Speaker's name: Thomas Cuisset, MD, PhD

X **I have the following potential conflicts of interest to report:**

x Consulting: Daiichi Sankyo, Eli Lilly

❒ Employment in industry

❒ Stockholder of a healthcare company

❒ Owner of a healthcare company

x Others: Lecture Fee, Travel Expenses

Abbott Vascular, Astra Zeneca, Biosensors, Biotronik, Boston Scientific, Cordis, Daichi Sankyo, Edwards, Eli Lilly, Iroko Cardio, Medicines Company, Medtronic, Sanofi, Servier, Terumo

❒ **I do not have any potential conflict of interest**

Case presentation: how to treat an elderly diabetic patient presenting for high-risk NSTE-ACS with distal left main disease?

Thomas Cuisset, Marseille, FR

Under the auspices of the Argentine College of Interventional Cardioangiologist (CACI) and the Atheroma Coronary and Interventional Cardiology Group (GACI)

Clinical Presentation

- 82 year-old man, 79 kgs
- Medical History: prior history of AF
- Risk Factors: Diabetes, Hypertension
- Medications: ramipril 5 mg, metformine, coumadin

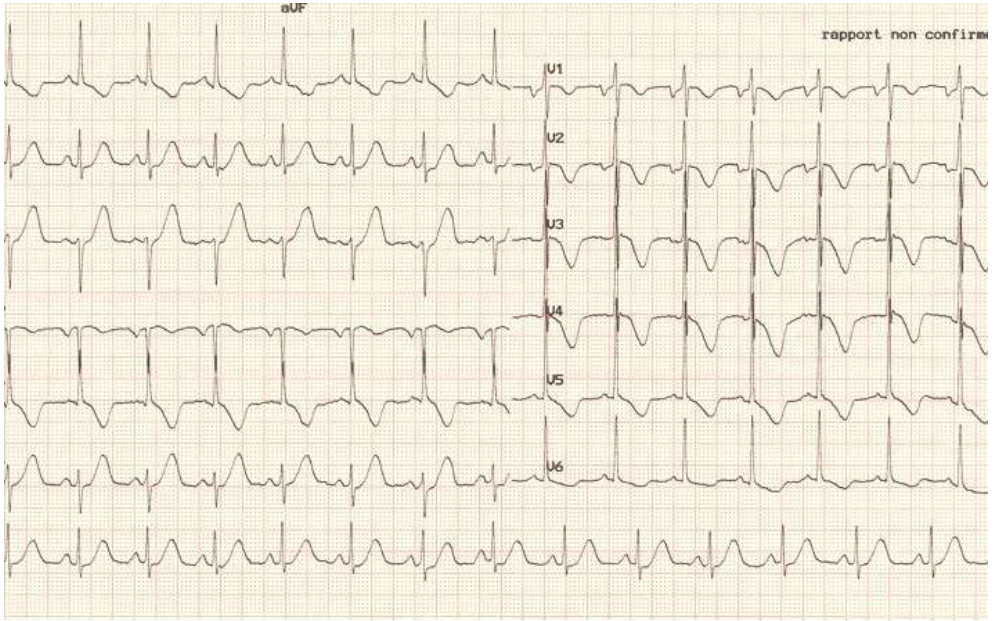
Clinical Presentation

- Admitted for acute chest pain (15') at night

- Emergency Room 2 h after Symptom (9 am), normal clinical examination, BP 126/74, HR 92 bpm

- No residual chest pain

ECG



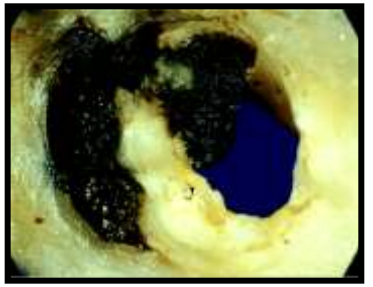
TTE: LVEF 45%, anterior hypokinesia

Laboratory Results:

- Creatinin 116 µmol/L (CC 37 ml/min)
- Troponin I = 2.4 IU
- INR 2.2

→ **High Risk NSTEMI**

Invasive Strategy in NSTE ACS



Very High Risk NSTE ACS
- Refractory Angina
- Dynamic ST changes
- Ventricular arrhythmias
- Haemodynamic instability

→ **Urgent Invasive Strategy (< 2 h)**
« STEMI like » Approach

High Risk
High Risk ACS
- GRACE risk score > 140
- **Recurrent chest pain**
- **Positive Troponin**
- EKG changes (ST, T wave)

→ **Early Invasive Strategy (< 24 h)**

High risk patient
- Diabetes mellitus
- Renal Failure
- Low EF (< 40%)
- Prior PCI/CABG
- Post MI Angina

→ **Invasive Strategy within 72 h**

Low Risk
- Negative Troponin
- Normal EKG
- No High risk criteria

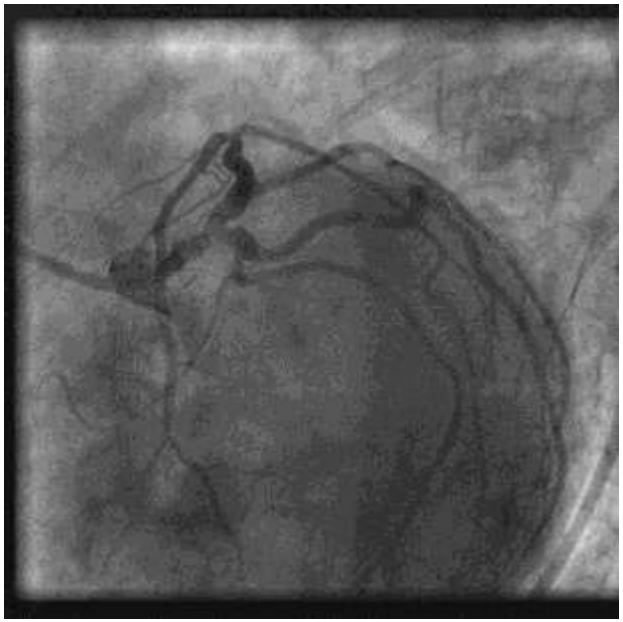
→ **Invasive Strategy / CT or Functionnal Test**
If Invasive strategy, within 72h

*** ST changes > 2 mm, ST changes > 1 mm, Negative T waves > Normal EKG**

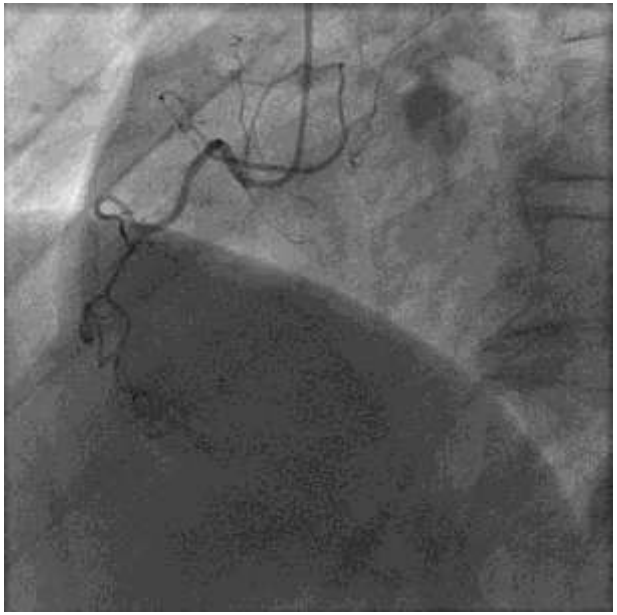
Preparation for ICA

- Prevention of CIN (Creat Cl > 90): hydratation
- CC=37 ml/min → Max. Contraste = 150 cc (4 CC)
- Radial access 6F
- Pre treatment: aspirin + clopidogrel 600 mg

Coronary angiography



Tight isolated stenosis of distal LM
Bifurcation 1.1.1
Evidence of anterior ischemia (ECG)



Hypoplasic RCA

Strategy ?

- CABG vs PCI for Left Main ?

- if PCI:

Access ? Material ?

DES vs BMS if PCI ?

Bifurcation technique ?

- Ad-hoc PCI or staged procedure ?

- Per procedure and Long term antithrombotic strategy ?

euro PCR 2013

We might have different opinions… but we'll still be friends !