[] DOUSING THE FIRE DRAGON!

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Dr.Afrah Y. A. Haroon, Dr. Shayful .A. Yahia, Dr. Al fazir Omer
National heart institute –Kuala Lumpur, Malaysia.

HISTORY & PHYSICAL

A 62 years gentleman with background history of Hypertension, Dyslipidemia, chronic kidney disease stage 3 and old CVA with residual right hemiparesis.

He was admitted with acute coronary syndrome ACS NSTEMI with APO, secondary to hypertensive emergency.

Coronary angiogram done in other hospital showed 3 vessel and distal LM stenosis & referred to our center for CABG. His surgery was postpone because he was admitted with APO precipitated by Hypertension emergency.

CLINICAL EXAMINATION

Was normal only

Lt sided renal bruit & high BP of 170/97 (5 types of anti-hypertensive drugs)

Echocardiogram: showed EF 53%, concentric LVH and normal valves.

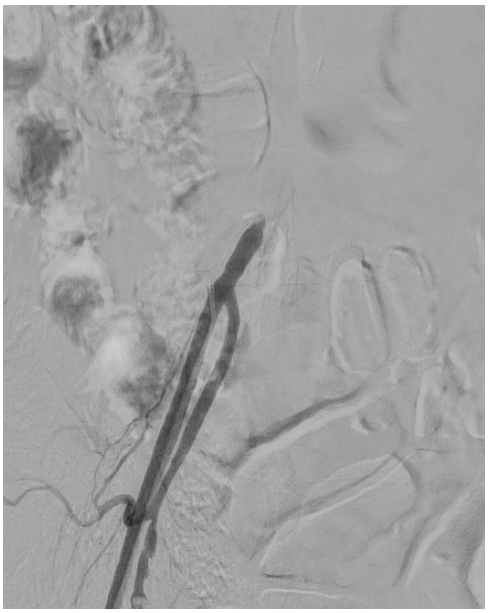
Abdominal U/S revealed normal renal arteries, no stenosis.

Decided to proceed with renal angiogram & stenting if required and to refer back for CABG.

Renal Angiogram

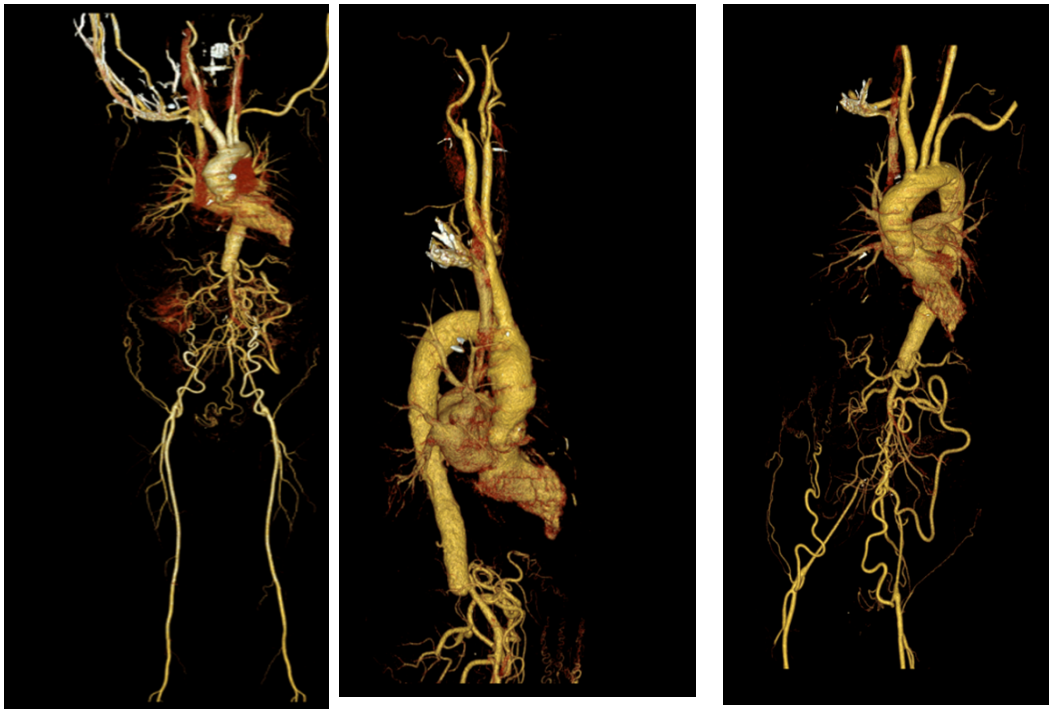
Rt femoral approach , finding total occlusion of common Rt. CFA as seen in figure-1.

Fif-1:



We thought of Lt. femoral approach or RRA, but decided for CT angio to assess all

Fig-2:



Mild stenosis at origin of LCIA

Complete occlusion of abdominal aorta below SMA. abdominal Co-artication

Reconstitution from Rt & Lt external iliac arteries, normal distal both CFAs.

Normal renal artery

Issues:

Patient with Resistance hypertension & IHD TVD with LMS.

Refer vascular surgeon for for bilateral Aorto-iliac bypass & then CABG, he was turned down by them in view of his TVD as well as for CABG in view of his PVD Aorto-iliac.

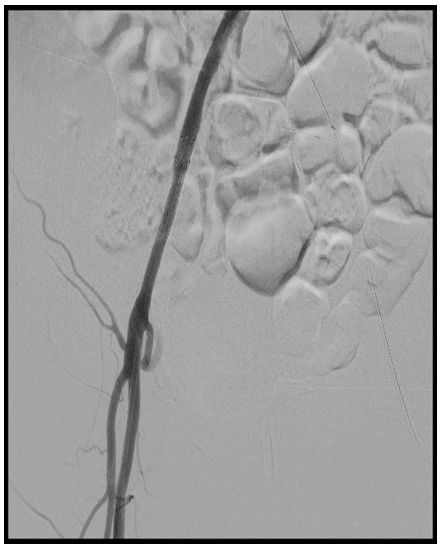
plan

Decided for PTA CFA then surgery.

3 arterial access: left brachial artery 6F sheath, right femoral artery 6F sheath and left femoral artery 6F sheath
attempted antegradely using Terumo stiff wire and JR 3.5 6F support but wire in false lumen

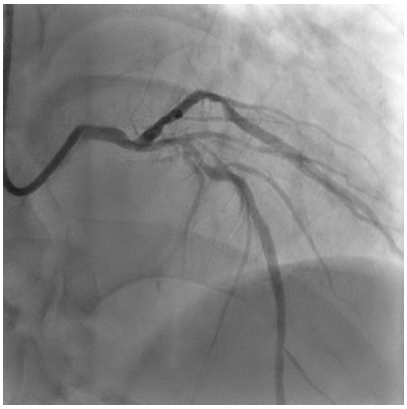
Changed to retrograde approach via right femoral access and crossed with command 0.014 wire using Subintimal Arterial Flossing with Antegrade-Retrograde Intervention (SAFARI) technique.
Balloon with Admiral Xtream 4.0/60mm then 5.0/20mm then 7.0/60mm
Wire externalized to right femoral artery
Stented with EPIC 14/60/7.0, 7.0/150mm and 7.0/60mm
Postdilated with Comral Xtreme 7.0/60mm.
Good flow in right femoral artery.

Failed to cross into left common iliac and tip of Terumo stiff wire snapped and left behind about 2cm.
BP 150/90mmhg drop to right after the procedure.
Post PTA Aorto-ilaic:

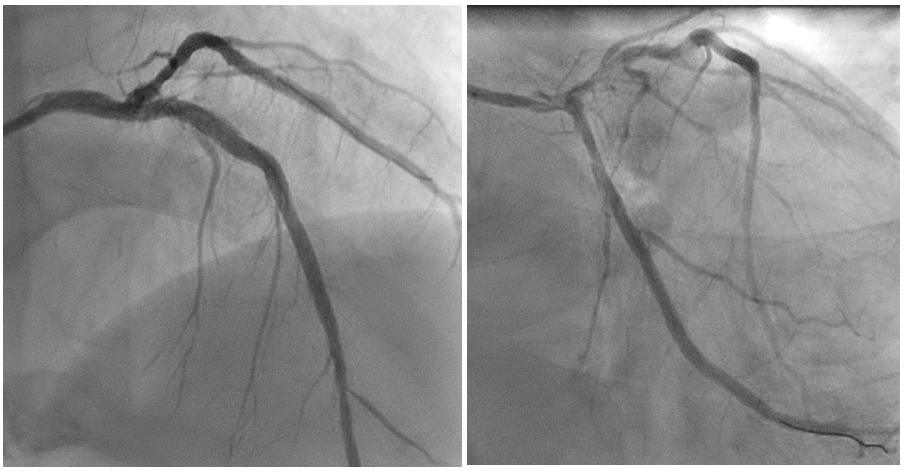


Unfortunately he developed NSTEMI while waiting in the ward, ECG showed anterior ischemia with raised cardiac enzymes. Repeat echo EF dropped from 53% to 38%
Nuclear scan showed infracted distal LAD, surgeon declined his CABG

Discussed with patient and agreed for high risk PCI to LM/LAD/LCX and medical therapy to PL branch of RCA
We proceed PCI to LM into LAD Provisional single stent technique.
BP was better controlled and antihypertensive medications was reduced from 7 to 4.
He was angina free and discharged well after 3 days.



Post PCI image:



LMS/ LAD/LCX post PCI

LEARNING POINTS

In resistant hypertension, secondary cause should be excluded.

Early intervention will prevent hypertension, complications of high BP ,APO, ACS & CKD &stroke.