24 mm to treat the distorted stent
• Stent LM to LAD, 3.5 x 18 mm overlap
• Stop or continue CX

• Cx lesion appeared nasty,
• Rewiring, small balloon through LM stent, bigger balloon
• Stent osteal and proximal CX 3.0x 24 mm
• Crush by LAD Left main balloon
• Final kissing
Follow up

- Tolerated the procedure very well
- Discharged next day
- Serum creatinine did not increase, total contrast 70 ml, creatinine clearance 70 mm
- Had transient AF when seen after 2 weeks, disappeared after amiodarone for few days
- Plan clopedogrel, ASA, statin for life