noncompliant (NC) balloon, and prescribe DAPT). We hypothesized that in selected ST elevation myocardial infarction (STEMI) lesions it would be possible to do away with predilation (one of the Ps) and this would be associated with reduced slow flow.
Our protocol in STEMI is to pre-treat these patients with aspirin chewable (325 mg) half tablet, if the patient is on aspirin, full tablet, if the patient is not on aspirin plus prasugrel 60 mg or clopidogrel 300 mg or ticagrelor 90 mg 2 tabs in the ER. IV access is obtained. After heparin 5000 IV is administered, the patients are shifted to the cath lab. Right radial access is obtained. 6F sheath is placed. In anterior wall MI, we proceed with the XB guiding catheter directly (as per Direct study protocol). The patients are given Inj. Bivaluridin bolus followed by infusion. Heparin plus GP IIB inhibitors are used in patients who do not receive bivaluridin. 2 orthogonal views of the infarct related artery are obtained. The lesion is crossed and thrombosuction is done. For direct BVS deployment, patient has to satisfy the following criteria: Age < 55 years, no fluoroscopic calcium, no history of prior angina. All patients received intracoronary (I/C) nikorandil 2 mg and NTG (100 mcg) as per the hemodynamic status. The Scaffold length was chosen as normal to normal vascular segment. The diameter of the BVS was upsized by 0.5 mm then the visual estimation of the vessel size. The BVS was deployed very gradually up to (maximum) 12 atms pressure. I/C NTG/Nikorandil was repeated. The scaffolds were post-dilated with noncompliant balloon, over-sizing upto 0.5 mm-more the scaffold size matching the vessel size. After completion of the BVS deployment, the RCA angiogram was obtained in anterior wall MI. In inferior wall, MI prior angiogram of left coronary artery was done, then RCA was hooked, and the procedure was completed.
Between Jan 2013 to July 2015, 52 scaffolds were deployed in various lesions of STEMI. 13 scaffolds were deployed without pre-dilatations of STEMI lesion. The mean ages of the patients were 36–85 years. 10 were male, diabetes (3 patients), smoking (3 patients), hyperlipidemia (7 patients), obesity (3 patients) were the coronary risk factors. The total ischemia time was 180 ± 75.8 min. The door to balloon time was 35 ± 14.5 min. Pre-procedure TIMI flow as follows TIMI 0–7 patients TIMI I-1, TIMI II-2, and TIMI III-3 patients. Post-procedure flow was TIMI II-1, patient TIMI III-2 patients. LVEF was $35 \pm 12\%$ during acute phase, which improved to $42 \pm 12\%$ at 3 months. All the patients are found to be in NHYA class I at 10 months of follow-up.
From this pilot project, we conclude that in selected STEMI lesions it is feasible to deploy BVS without lesion pre-dilatation. This is associated with good in hospital and intermediate term clinical outcome. A randomized controlled trial is warranted.

Percutaneous revascularization of sole arch artery for severe cerebral ischemia resulting from Takayasu arteritis

Varun Vishwas Nivargi *, Manuel Durairaj, C.N. Makhale, M.S. Hiremath, Jaibharat Bhalke, Salil Vaidya, Hammad Mommin

Ruby Hall Clinic, Pune, India

Background: Non-specific aortoarteritis (NSAA)/Takayasu arteritis (TA) is an inflammatory arteriopathy common in young Asian females affecting the aorta and its branches leading to significant ischemic events. Progressive NSAA may lead to obstructive lesions of all arch vessels leading to disabling neurologic symptoms. There is limited experience with endovascular revascularization in this situation. We report results of stent-supported angioplasty to stenosis of sole surviving arch vessel performed in our center.
Methods: Angioplasty and stent placement were performed in 8 consecutive patients with TA (age, 11–42 years; mean, 28.3 ± 4.1 y) with cerebrovascular symptoms caused by severe stenotic lesions of supraaortic (i.e., carotid, vertebral, and brachiocephalic) arteries from May 2010 to May 2013.
Result: No immediate procedure-related complication or neurologic deficits occurred. The symptoms improved in all patients. On follow-up (mean, 25 ± 7 months; range, 3–49 months), 6 patients were asymptomatic and two patients had recurrence of neurologic symptoms. These patients had in-stent restenosis of the carotid artery.
Conclusion: Stent-supported angioplasty of a sole supraaortic artery is safe and feasible and provides good symptomatic relief in patients with advanced NSAA.

Procedural, in-hospital and one year outcome of success versus failure percutaneous coronary intervention in chronic total occlusions

Vishwanath Hesarur *, Suresh Patted, Prabhu C. Halkatti

OPD No. 29, Department of Cardiology, KLES Hospital and MRC, Nehrunagar, Belgaum, India

Introduction: Percutaneous coronary intervention has become common in the management strategy of patients with chronic total occlusion. However, despite improving techniques for opening chronic total occlusions, the benefit of successful recanalization of the artery remains unclear.
Objectives: The purpose of this study was to know the procedural success rates, guidewire strategies, in-hospital and one year outcome of patients undergoing percutaneous coronary intervention in chronic total occlusion.
Methods: CTO-PCI were attempted in 101 consecutive patients. 79 cases with successful PCI and 22 cases with unsuccessful PCI were enrolled in the study from January 2013 to February 2013. Chronic total occlusion was defined as thrombolysis in myocardial infarction flow grade 0-1 and duration >3 months. Detailed baseline clinical, angiographic, procedural, and outcome data were collected and compared success versus failed procedures.
Results: Procedural success was seen in 78% patients (79 of 101). Patients with unsuccessful PCI compared to successful PCI were mainly male (81.01% vs. 72.3%; $p < 0.02$), had a higher incidence of diabetes mellitus (31.1% vs. 20.9%; $p < 0.04$) and hypertension (53.3% vs. 42.3%; $p < 0.04$). Most patients in successful group had single vessel disease (63.4% vs. 46.7%; $p < 0.001$) and less three-vessel disease (11.8% vs. 22.8%) compared to unsuccessful group. In-hospital MACE was insignificantly higher in unsuccessful PCI (33.1% vs. 0%). Unsuccessful PCI was significantly associated with higher rate of one year MACE (61% vs. 18.1%, $p = 0.01$), especially revascularization (33.3% vs. 12.2%, $p = 0.02$).
Conclusions: Patients with successful recanalization of CTO with PCI have better symptom relief, better clinical outcome, improved left ventricular function and better long-term survival compared with patients in whom the attempt to recanalize CTO has failed.

Rare case of intimal fibromuscular dysplasia treated with percutaneous intervention

Amit Bharadiya *, P.C. Rath

Room No. 105, Nehal Chambers, Opposite to Apollo Hospital, Film Nagar, India

In the general hypertensive population, renal artery stenosis (RAS) is the most common secondary cause of hypertension and is