OLGU SUNUMU

AKUT KORONER SENDROMDA KRONİK TOTAL OKLÜZYON DENEYİMİMİZ

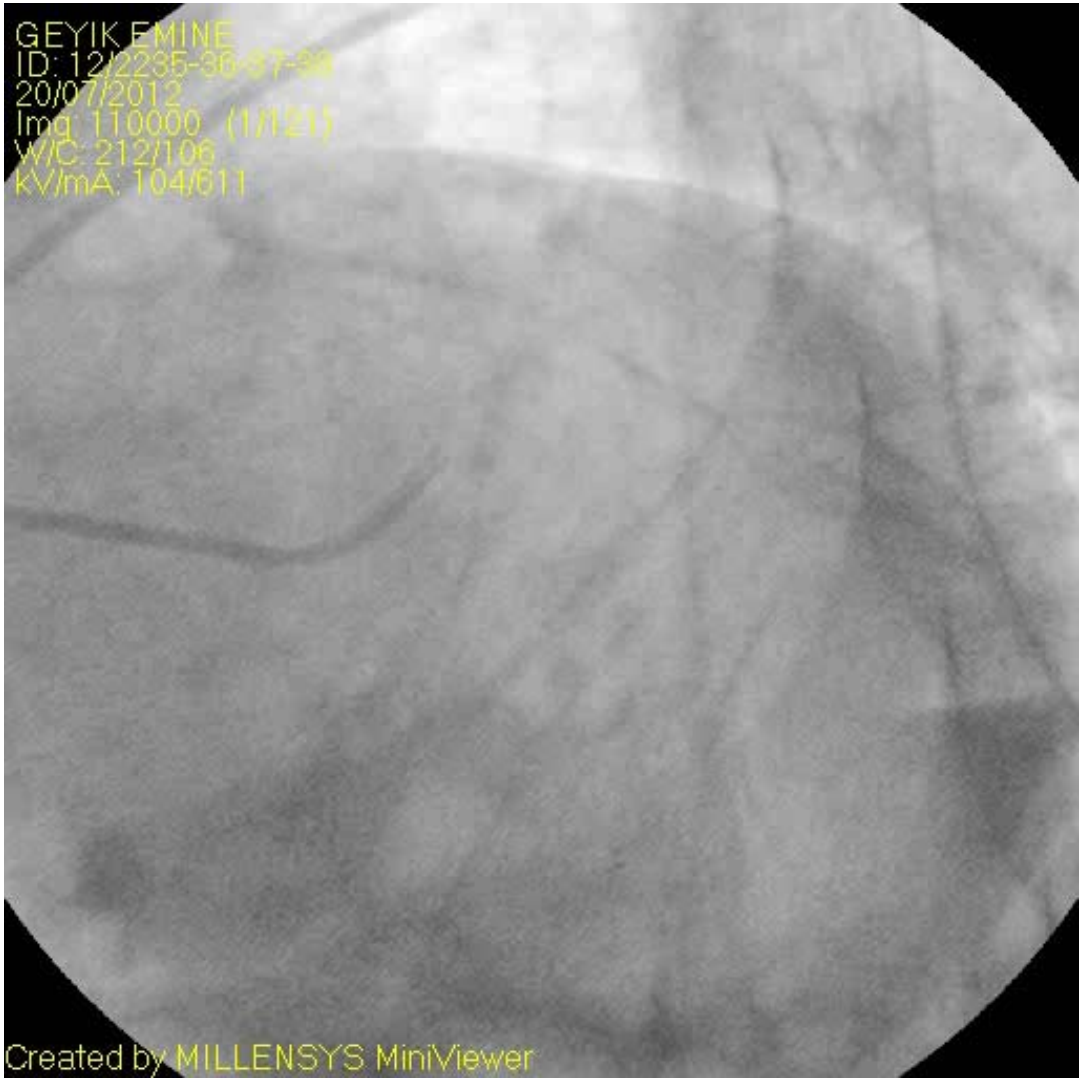
Dr. Ünal ÖZTÜRK

Necip Fazıl Şehir Devlet Hastanesi
Kahramanmaraş

OLGU

- 66 yaşında bayan
- 6 aydır efor angina ve dispne
- 1 aydır kreşendo angina, istirahat angina
- 2 yıl önceki MPS normal
- Bilinen kardiyak risk faktörü yok
- EKG: Sinüs, 80/dk, LBBB
- EKO: LVEF:%54, MY (hafif), inferolateral hipokinezi
- Laboratuvar: Normal

KAG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kV/mA: 104/611
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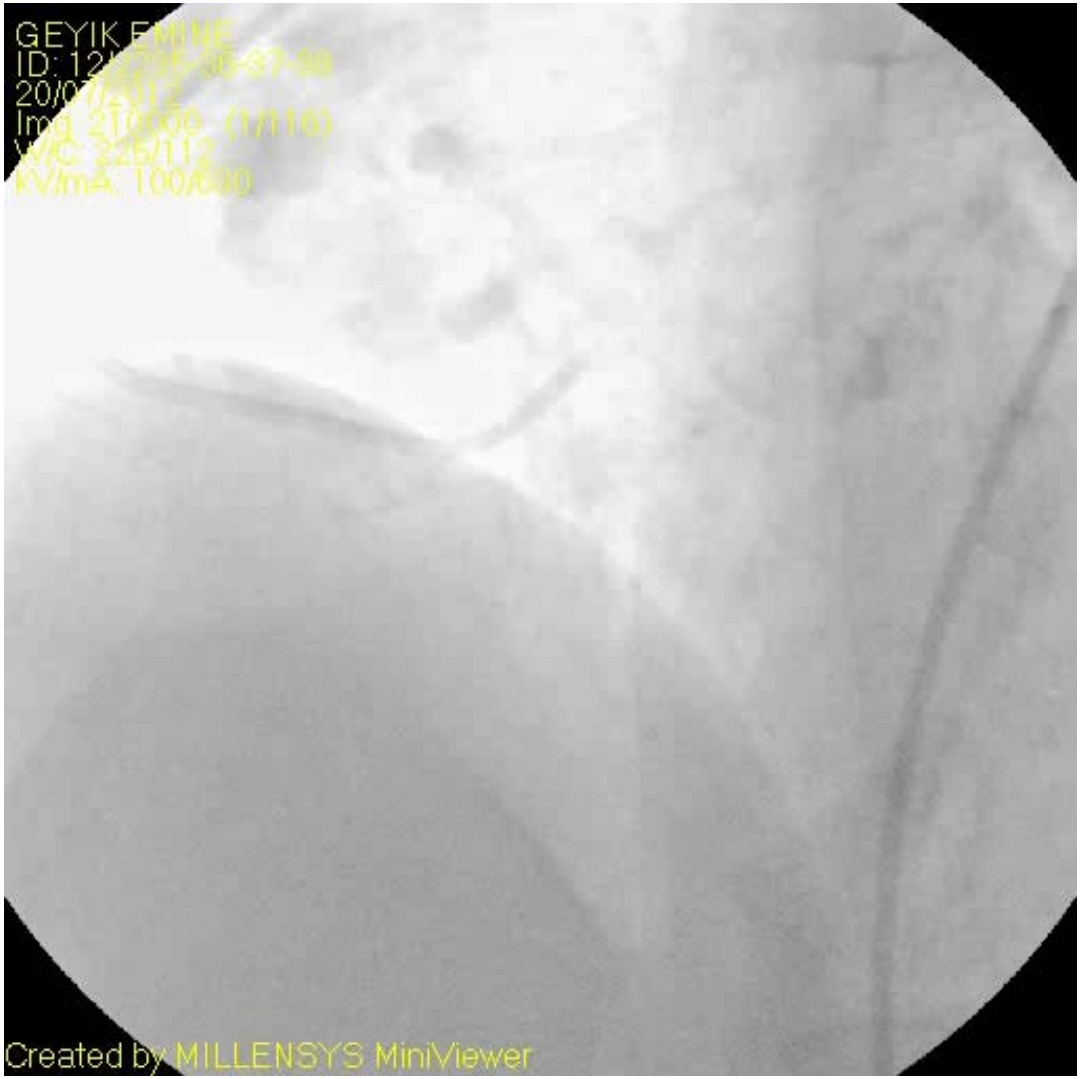

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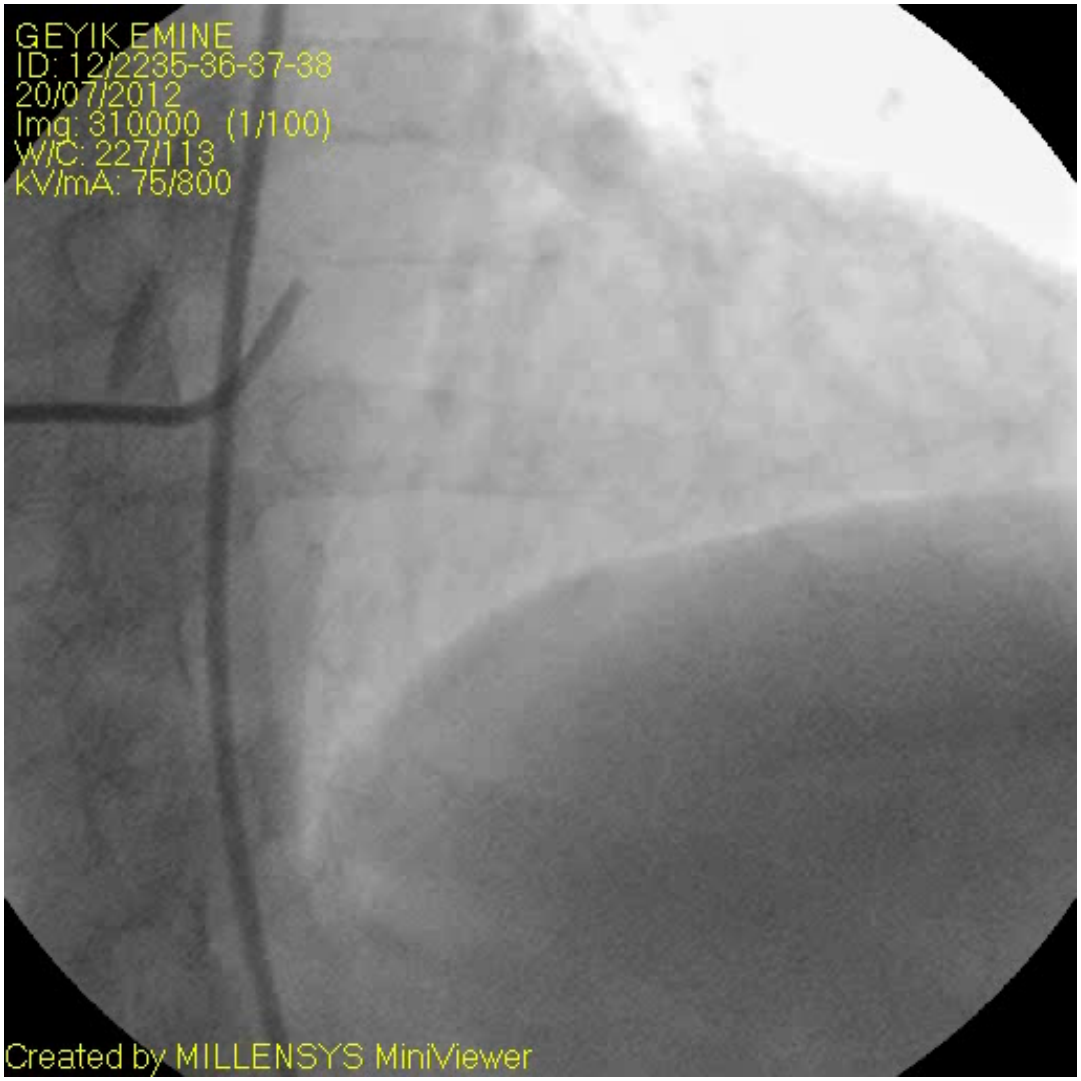
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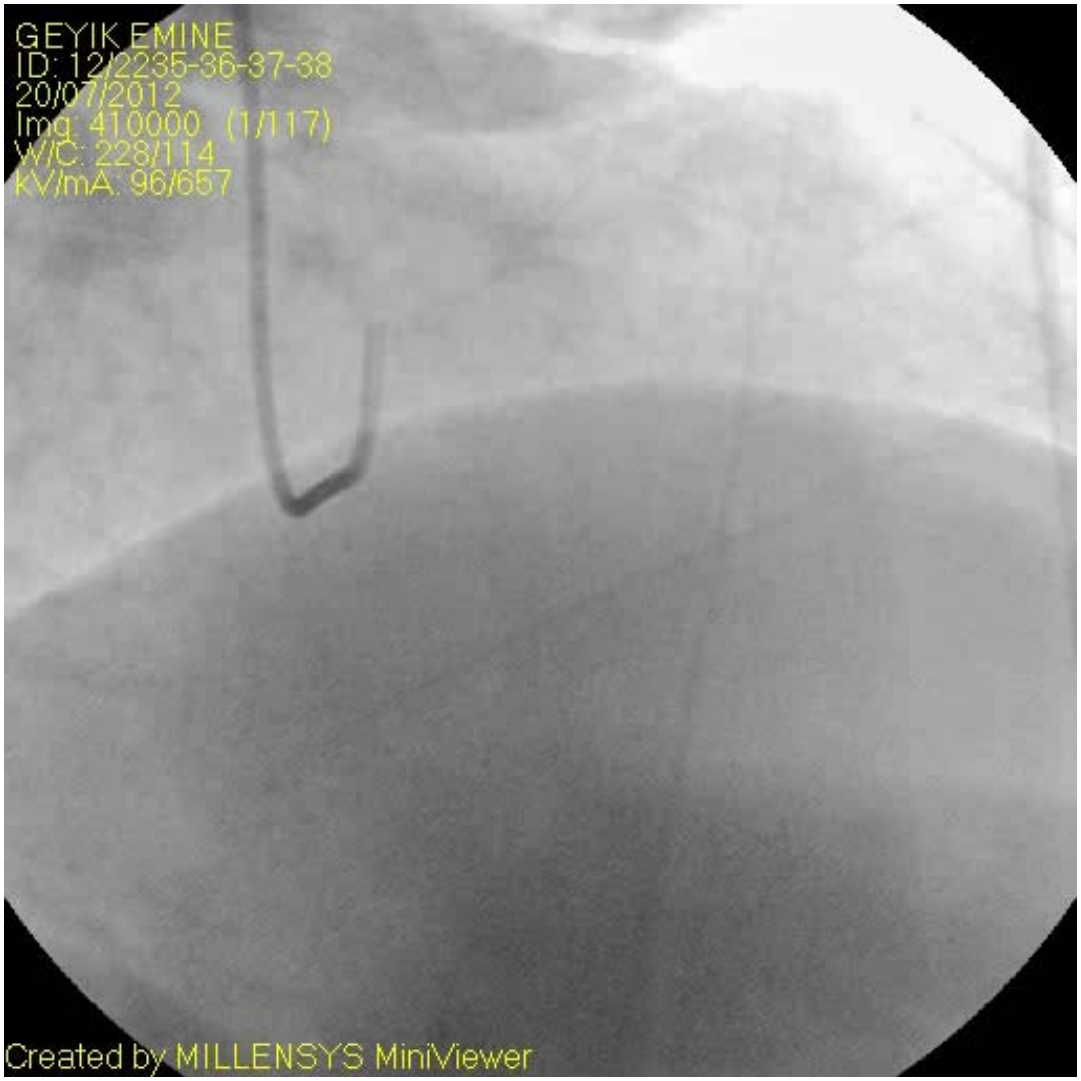
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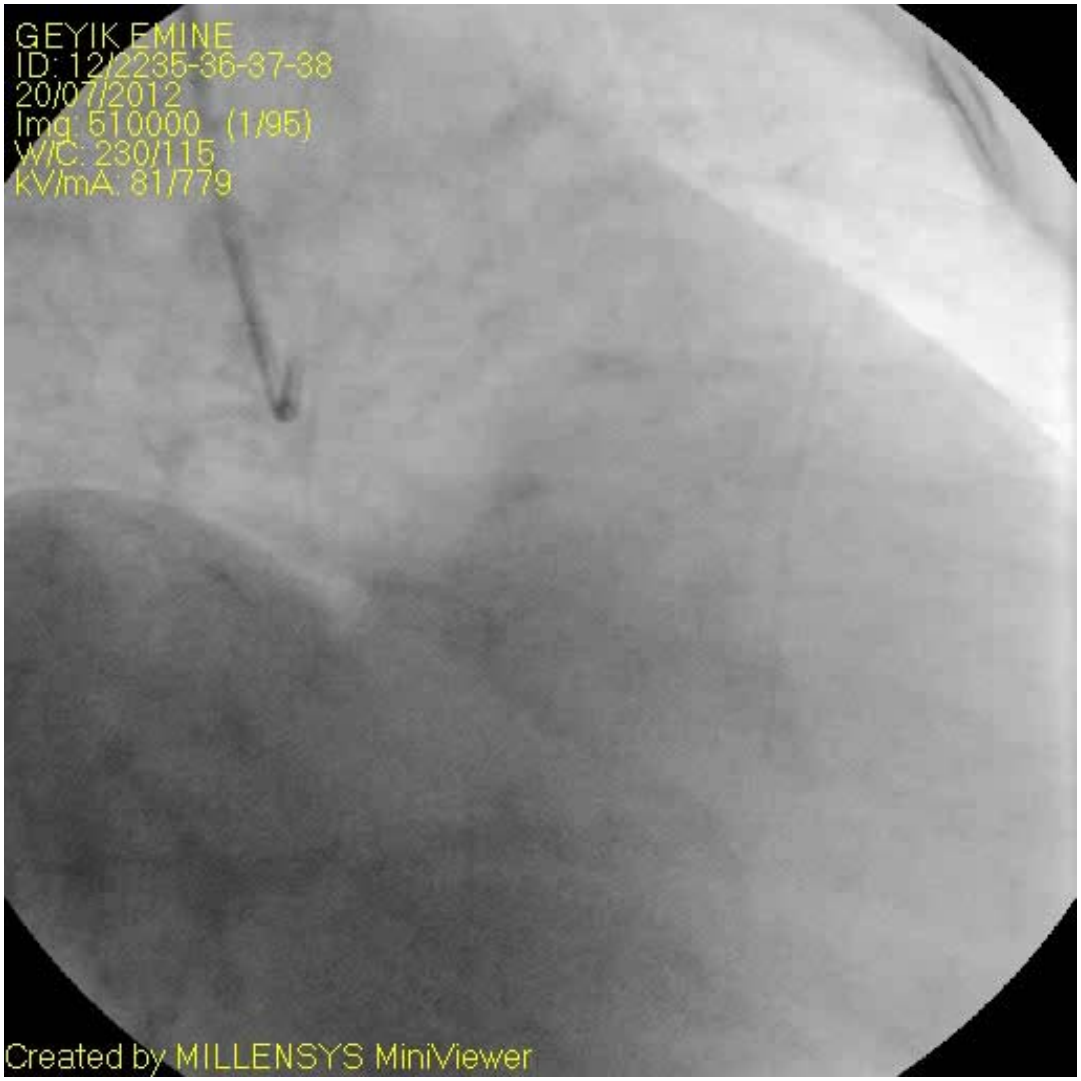
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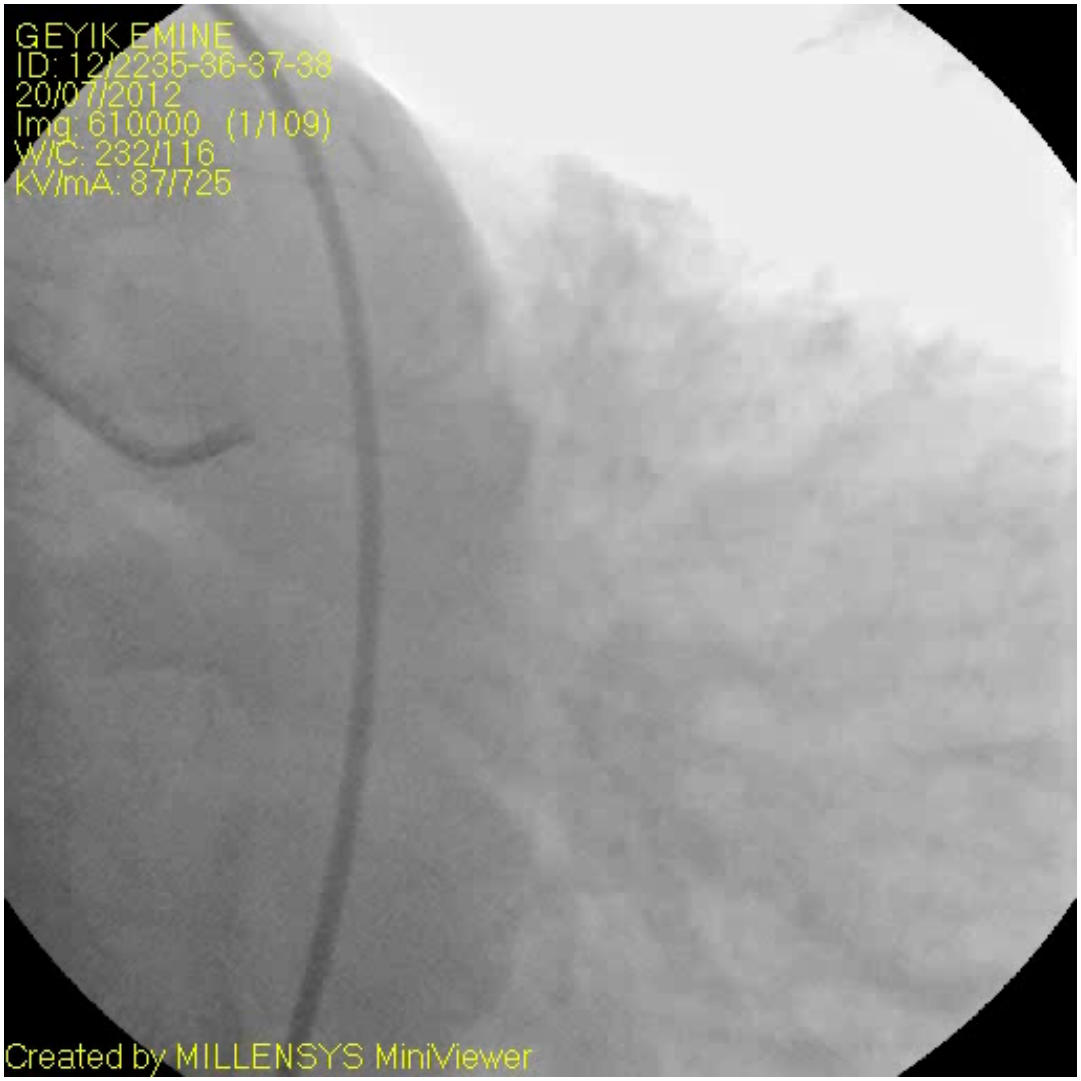
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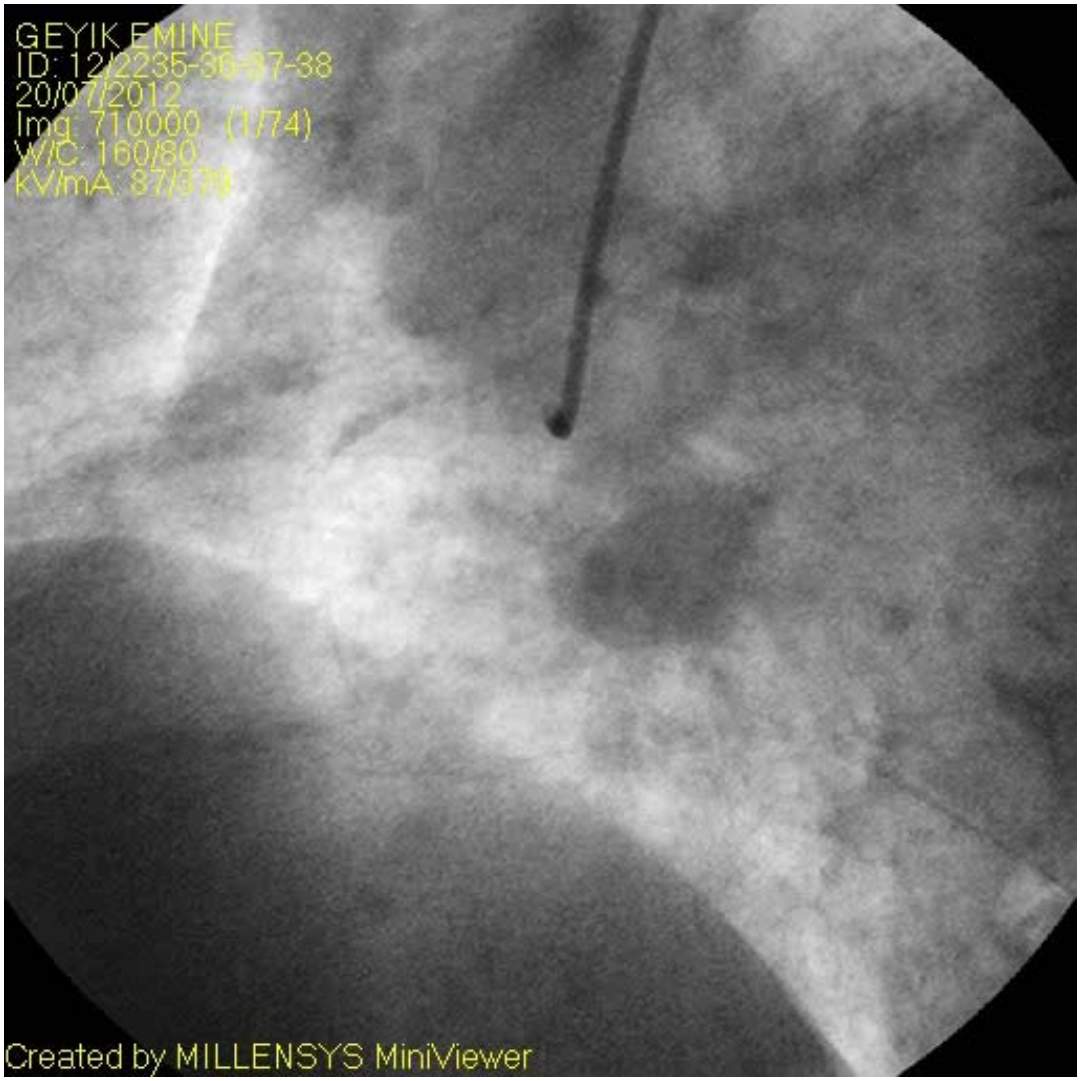
KAG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Created by MILLENSYS MiniViewer

KAG DEĞERLENDİRME

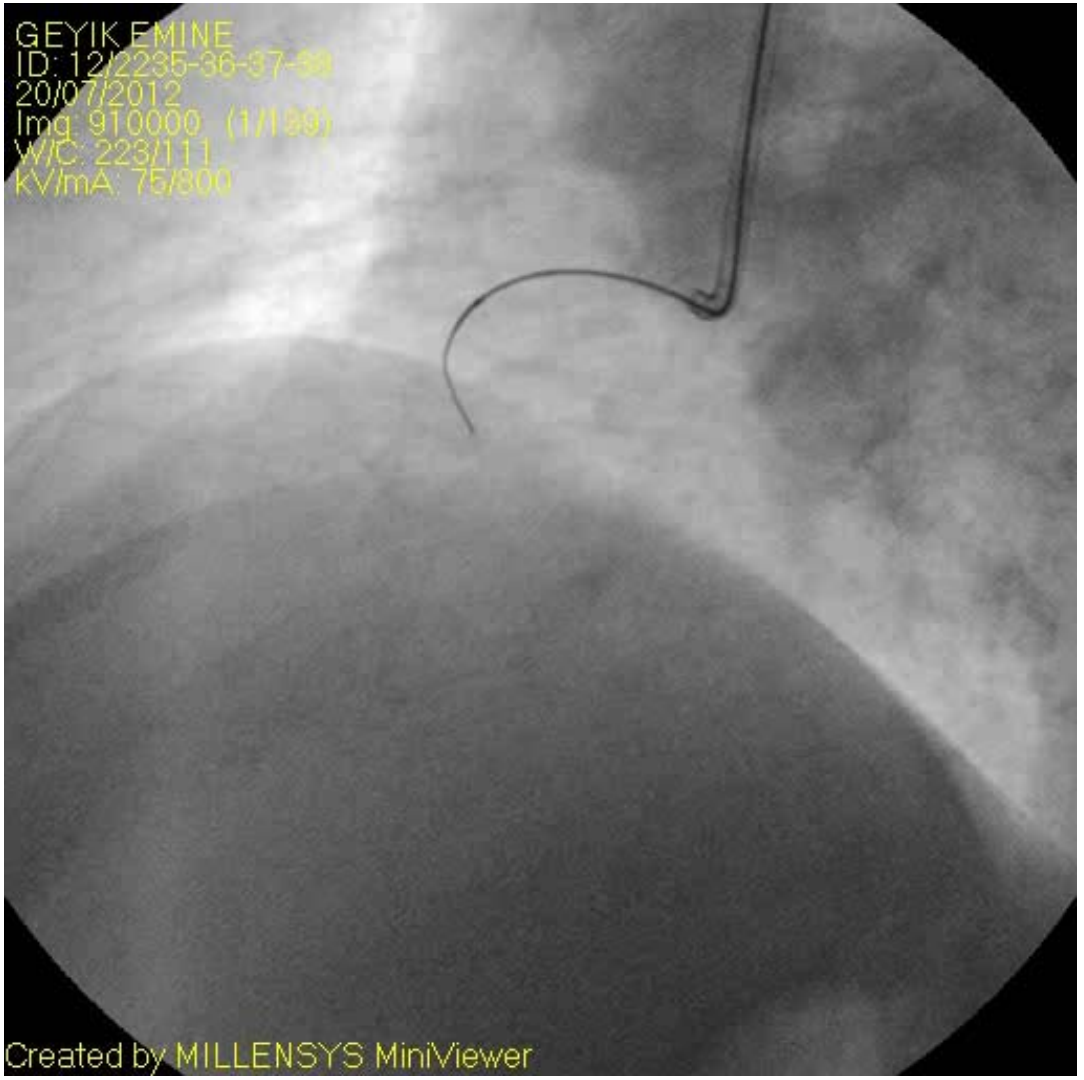
- LM = Normal
- LAD= Proksimal %30 ve mid segment de %40 non kritik plaklı
- CXA=Proksimal %98 tip C lezyon,distal TİMİ III akım
- RCA= Mid segmentte %100 tıkalı(CTO)

Karar? Nasıl Yaklaşalım??

- Hedef lezyon CXA primer PCI uygulayalım ve RCA daki KTO lezyona elektif girişim planlıyalım
- CXA deki primer hedef öncesi RCA daki KTO lezyona girişim yapalım

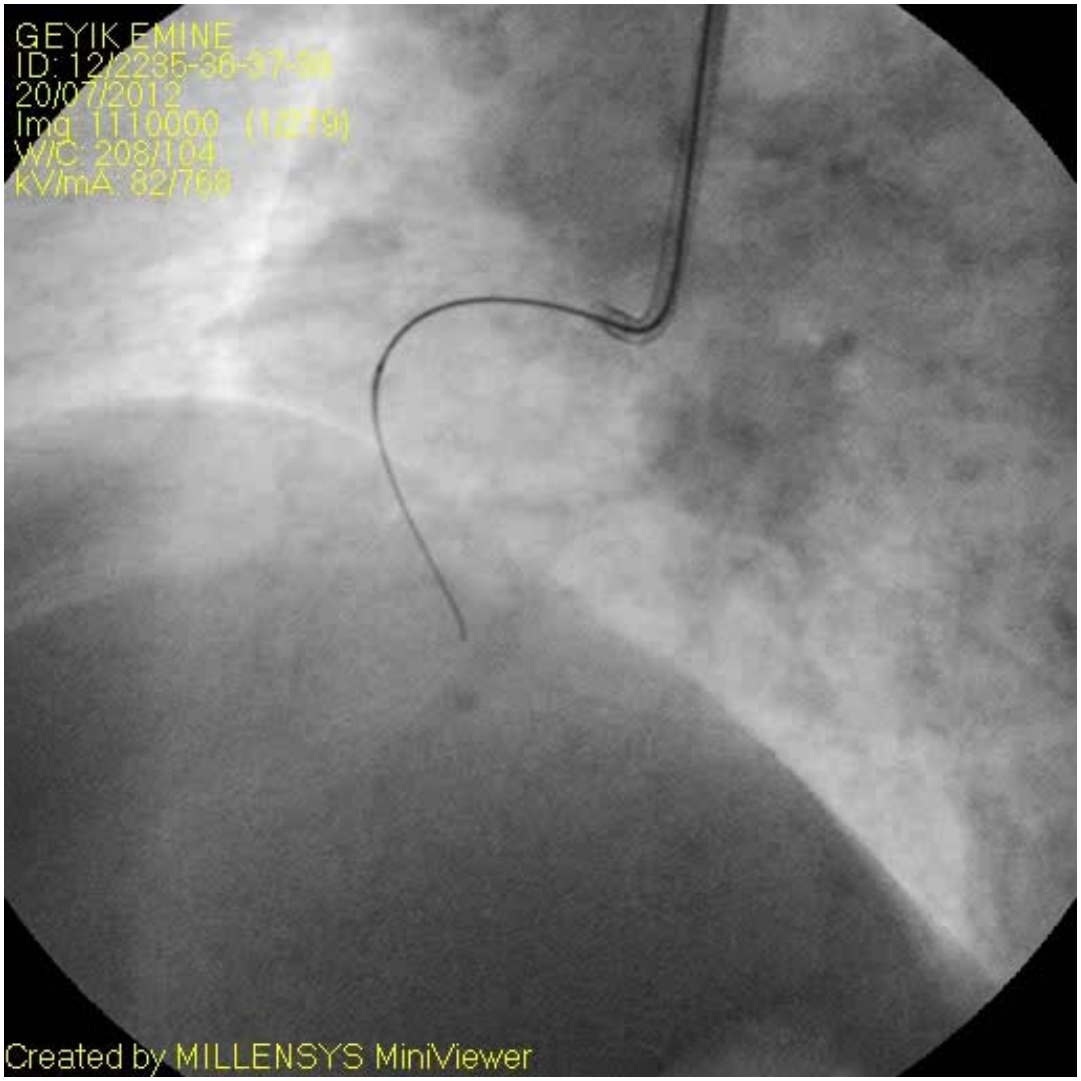
KTO

Corsair mikrokateteri ve Fielder XT GW



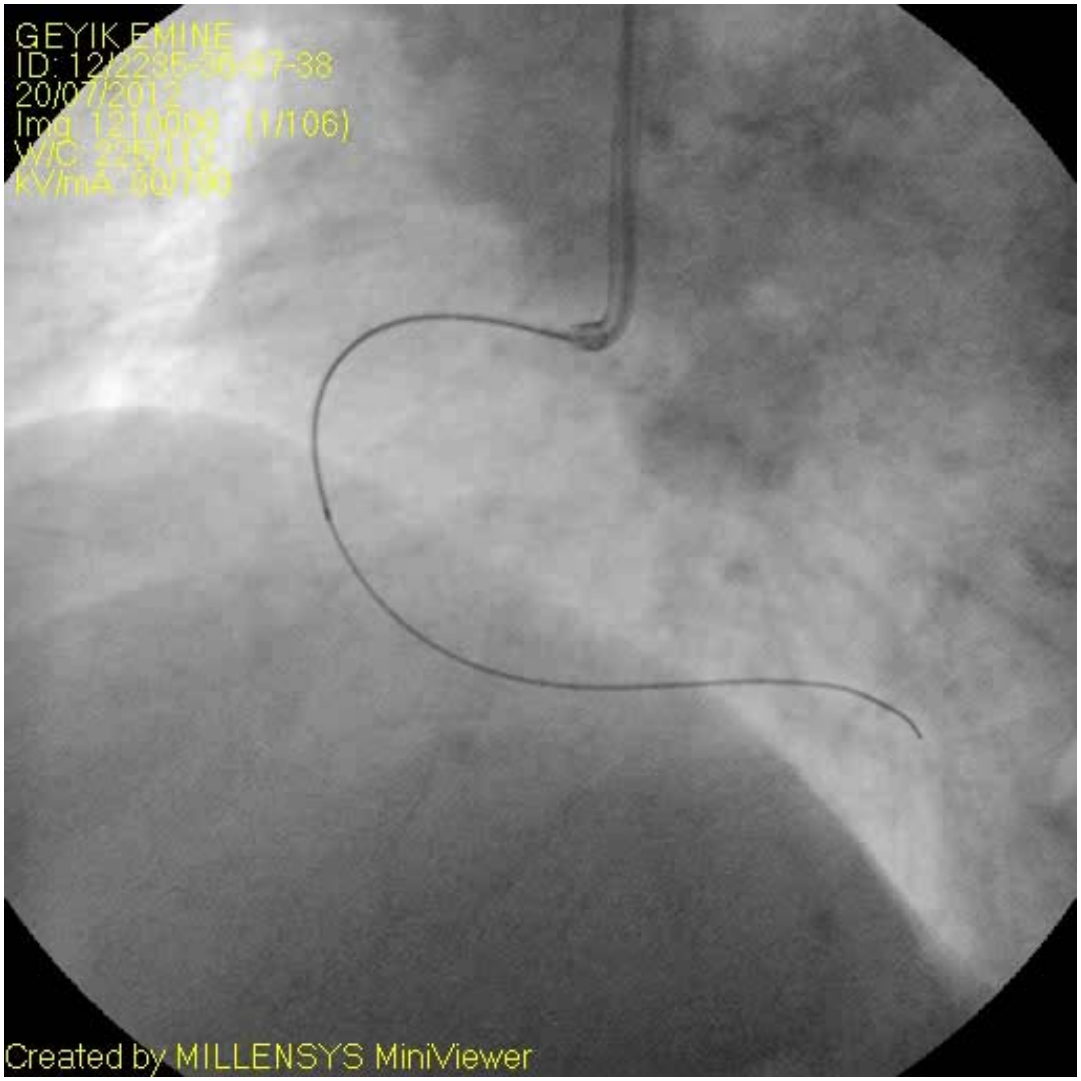
KTO

Miracle 6 GW lezyon geçildi. Corsair ve balon ile penetrasyon sağlanamadı



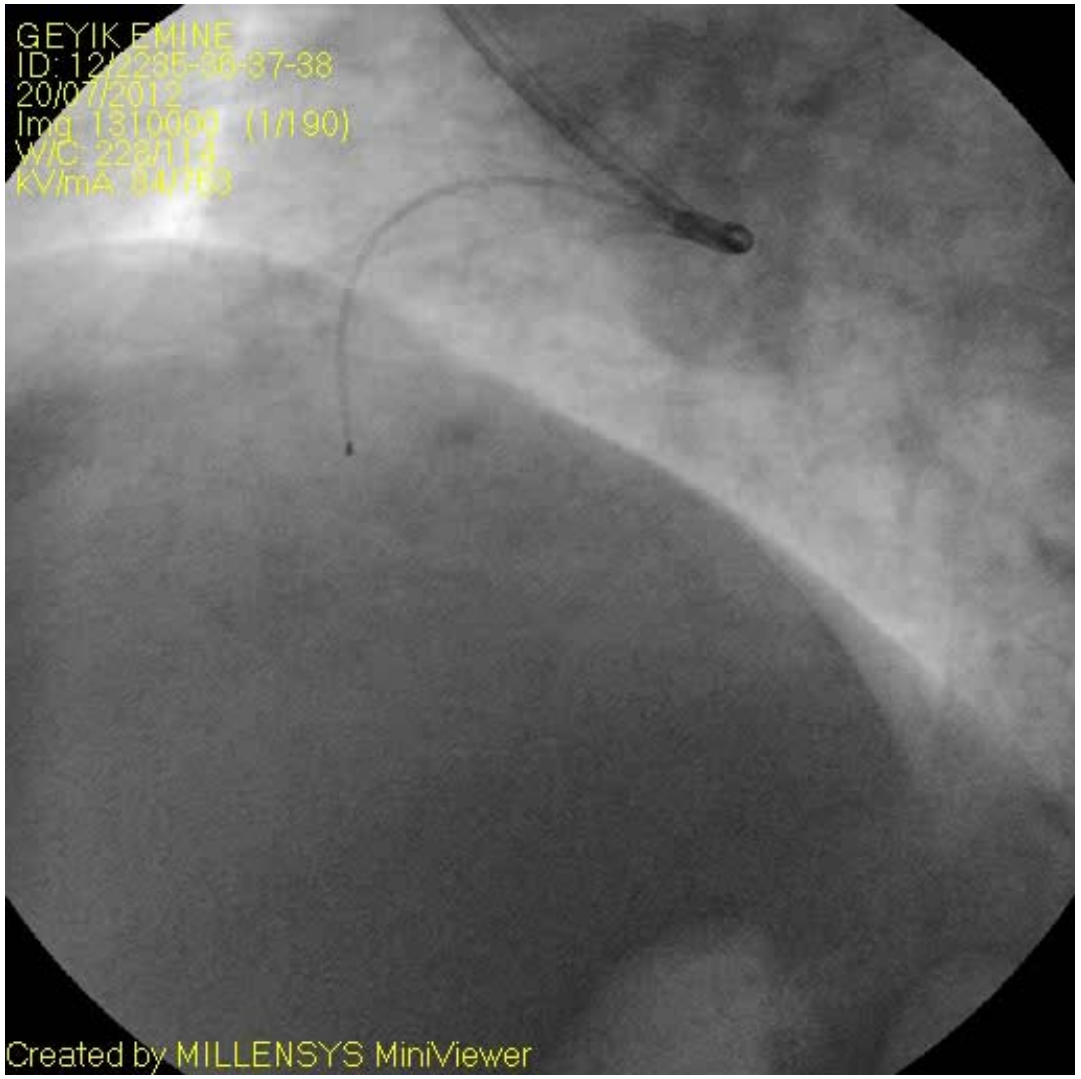
KTO

Tornus mikrokateter ile penetrasyon sağlandı



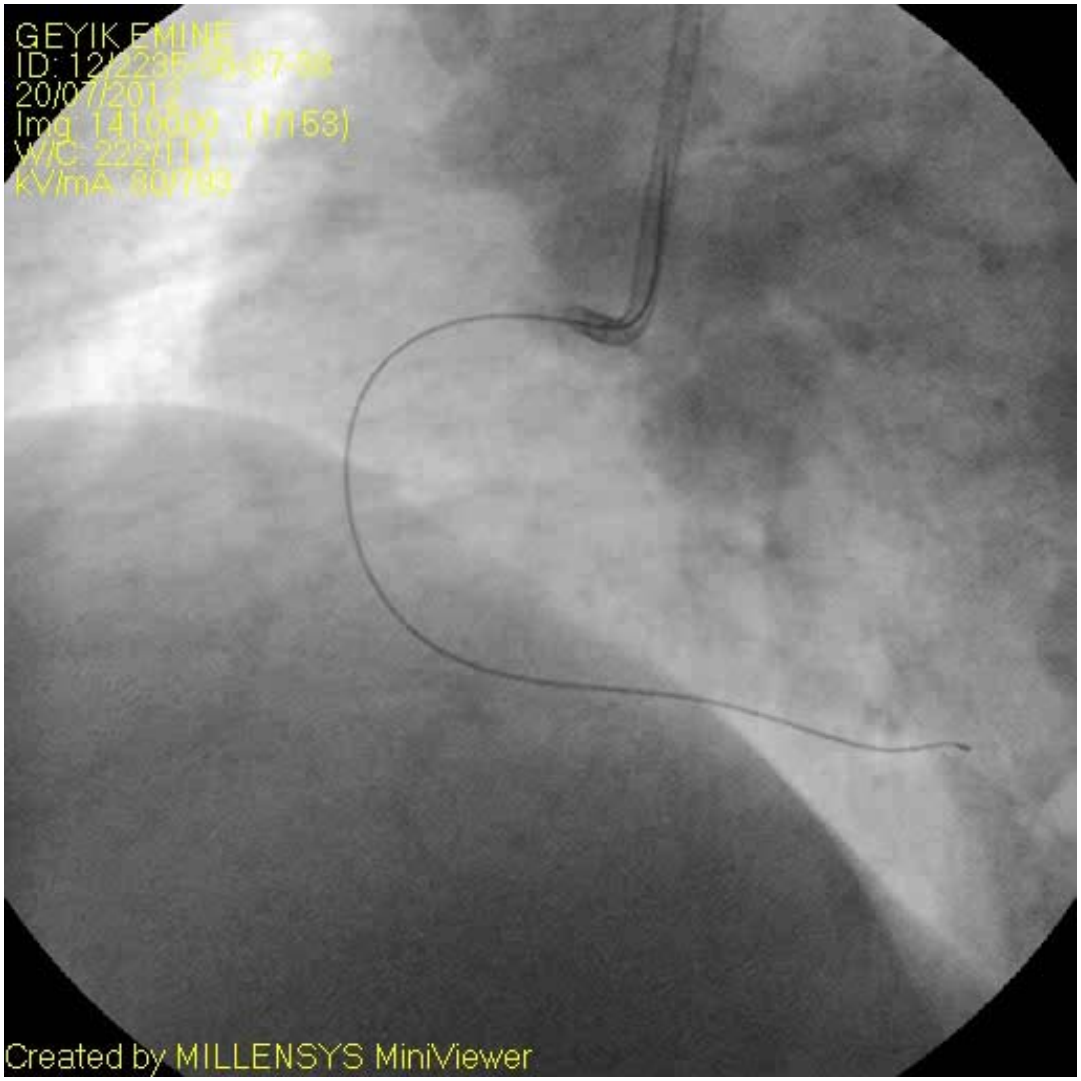
KTO

Miracle 6 GW Fielder XT GW ile değiştirildi



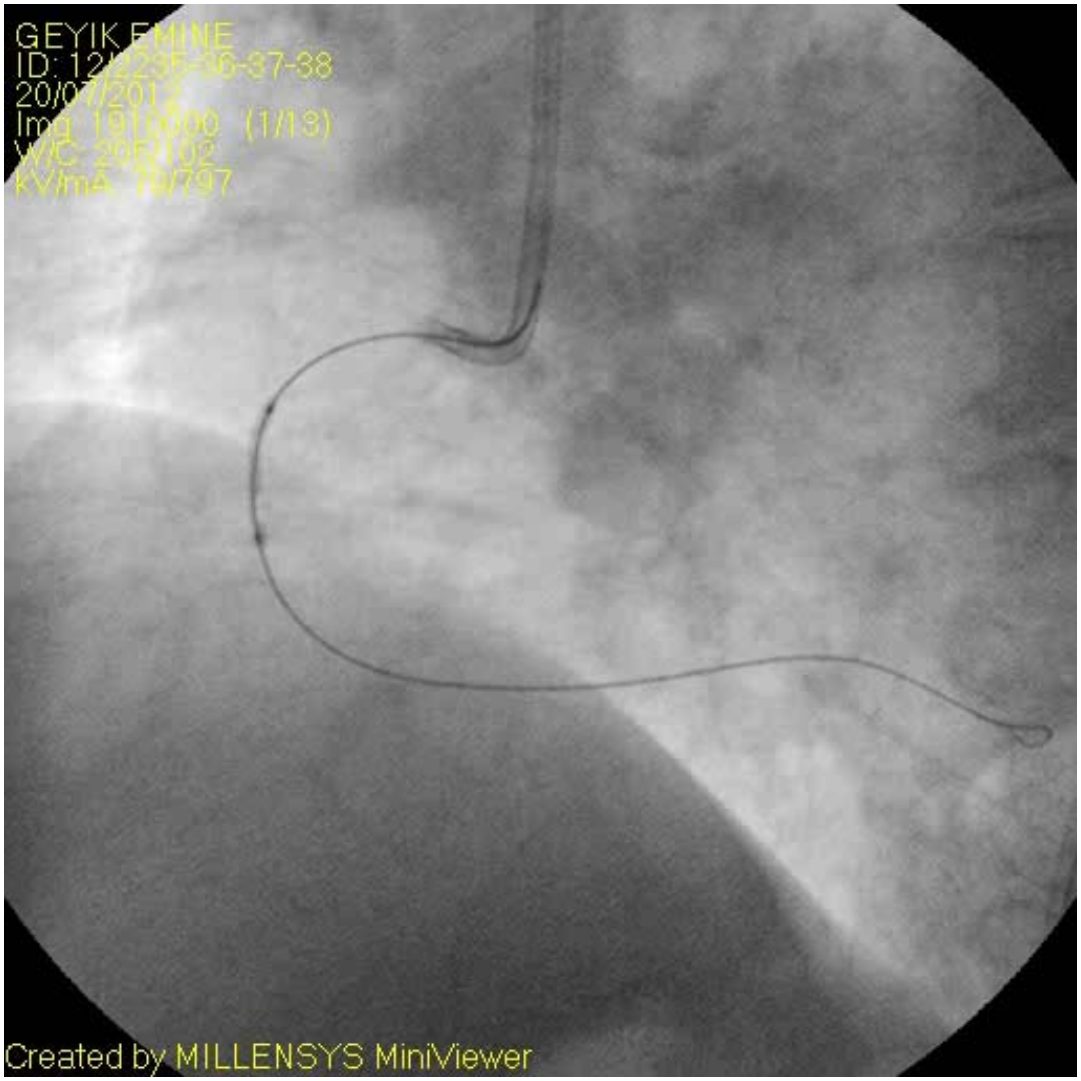
KTO

GW değiştirilerek yapılan KAG



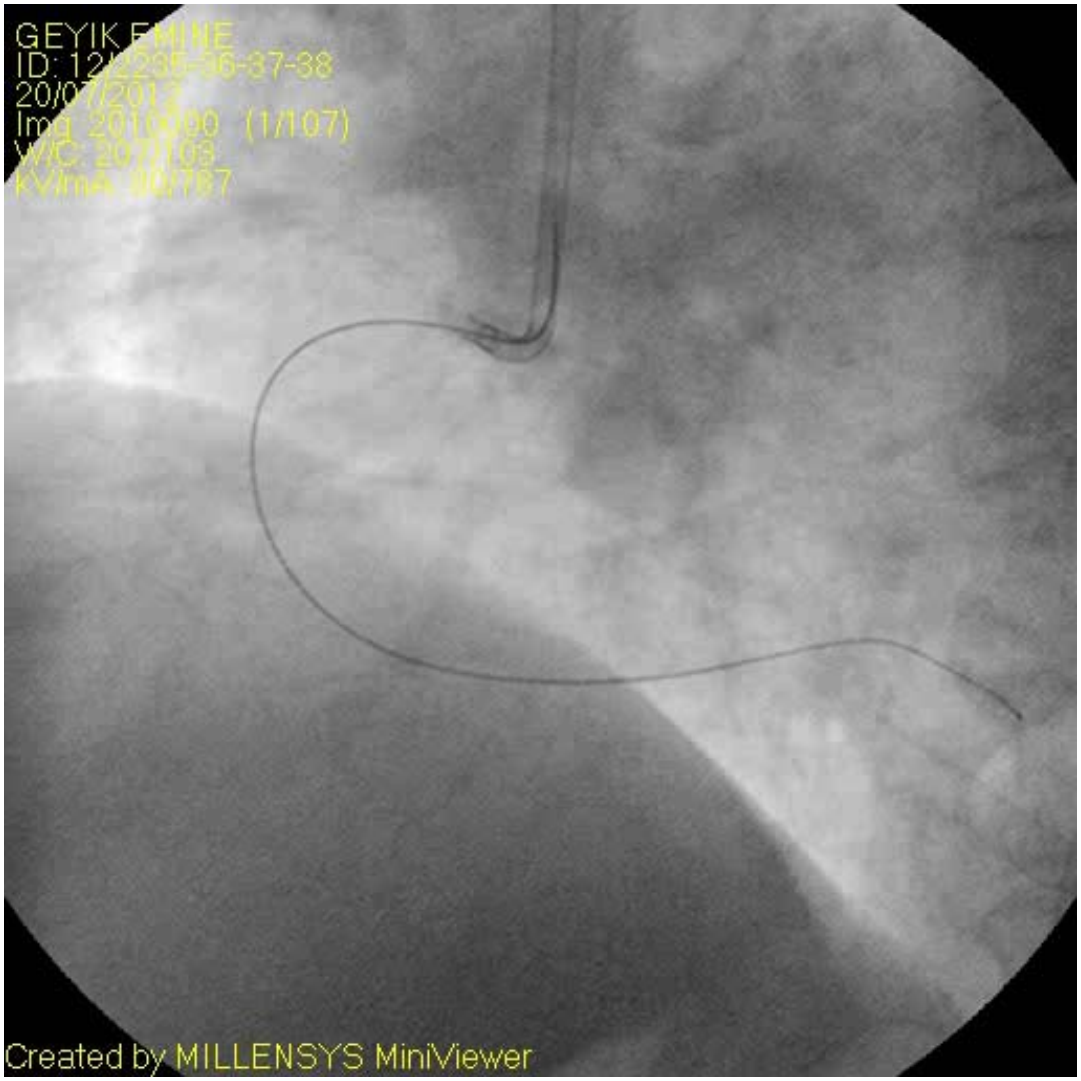
KTO

1.5*15 mm balon ile ardışık predilatasyonlar



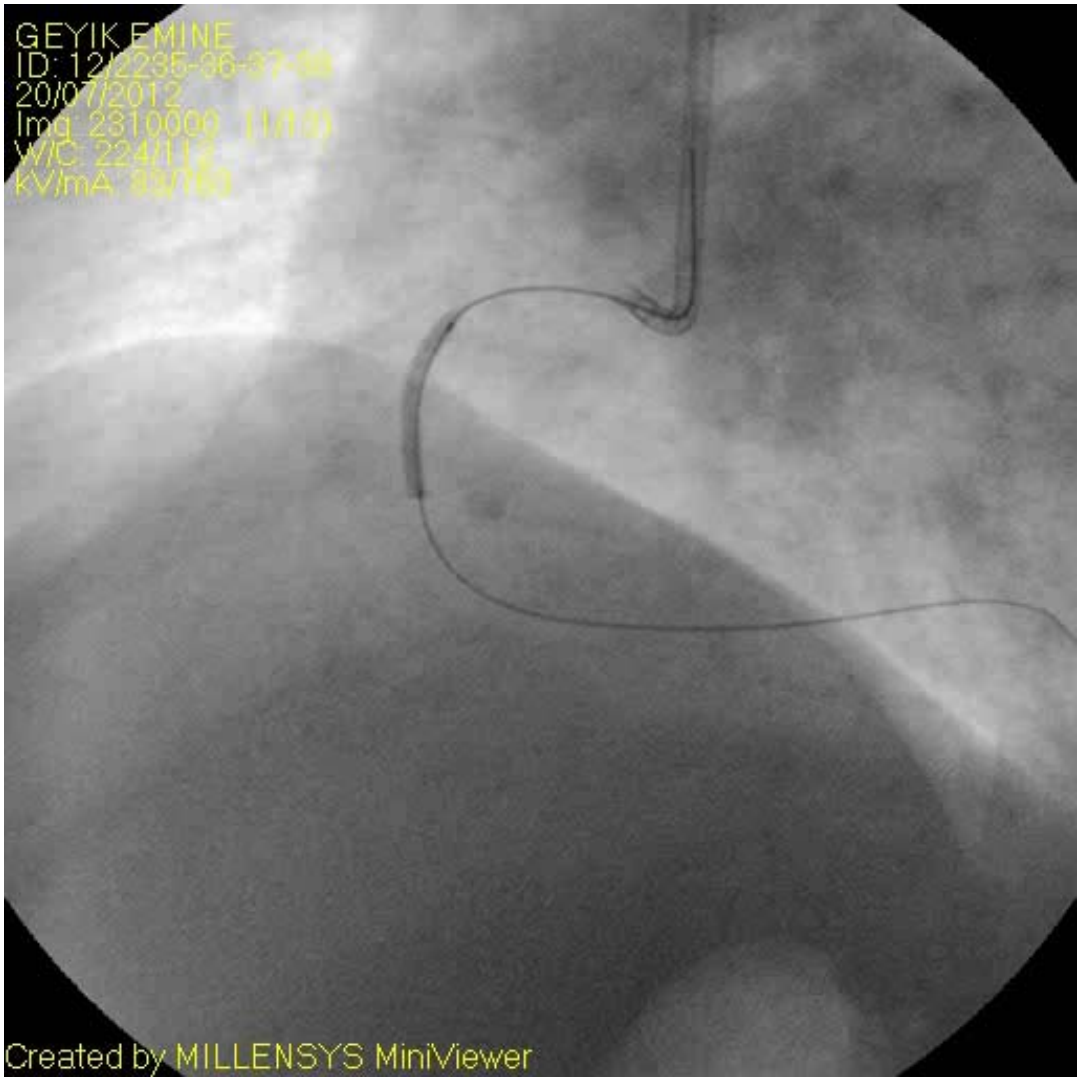
KTO

Kontrol KAG

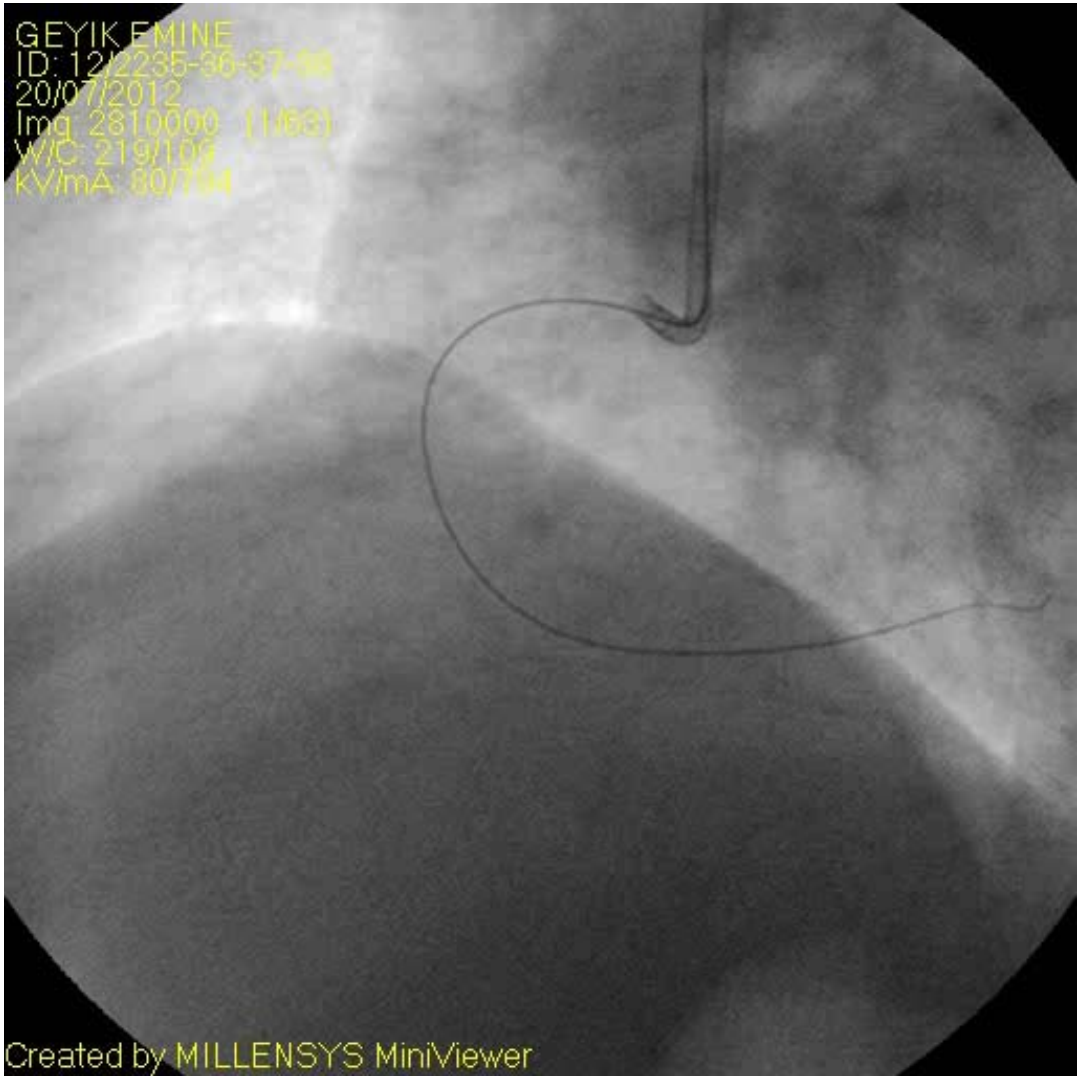


KTO

2.0*20 mm balon ile predilatasyon

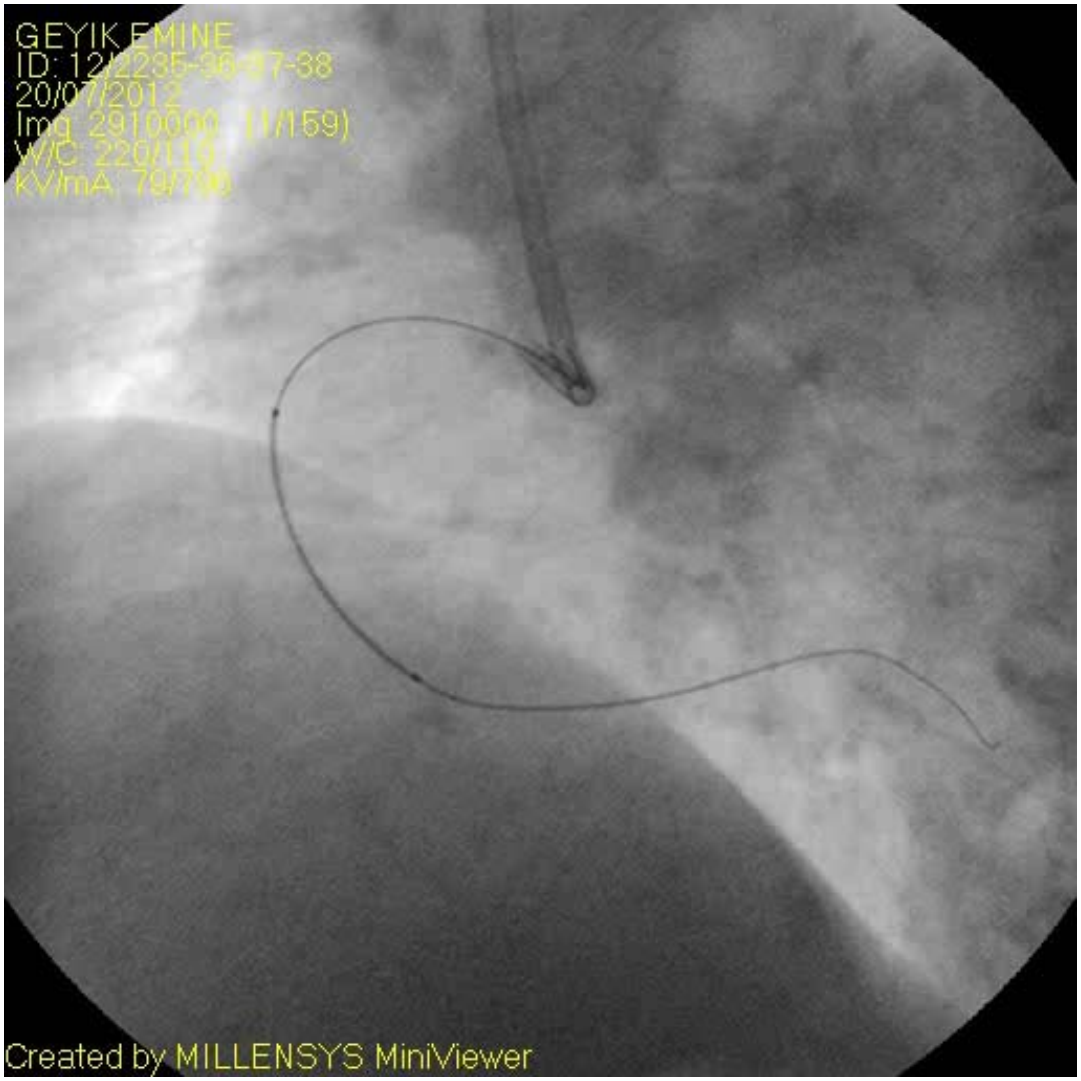


KTO
Balon dilatasyonlar sonrası kontrol KAG



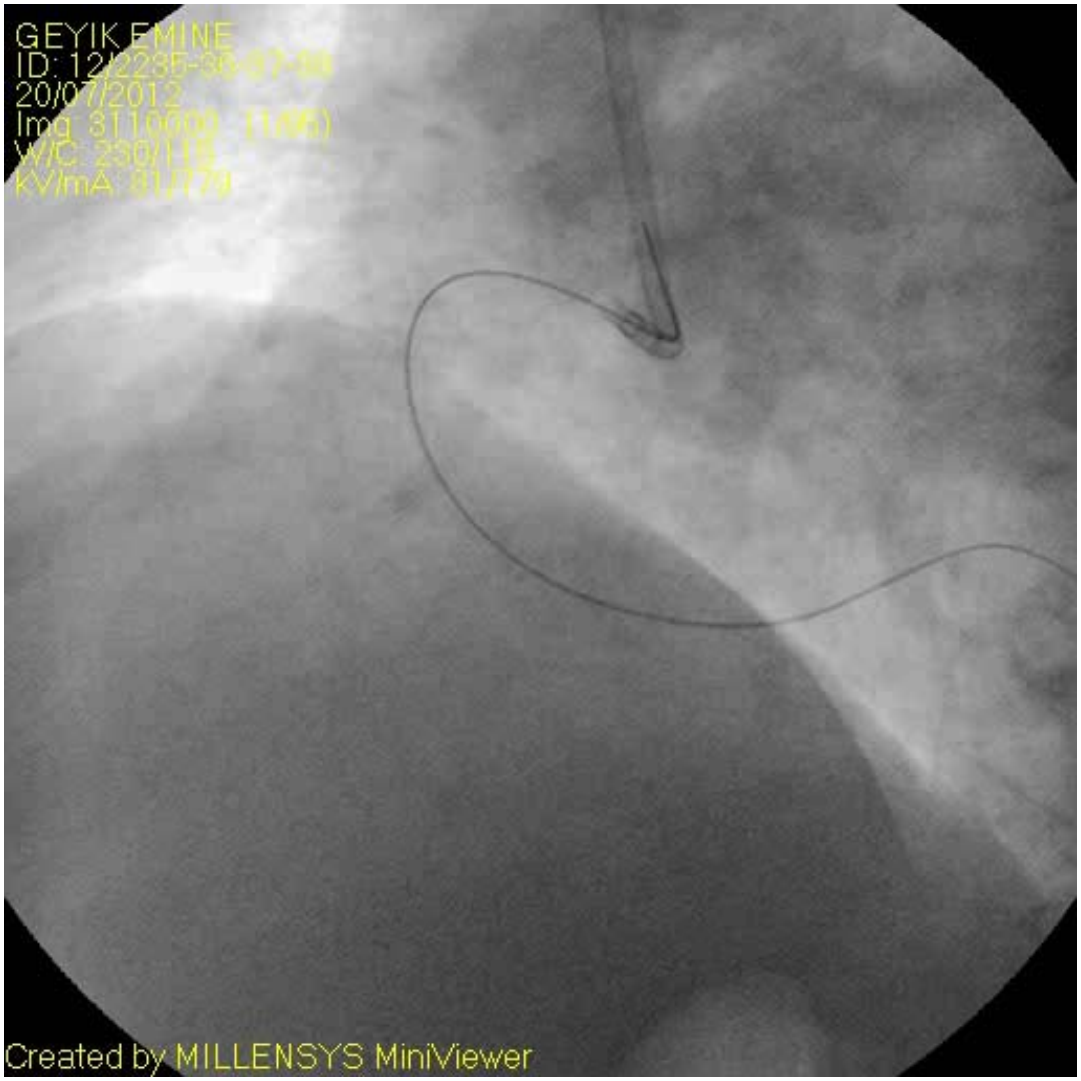
KTO

2.75*30 mm DES distale



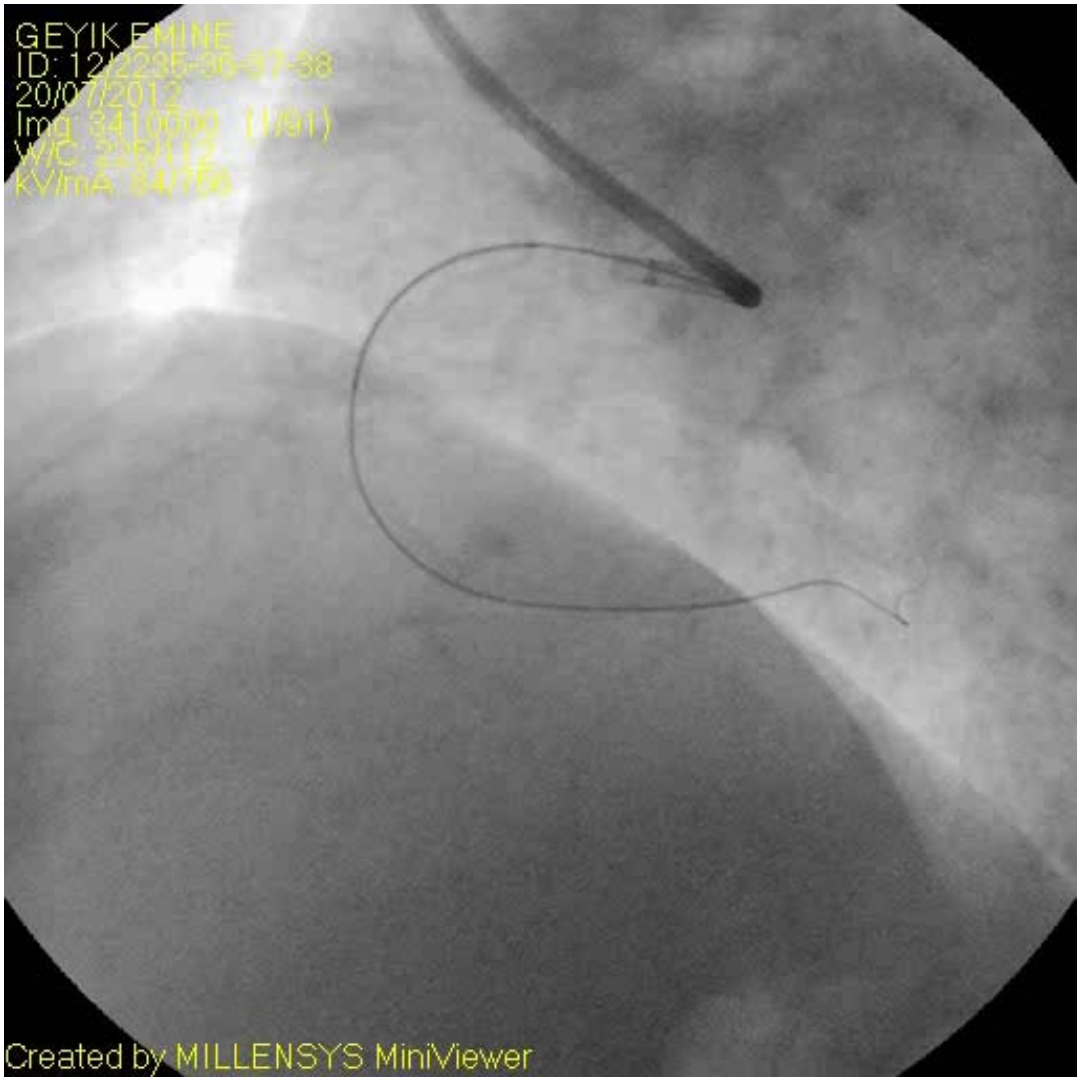
KTO

DES sonrası kontrol KAG



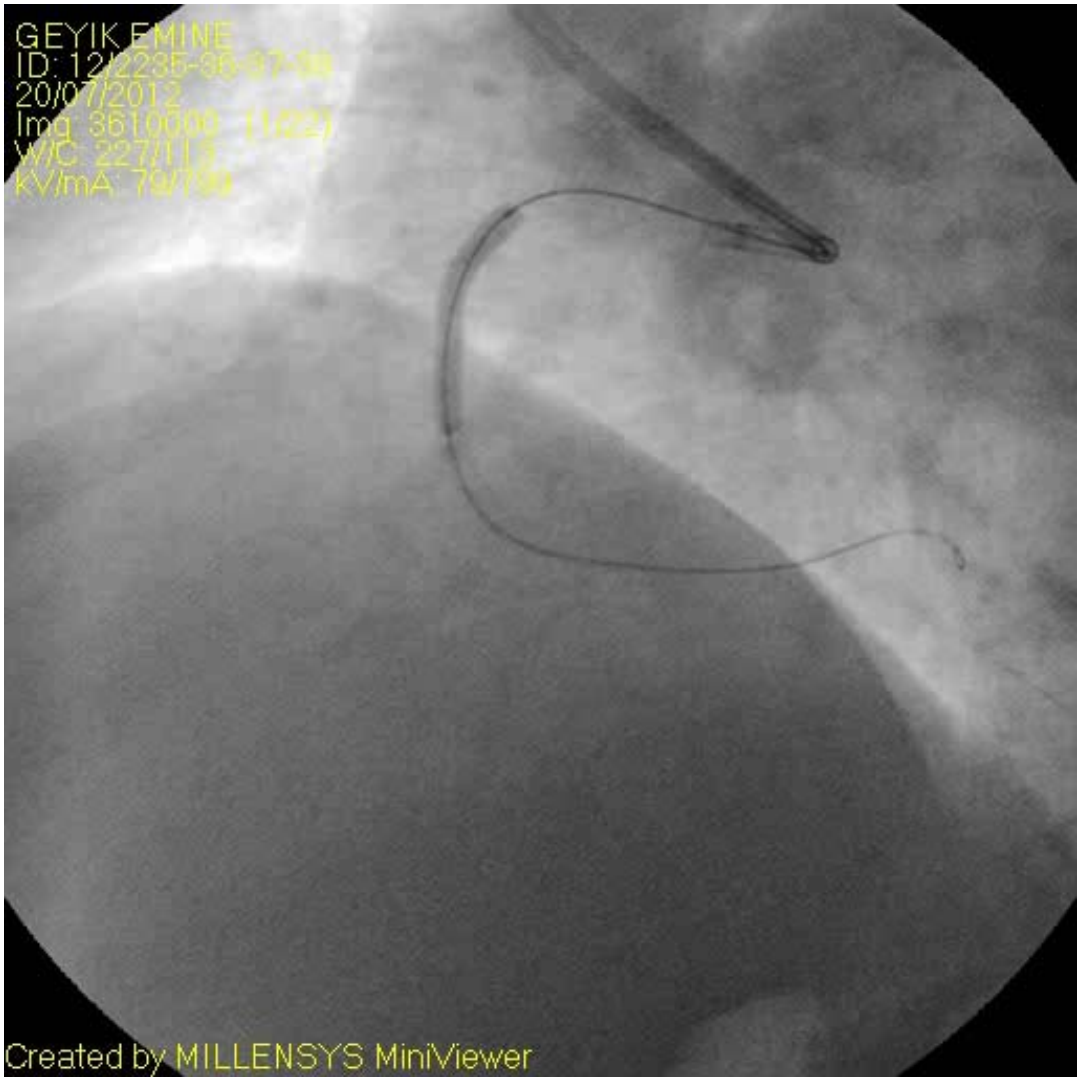
KTO

3.0*24 mm BMS proksimale



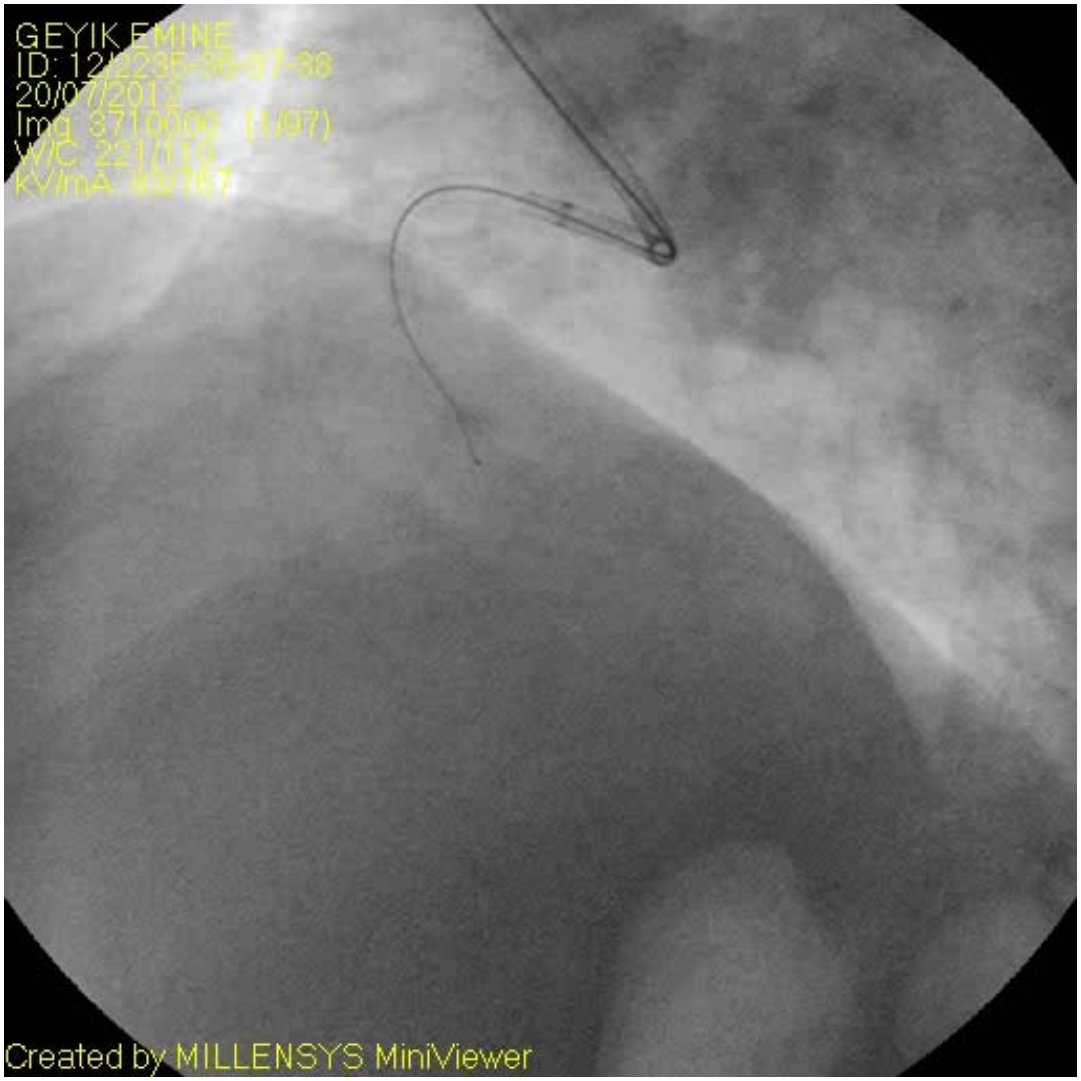
KTO

3.0*24 mm stent balonu



KTO

İşlem sonrası tam açılım



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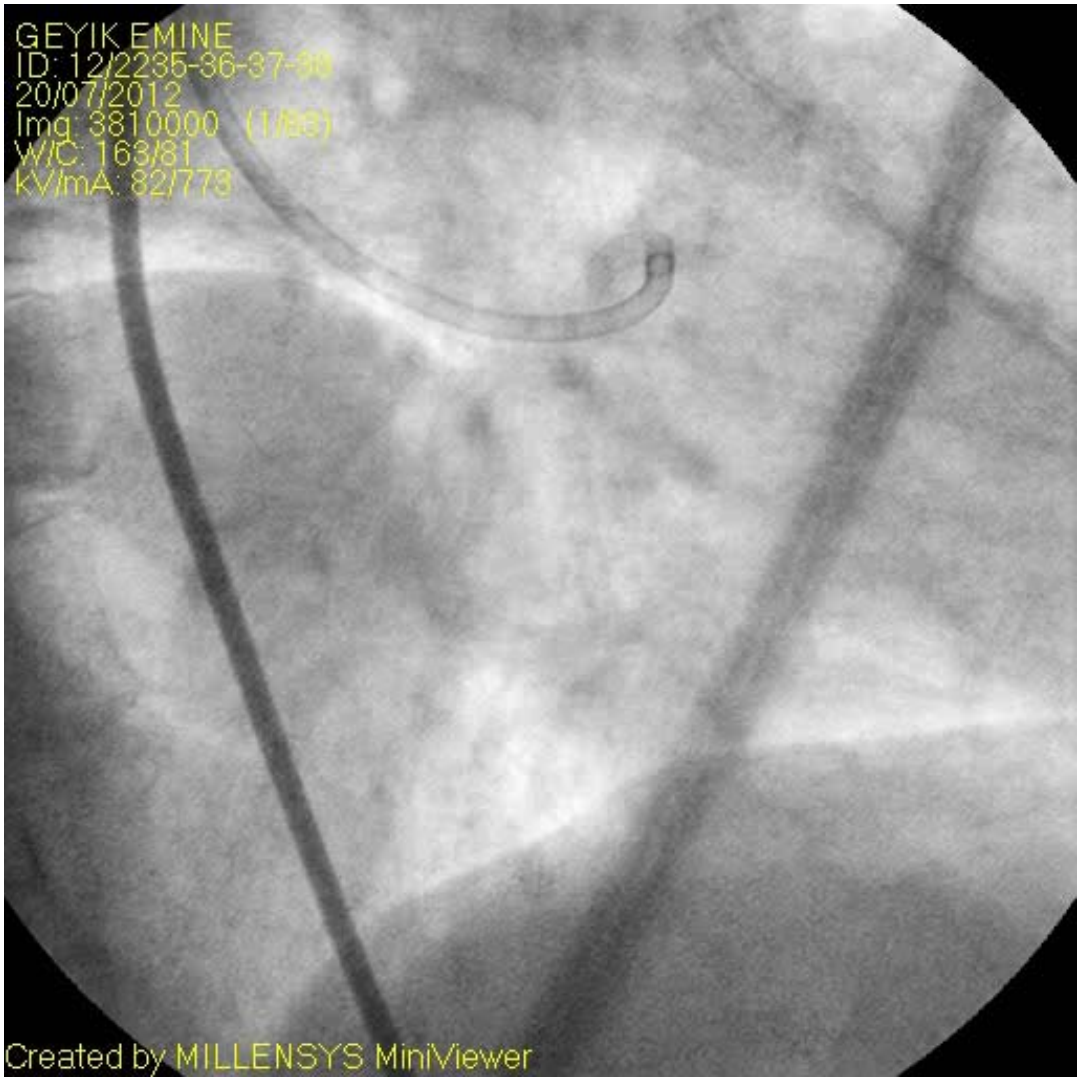
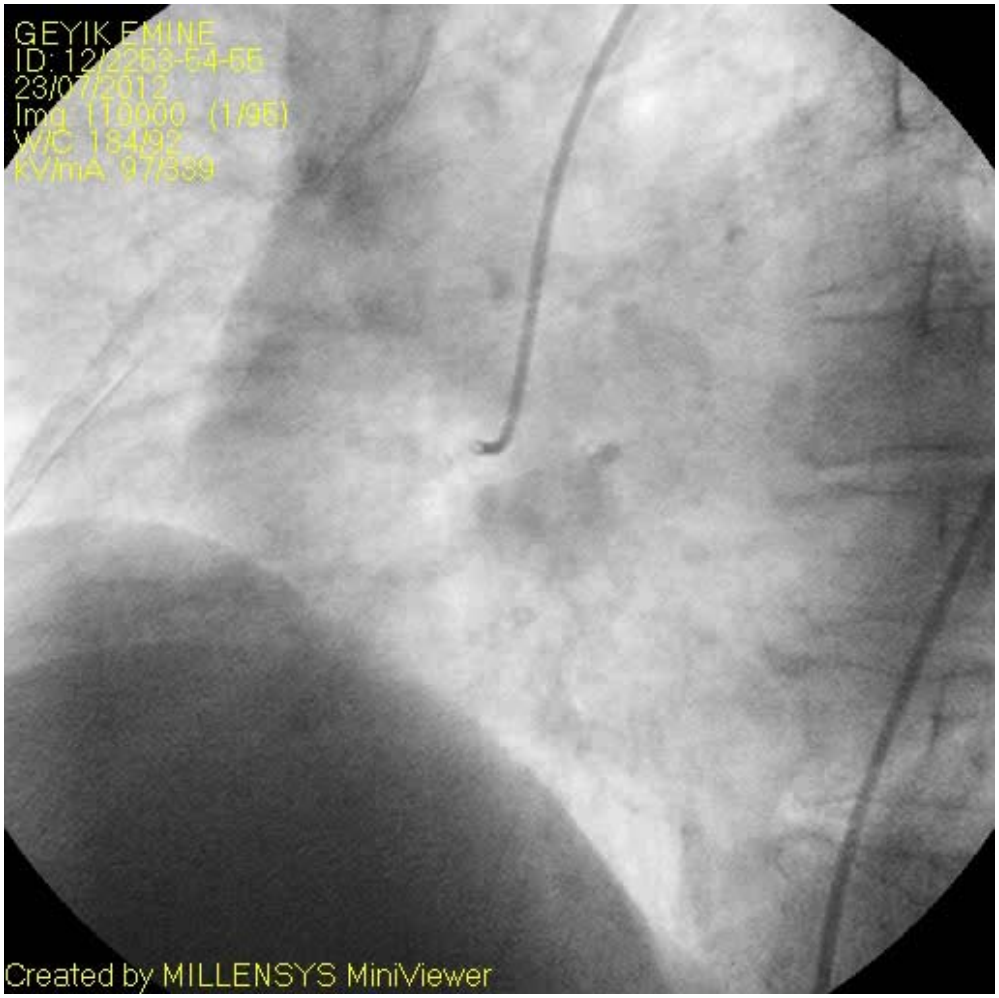
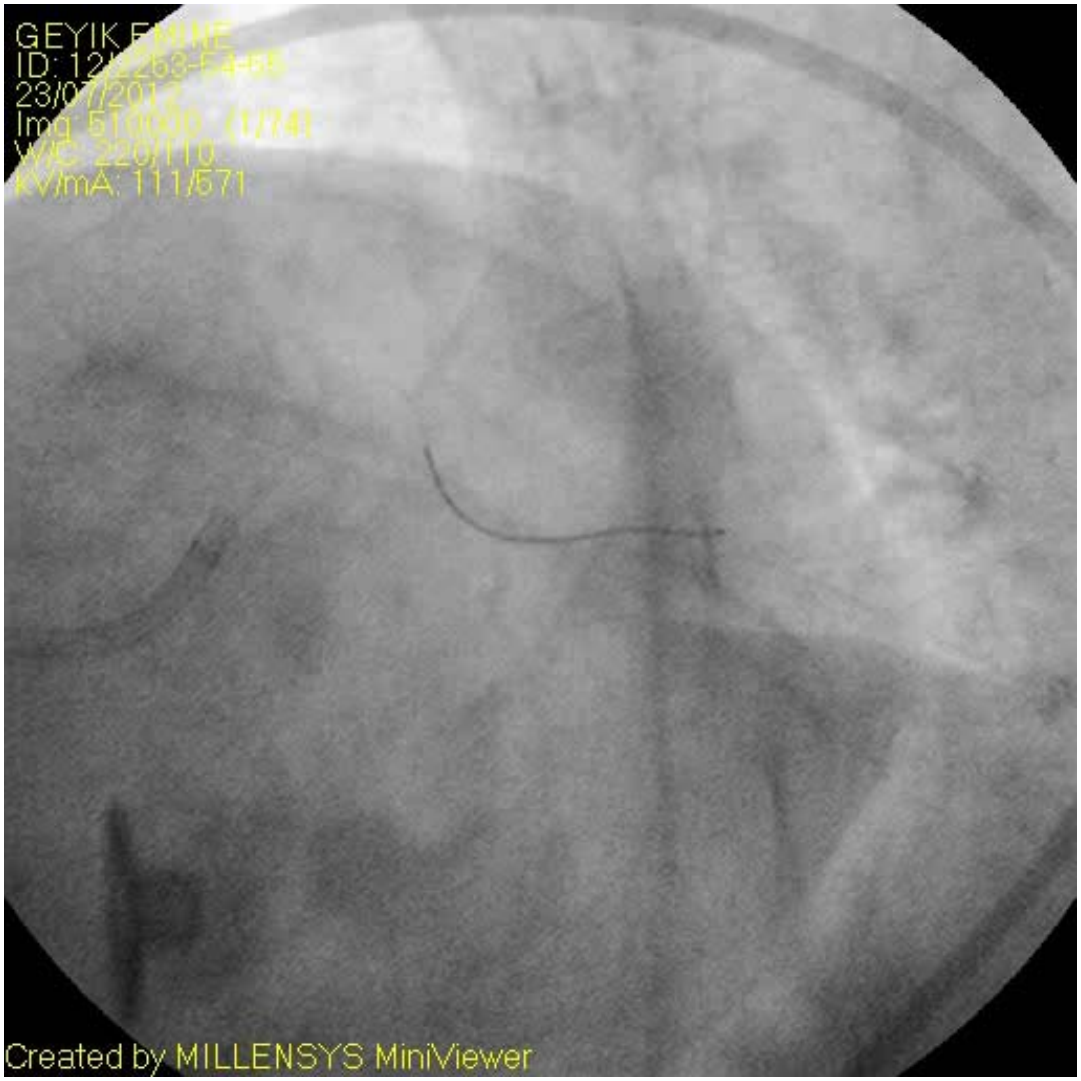


KTO

İşlem sonrası tam açılım

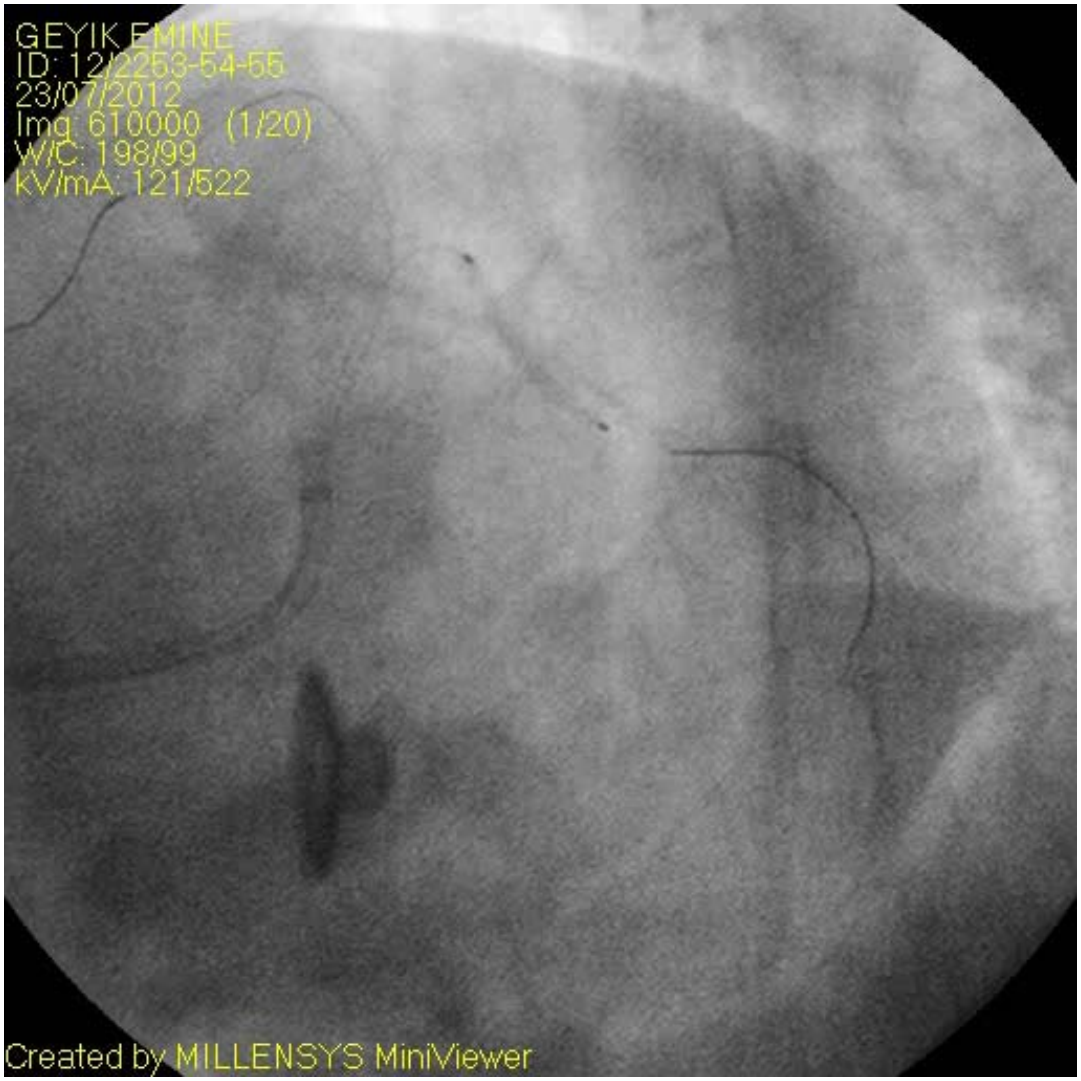


CX Artere PCI



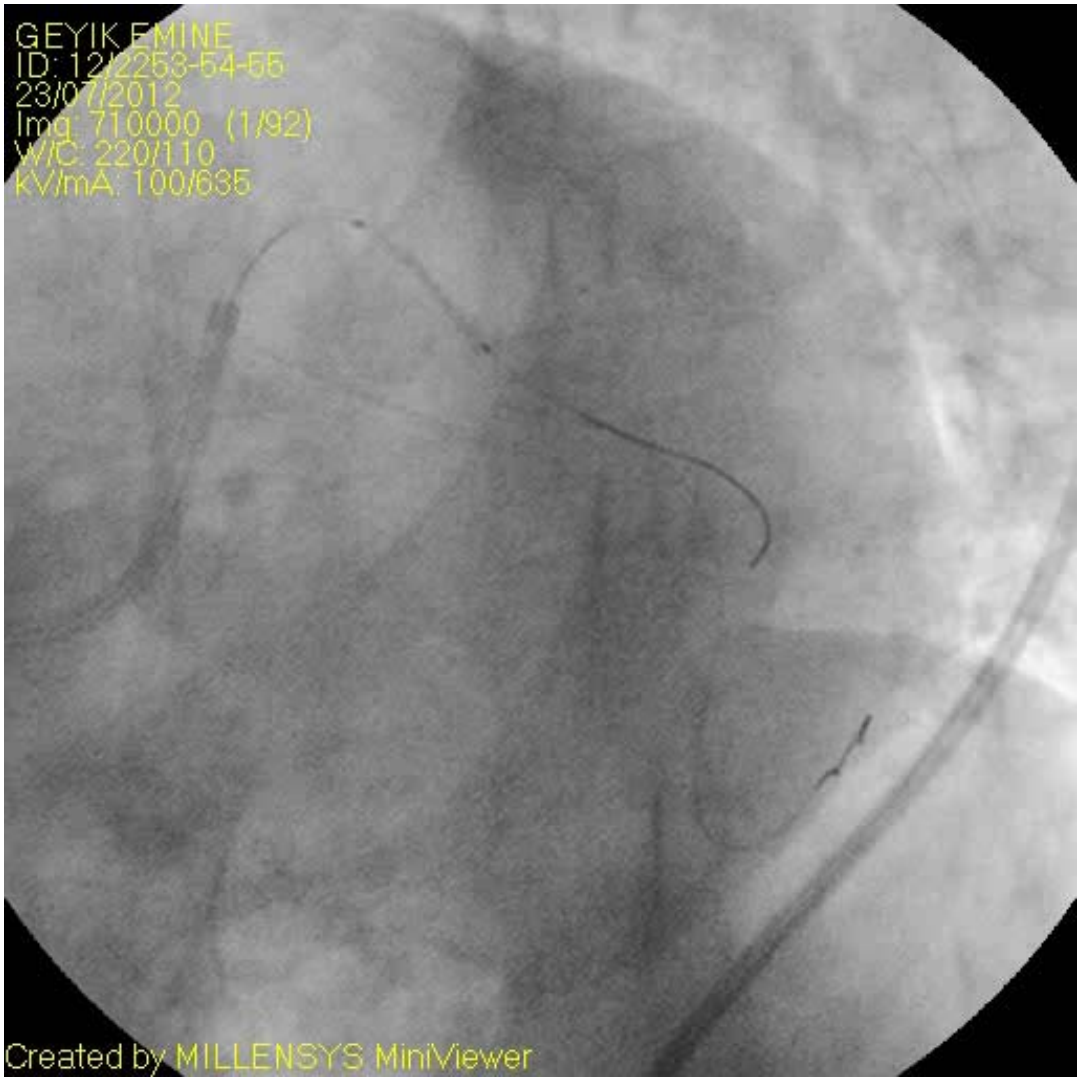
CX Artere PCI

Judkins GK, 0.014 Flopy GW ve 2.0*20 mm balon ile predilatasyon



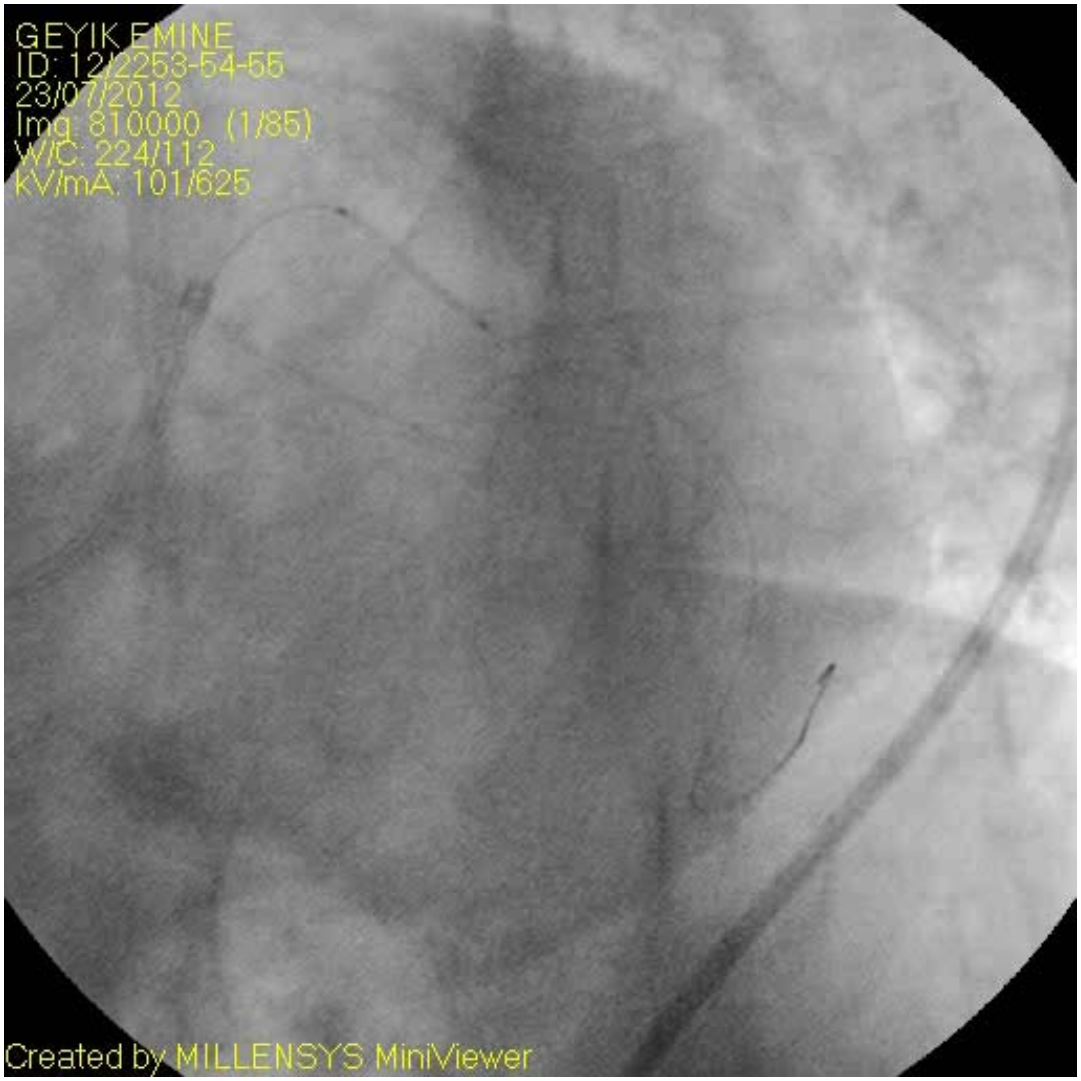
CX Artere PCI

EBU kateter, 0.014 Flopy GW, PT2 hidrofilik
GW 3.5*16 mm BMS



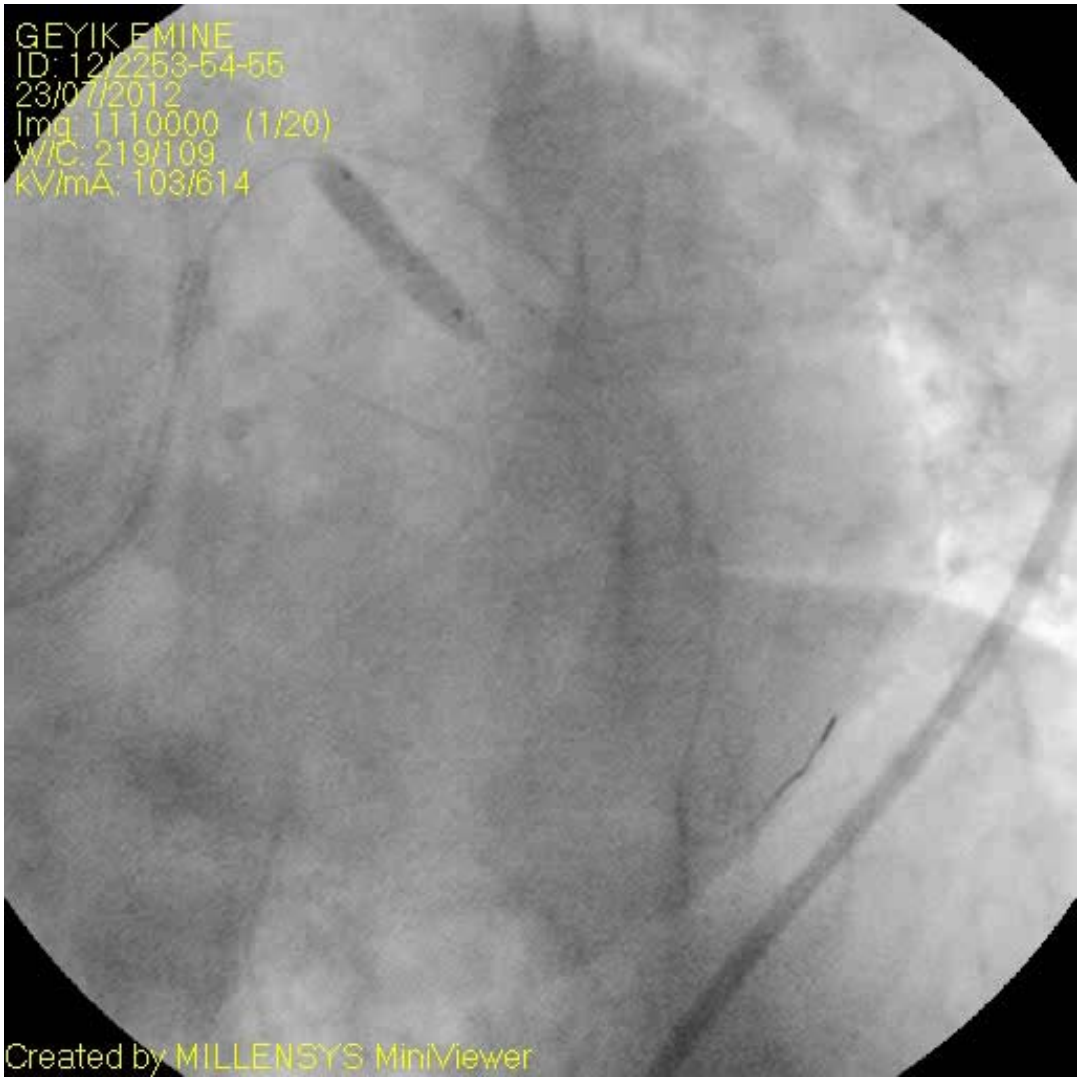
CX Artere PCI

PT2 GW ve 3.5*16 mm BMS yerleşimi



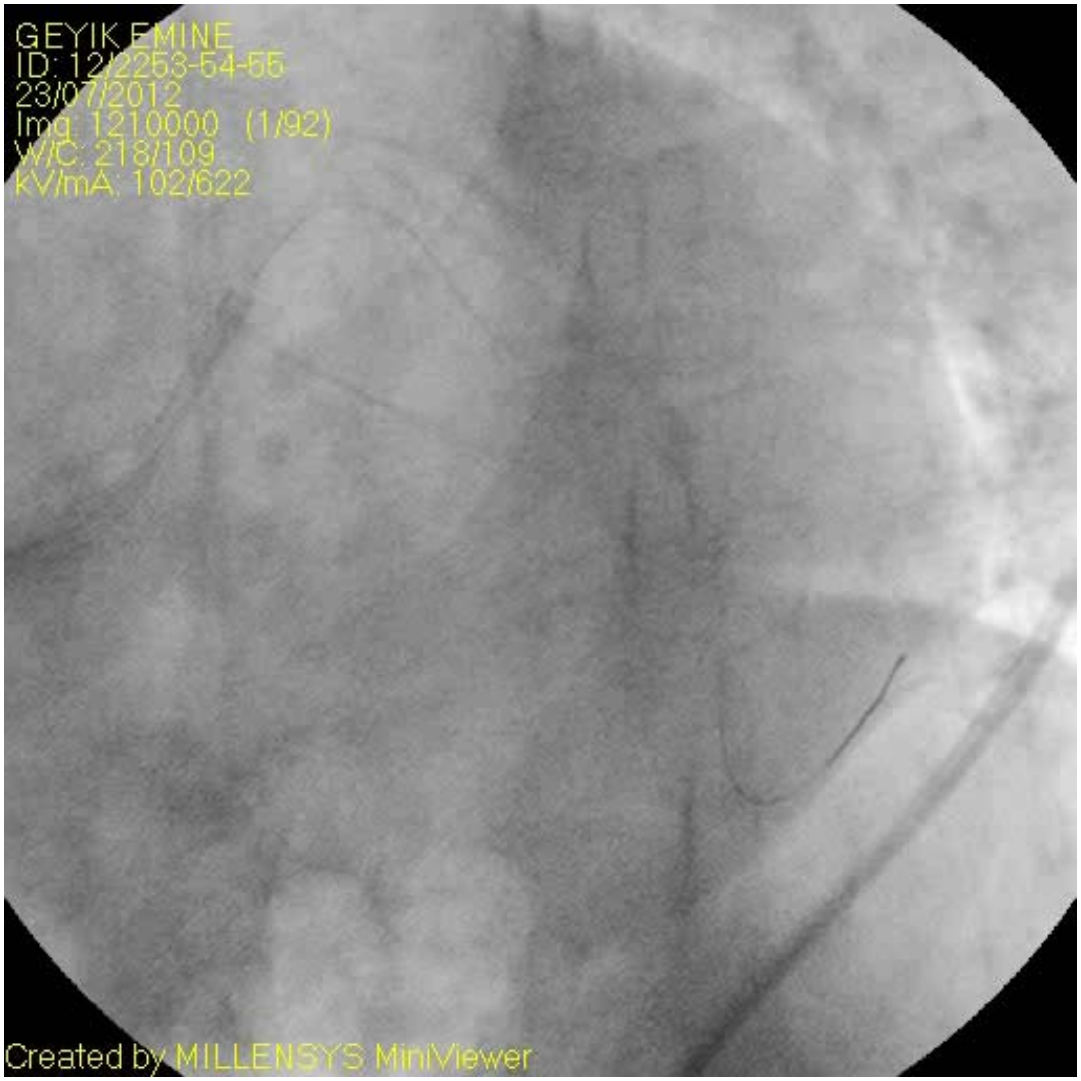
CX Artere PCI

3.5*16 mm BMS



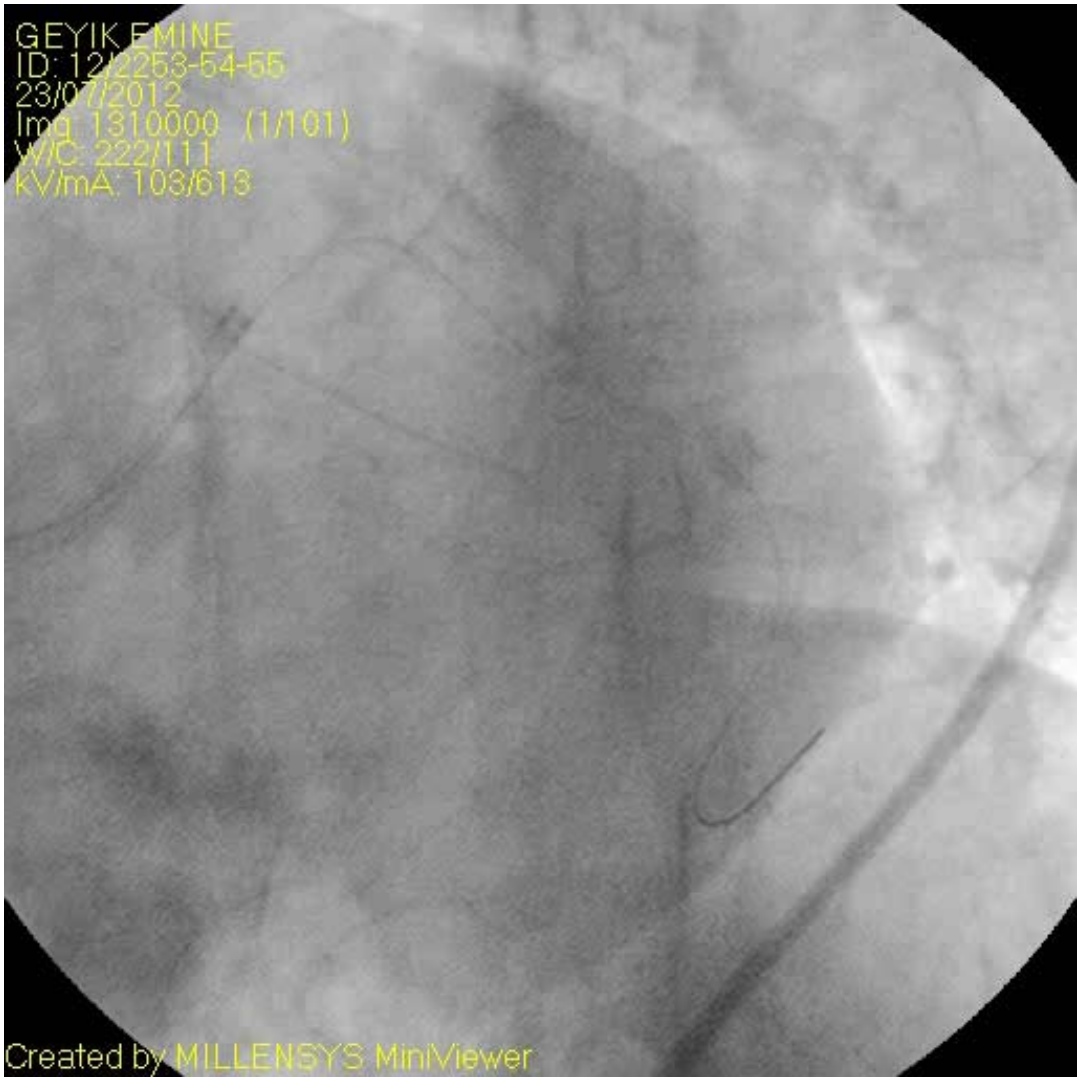
CX Artere PCI

Stent sonrası projeksiyonda Ellis Tip II perforasyon oluşumu



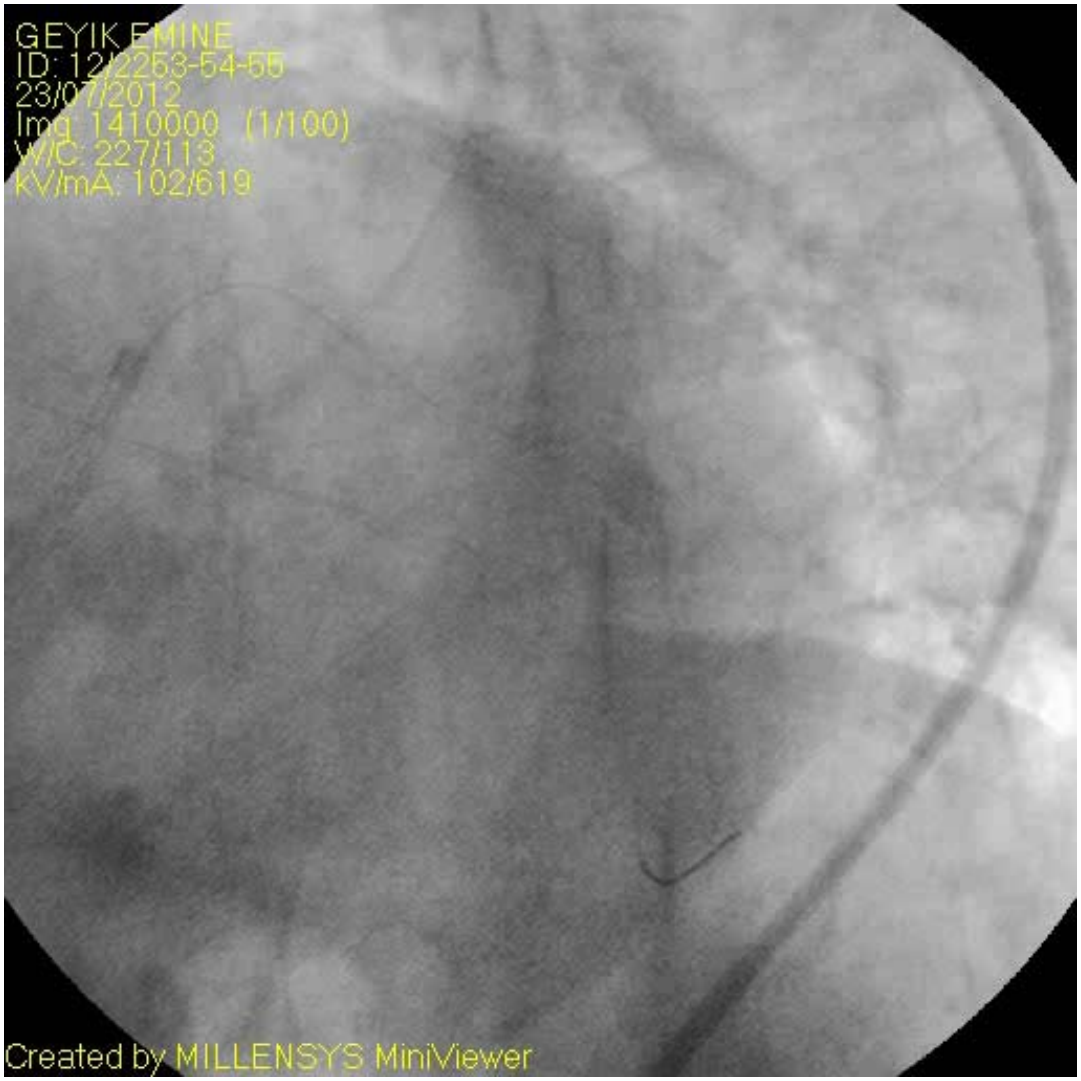
CX Artere PCI

perforasyon



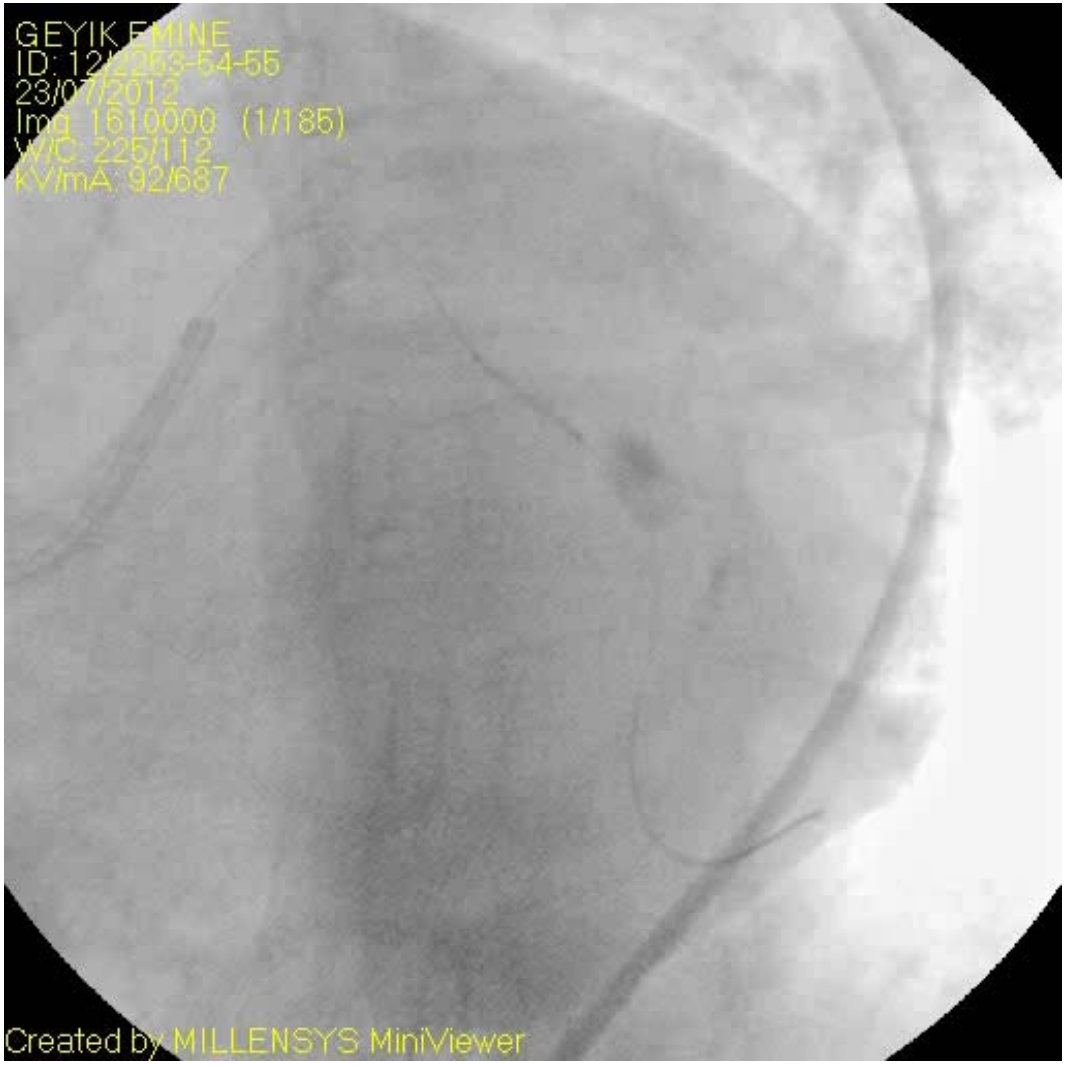
CX Artere PCI

perforasyon



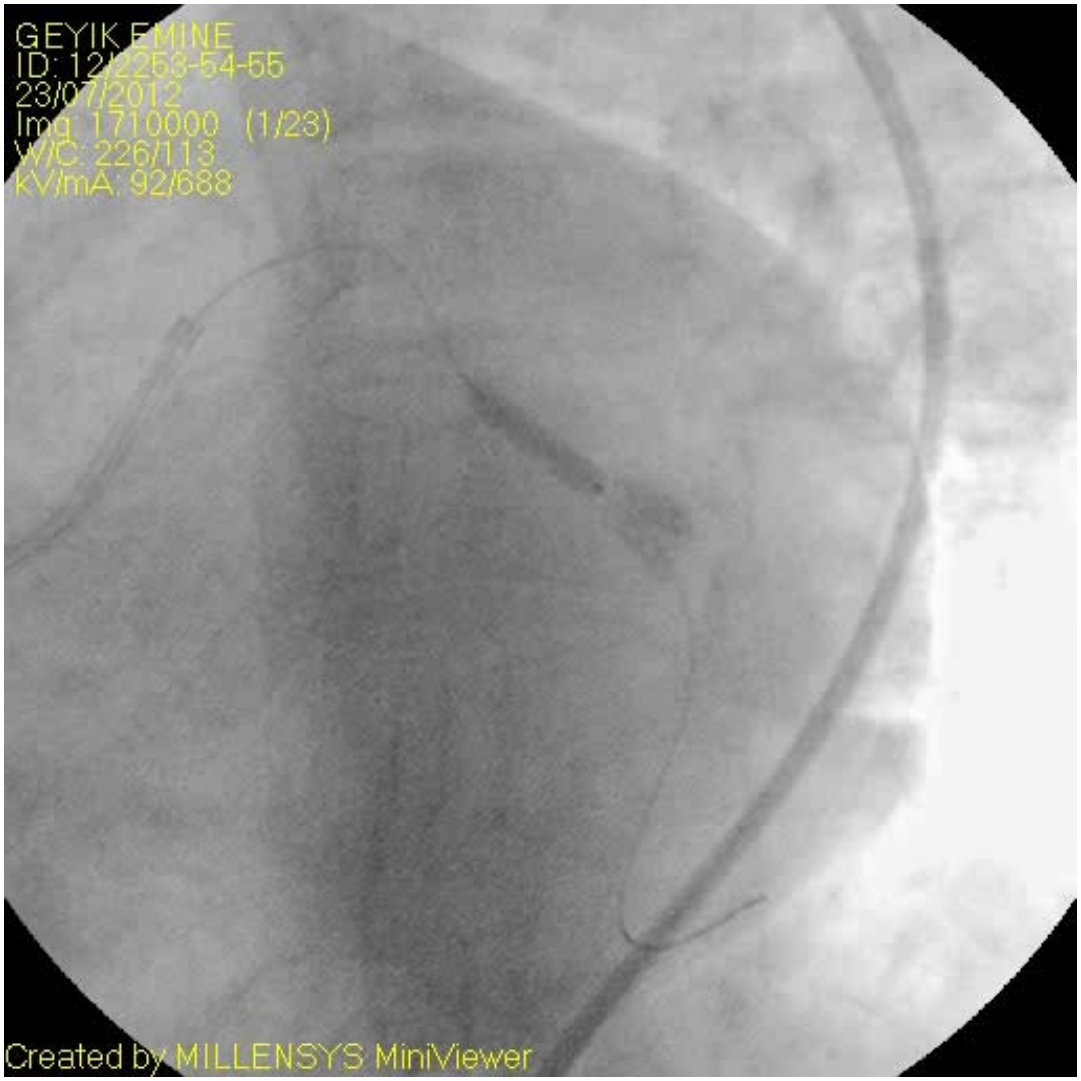
CX Artere PCI

proksimal stentin distaline 3.0*12 mm BMS



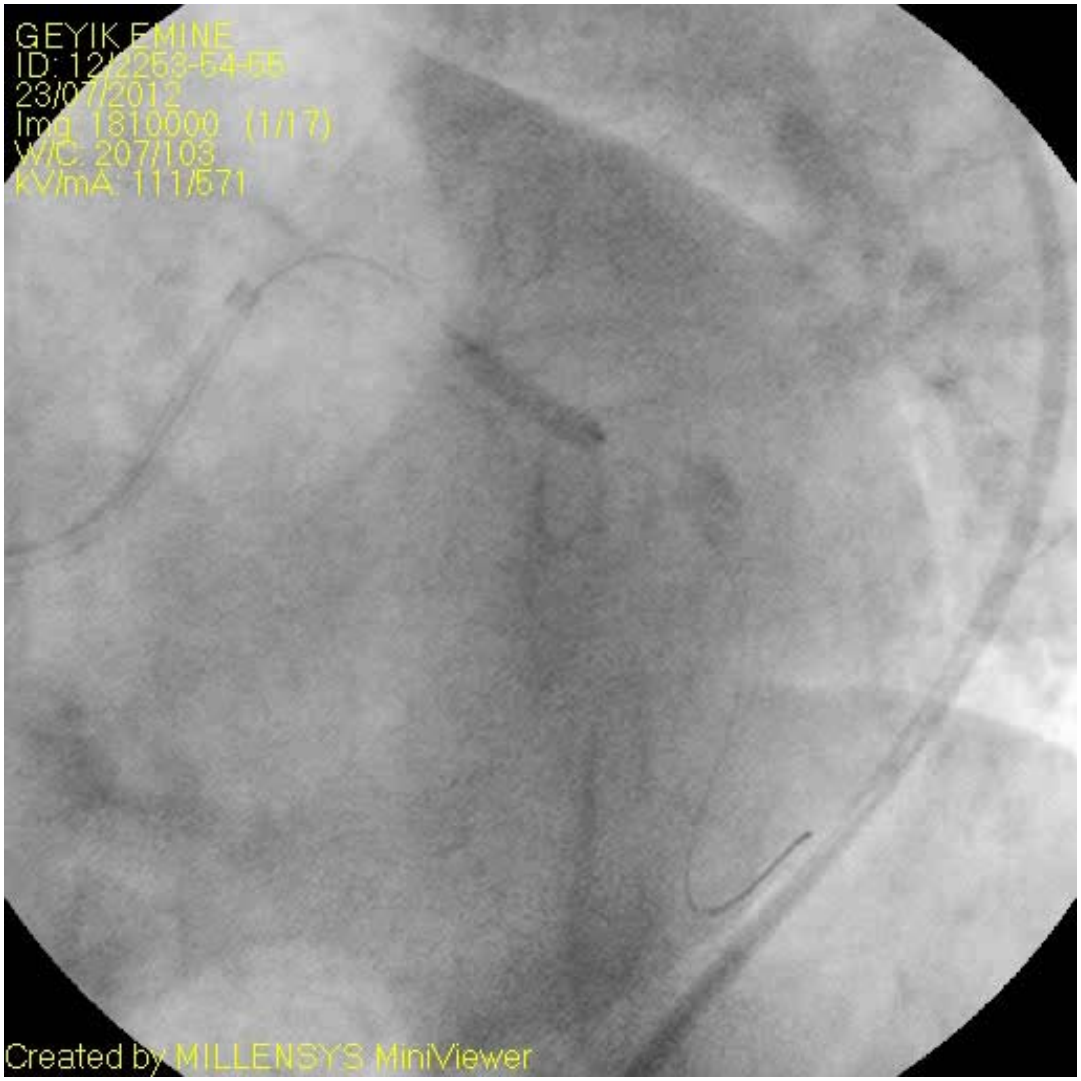
CX Artere PCI

3.0*12 mm BMS



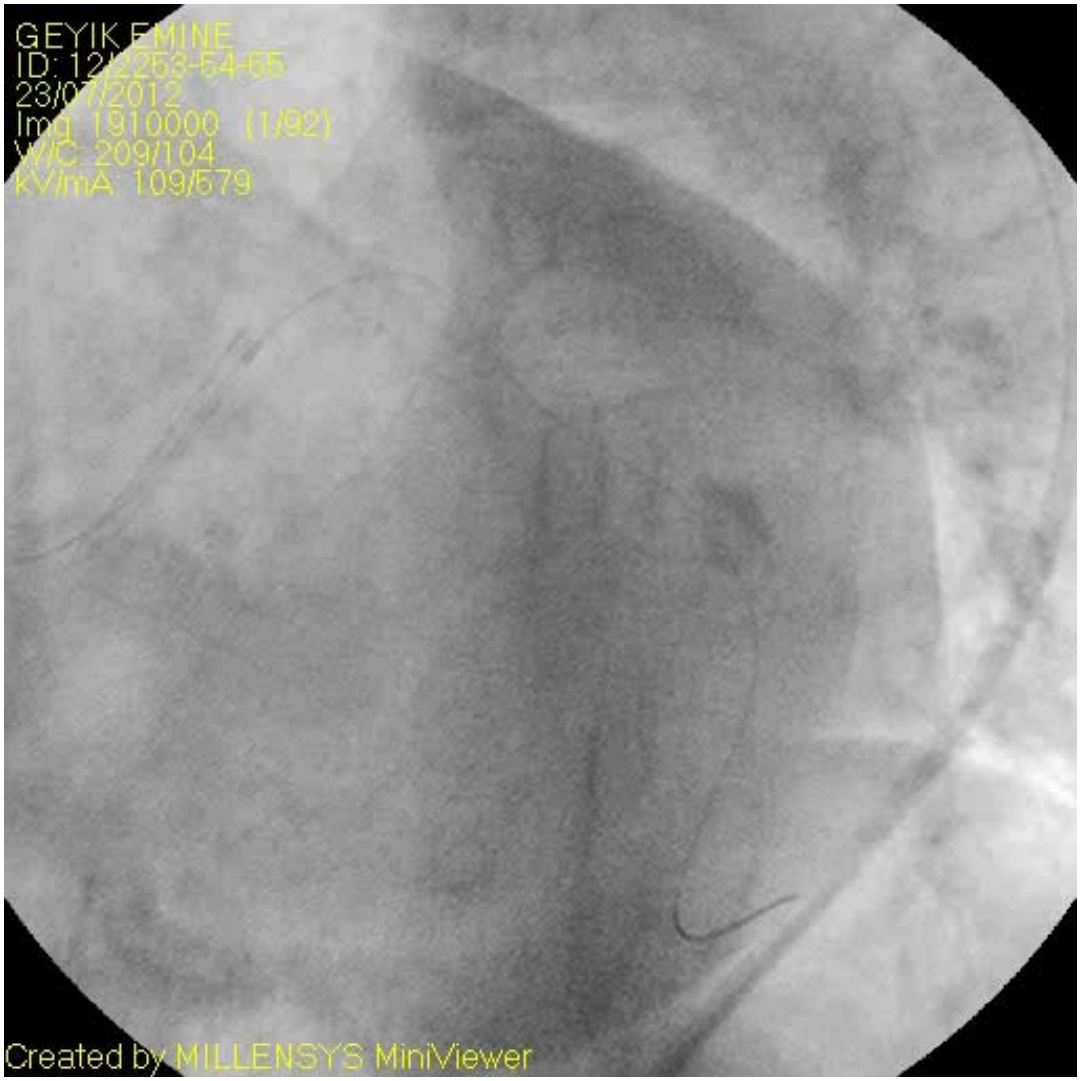
CX Artere PCI

3.0*12 mm stentin balonu proksimale çekilip 70 sn kadar şişirilerek beklendi



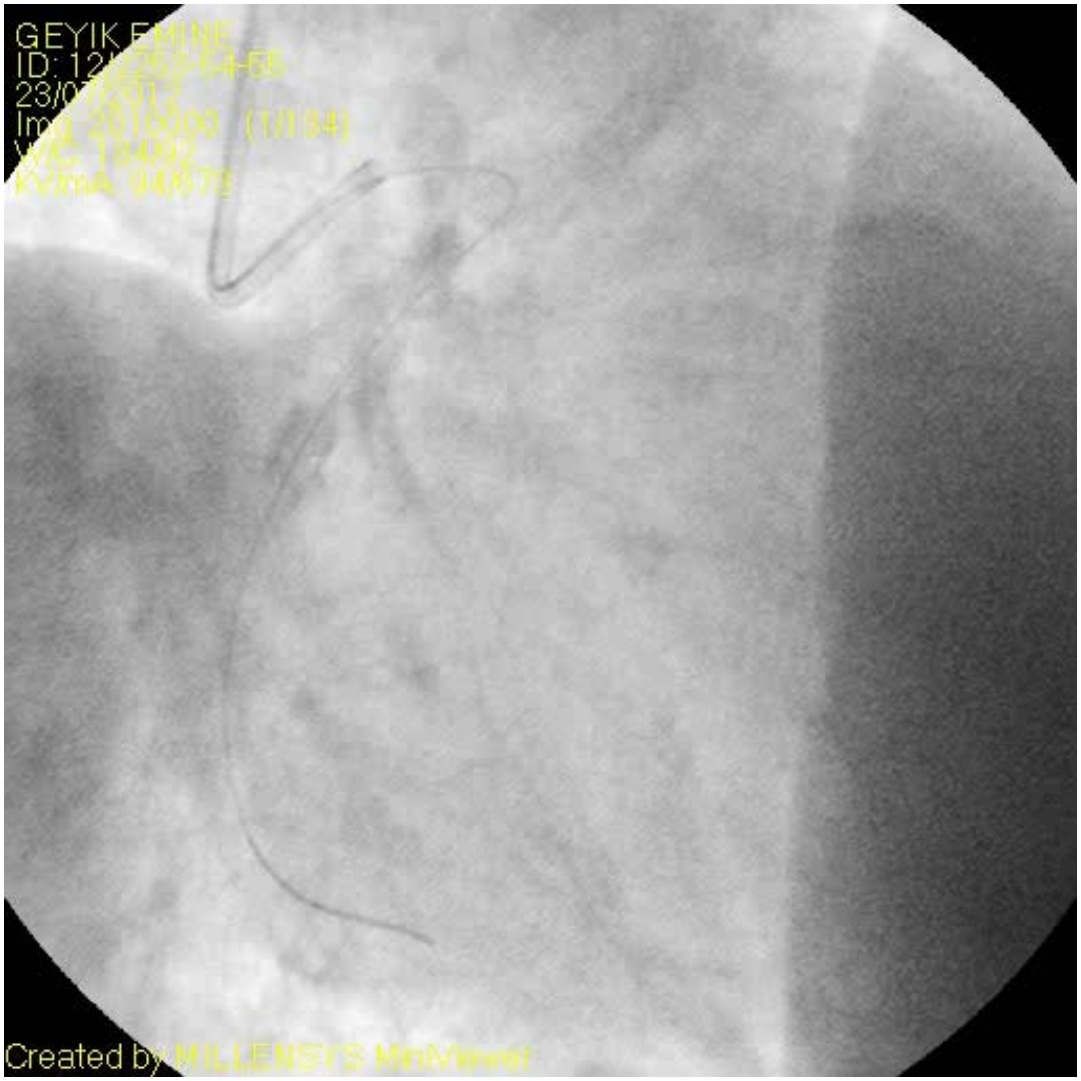
CX Artere PCI

Kontrol KAG



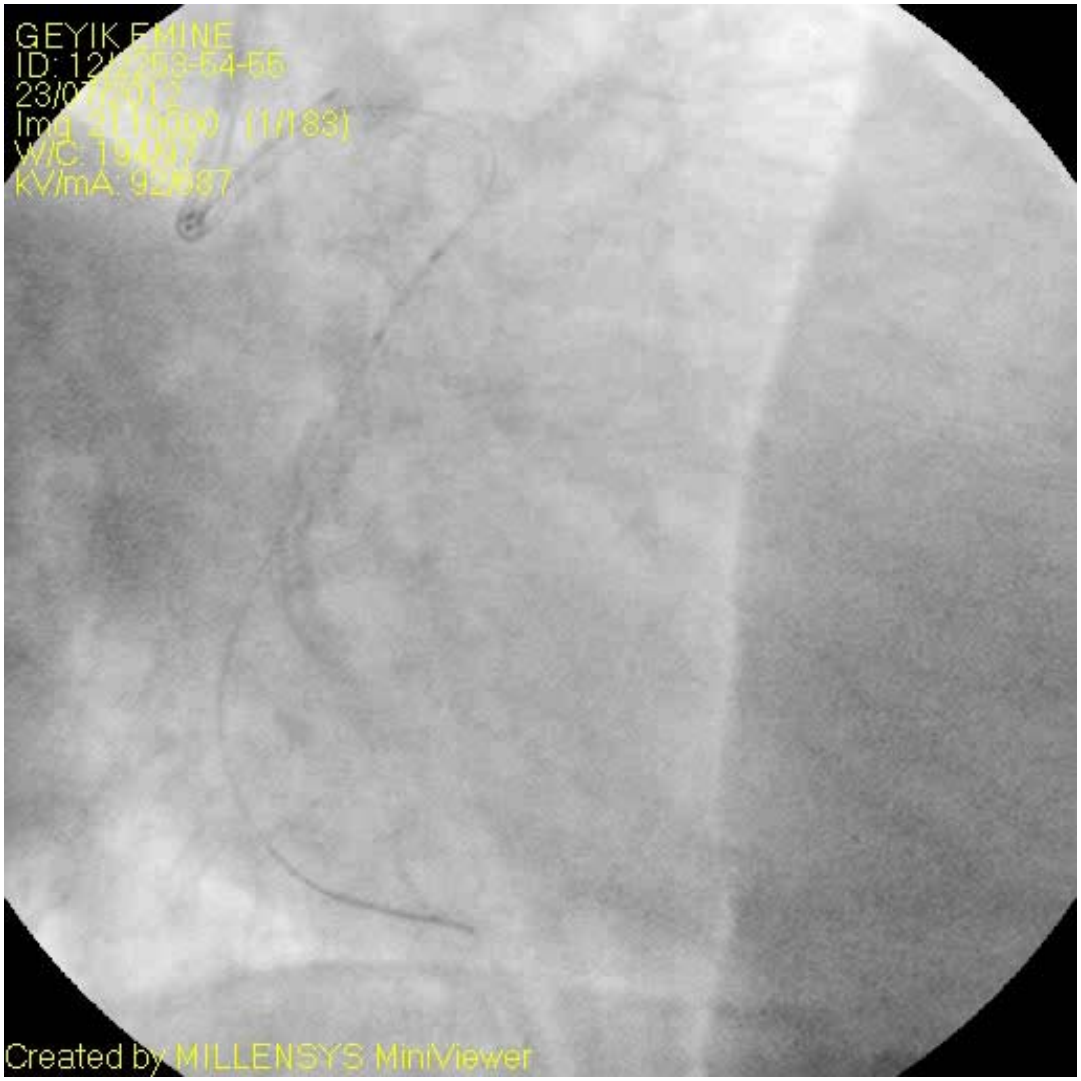
CX Artere PCI

Kontrol KAG



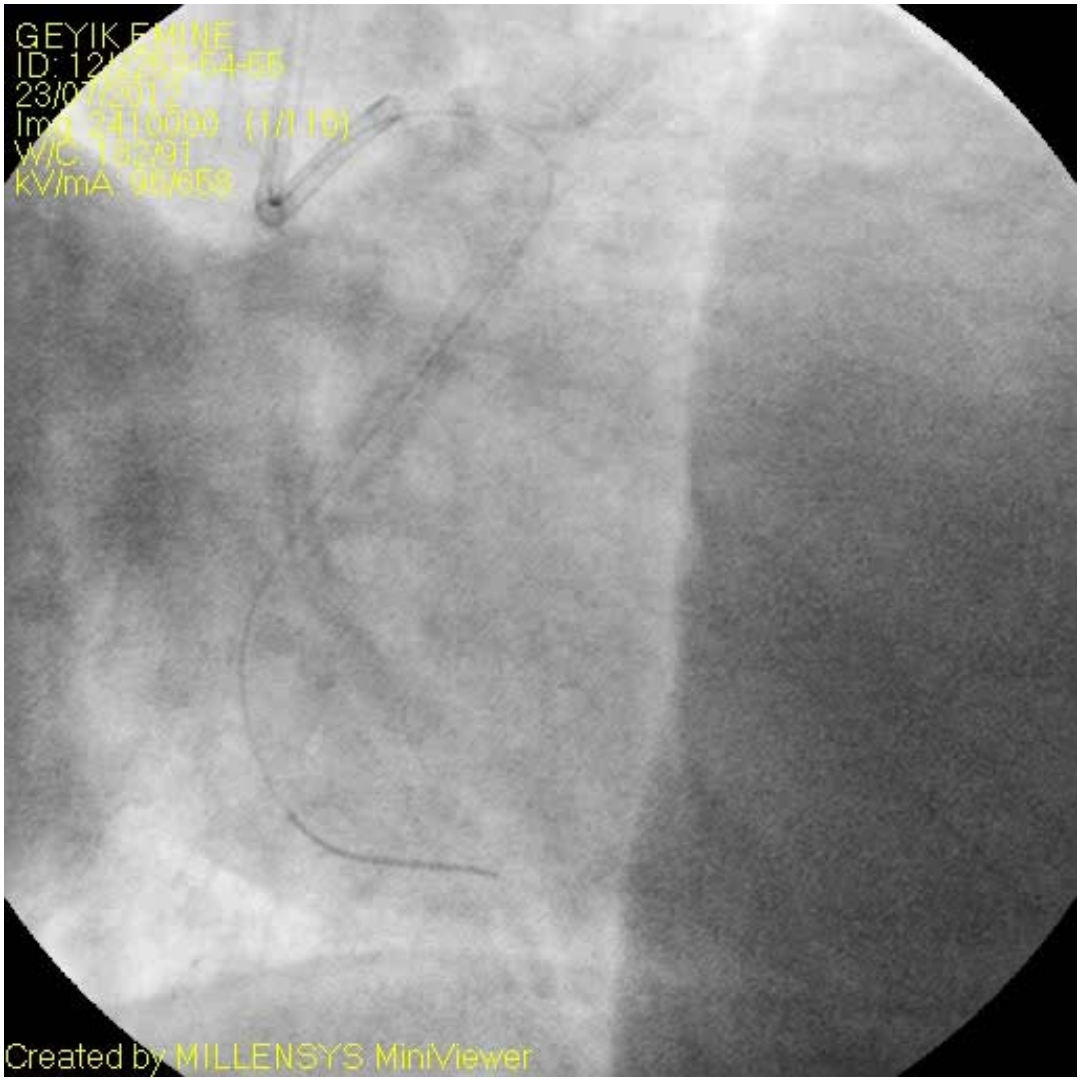
CX Artere PCI

3.0*8 mm BMS proksimal ve distal stentlerle over-lap yapacak şekilde yerleştirildi



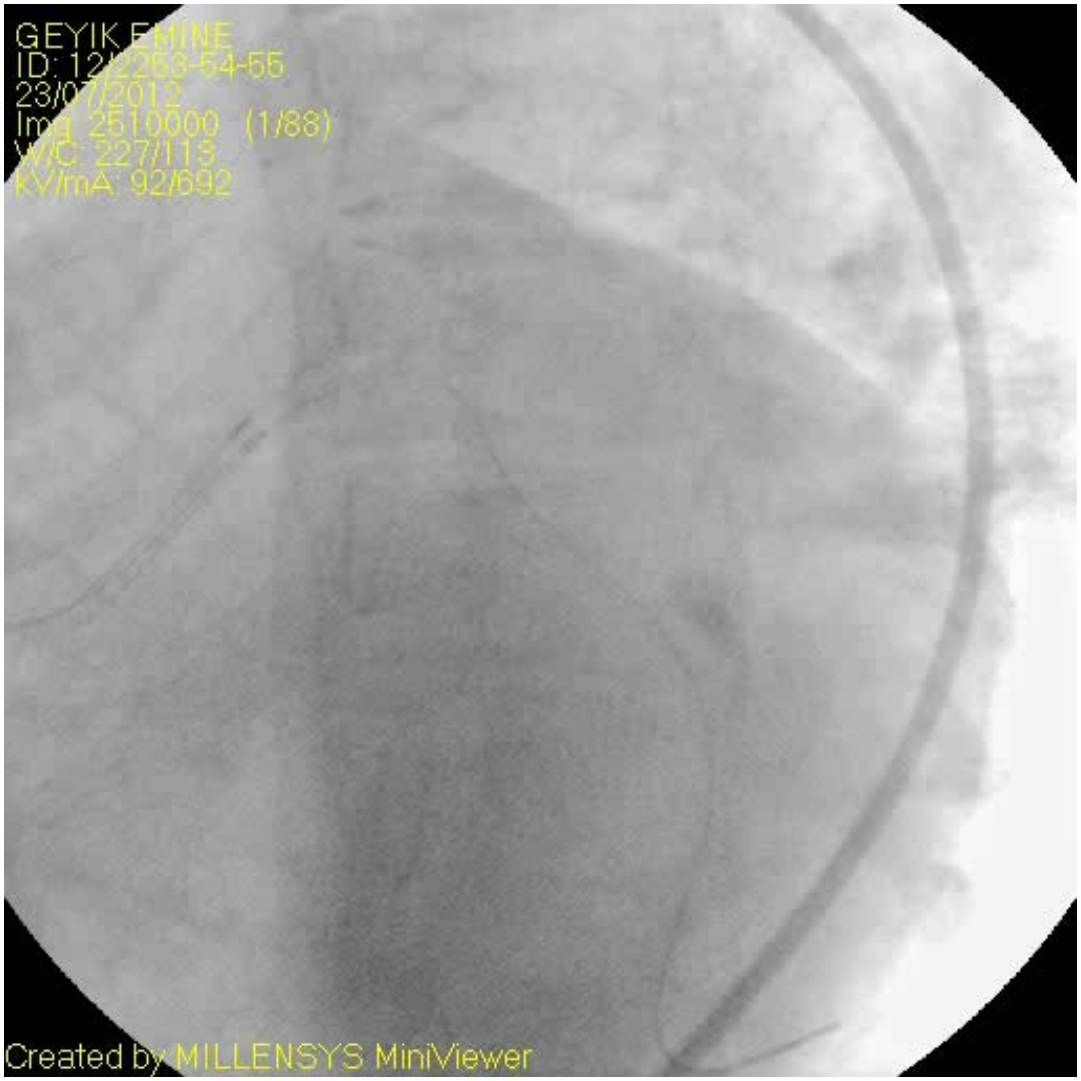
CX Artere PCI

işlem sonrası KAG



CX Artere PCI

işlem sonrası KAG



TAKİP

- KYB alındı
- Heparin stoplandı
- ACT 150 sn altında tutuldu
- Sık EKO takibi ve hemodinamik monitörizasyon yapıldı
- Sorunsuz taburcu oldu
- 20 gün sonra poliklinik kontrolü normal

SONUÇ

- AKS'de primer hedef, sorumlu arter lezyonunun revaskülarizasyonudur
- Stabil uzak damar lezyonlarına öncelikli müdahale önerilmez

SONUÇ

- Biz stabil AKS'li bir hastada primer hedef lezyon girişimine bağlı olası komplikasyon riskini azaltmak için önce KTO'a girişim yaptık
- Hedef damar reperfüzyonun komplike olabileceği stabil AKS'li hastalarda, alternatif yaklaşımların olası riskleri azaltabileceği kanaatindeyiz

Teşekkür ederim...