



19 - 21  
OCTOBRE | 2022

XXIV<sup>E</sup> CONGRÈS FRANCOPHONE  
DE CARDIOLOGIE INTERVENTIONNELLE

CFCIPARIS

HÔTEL MÉRIDIDIEN ÉTOILE



*Session paramédicale – Apprendre la technique*

# Technique de bifurcation: pas à pas

## Une Culotte propre

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**Limoges, France**

**Pas de conflits d'intérêt**



# Technique à 1 ou à 2 stents?

## Two stents required for large SB with diffuse disease

### EBC consensus:

- Main vessel (MV) stenting with provisional SB treatment, if needed, is recommended as the preferred technique for the majority of bifurcation lesions.
- Large SBs with significant ostial disease extending further into the SB are likely to require a two-stent strategy.
- Larger SBs whose access is particularly challenging should be secured by stenting once accessed.



# Techniques à 2 stents

## Main technical options for provisional double stent implantation

"True" bifurcation lesion with an important SB > 5-10 mm lesion length

Low risk of losing the SB after MB stenting

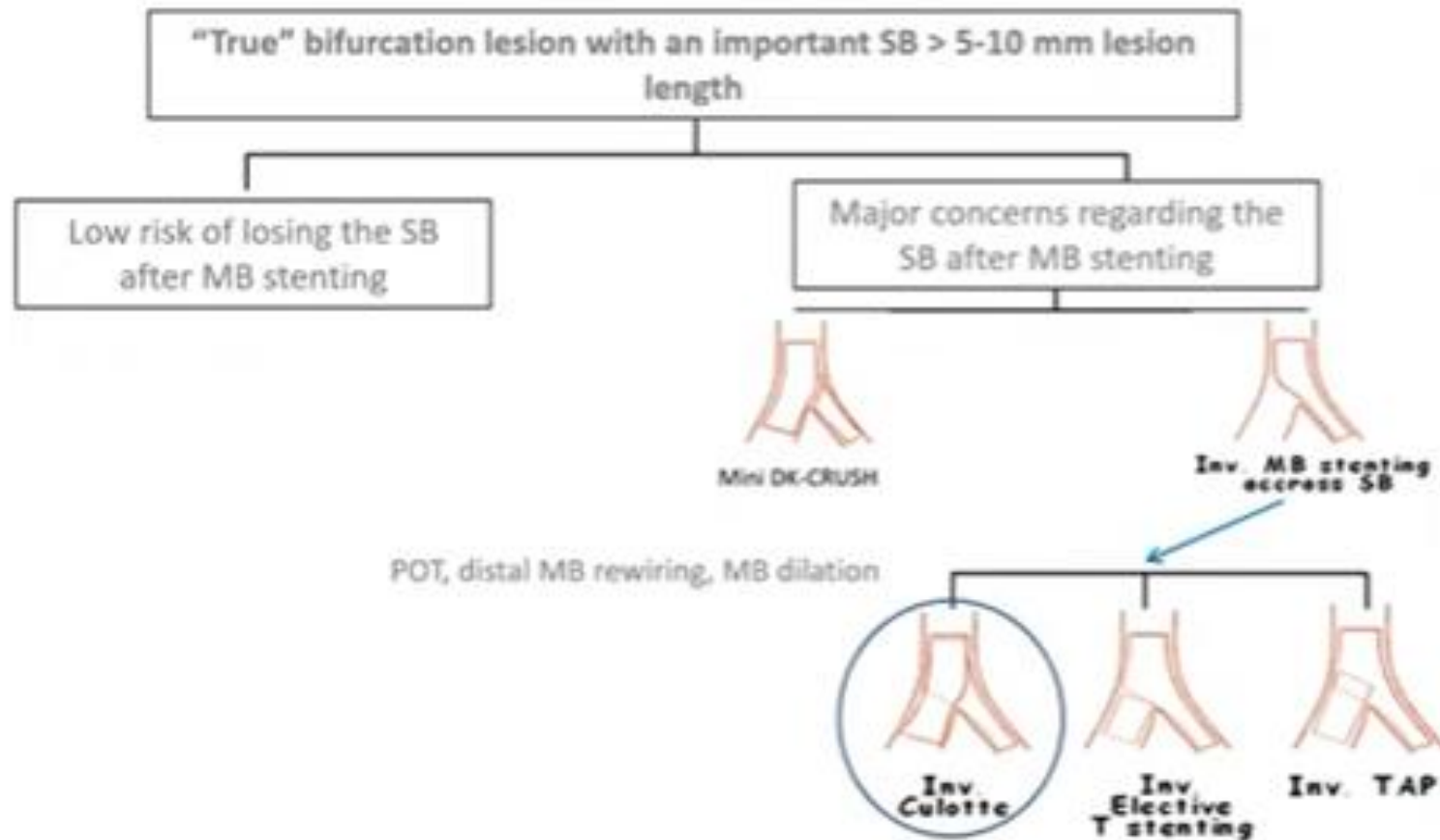
Major concerns regarding the SB after MB stenting

MB stenting followed by planned SB implantation

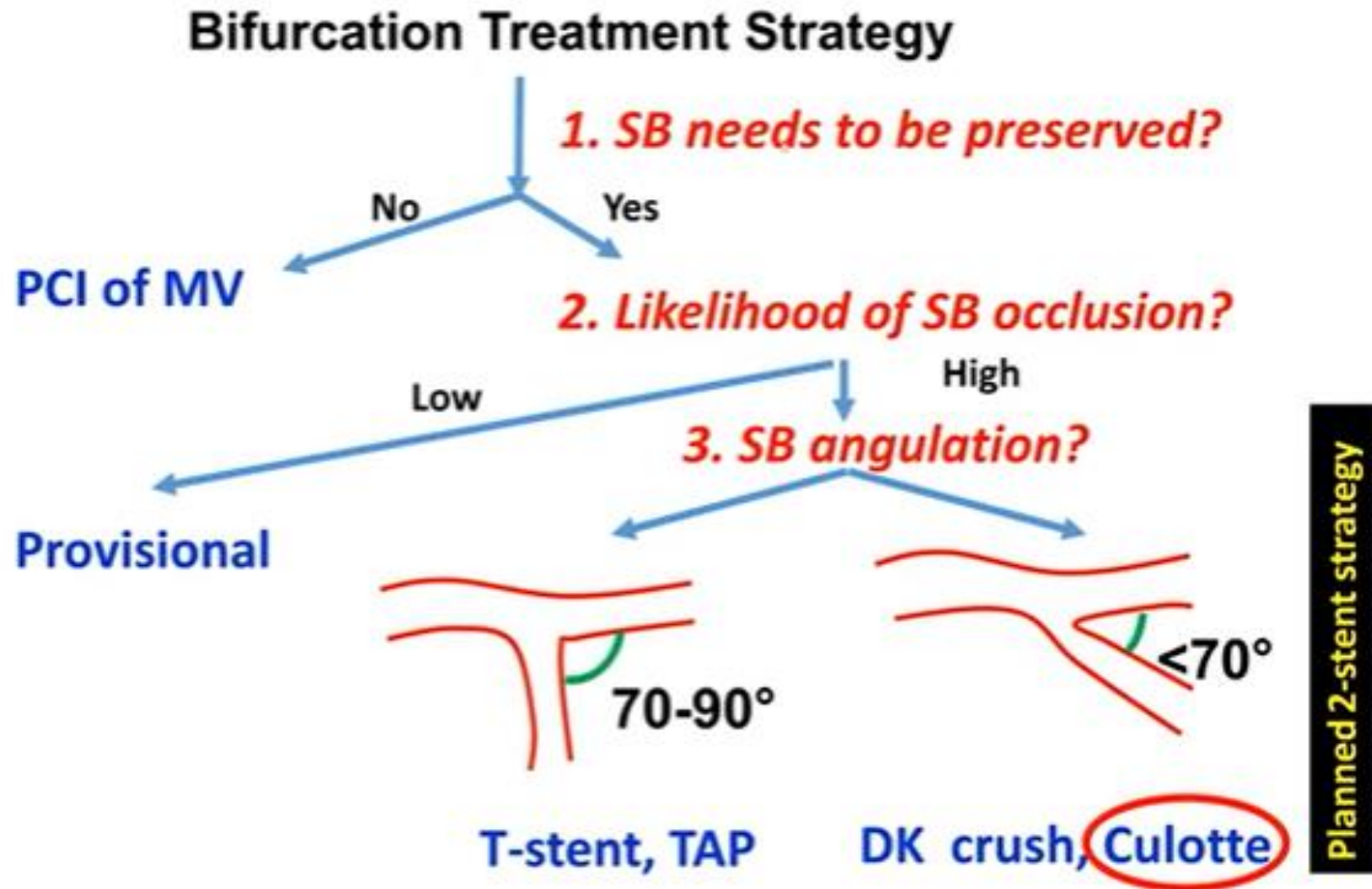


# Techniques à 2 stents

## Main technical options for planned double stent implantation



# Quand faire une Culotte?





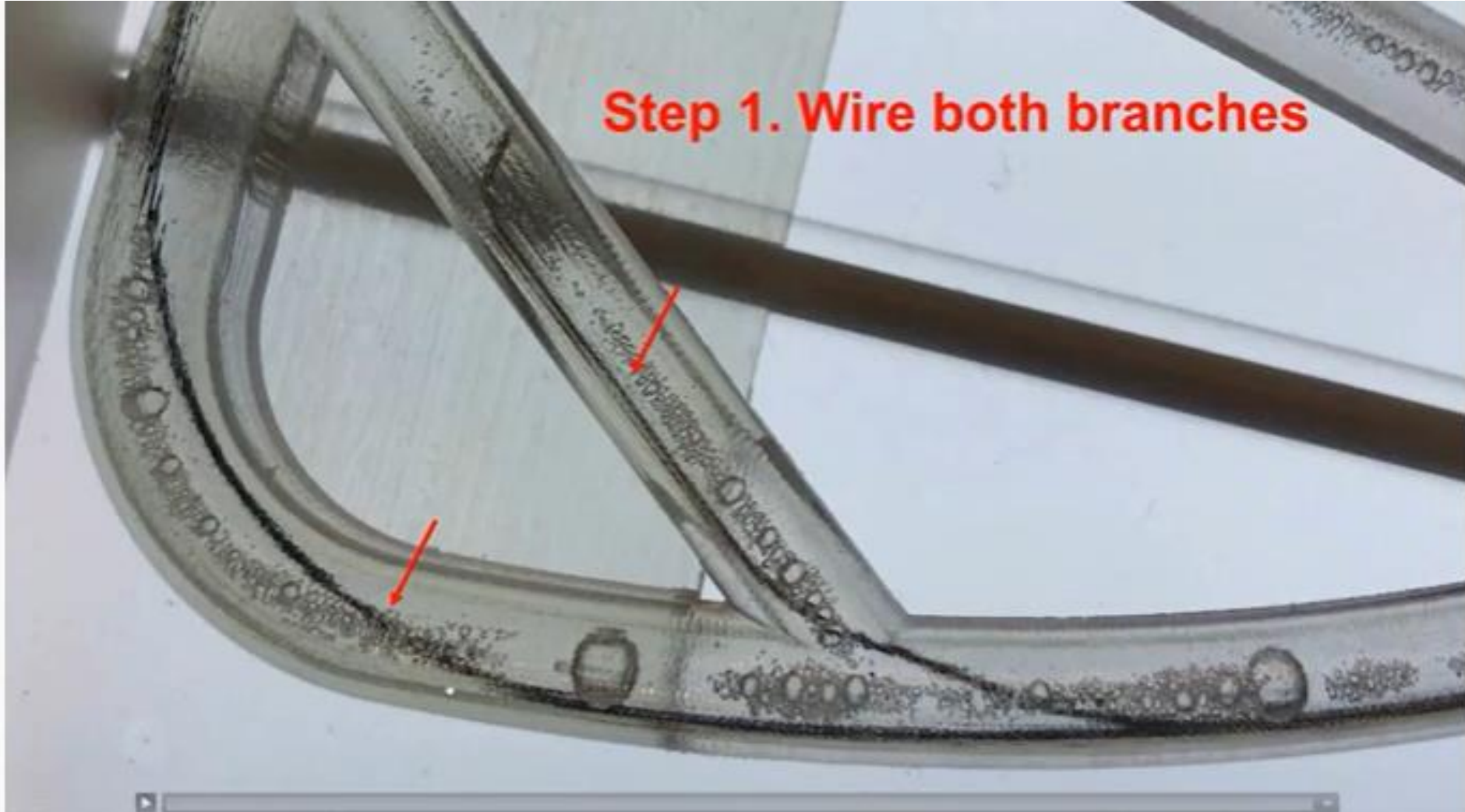
# Comment faire une Culotte

## Culotte steps

1. Wire both MV and SB
2. Predilate both MV and SB
3. Deliver + deploy first stent *in most angulated branch*
4. Remove stent balloon
5. POT
6. Rewire non-stented vessel + remove jailed wire
7. Dilate struts into non-stented branch
8. Deliver + deploy 2<sup>nd</sup> stent
9. POT
10. Rewire initially stented branch + remove jailed wire
11. Kissing balloon inflation

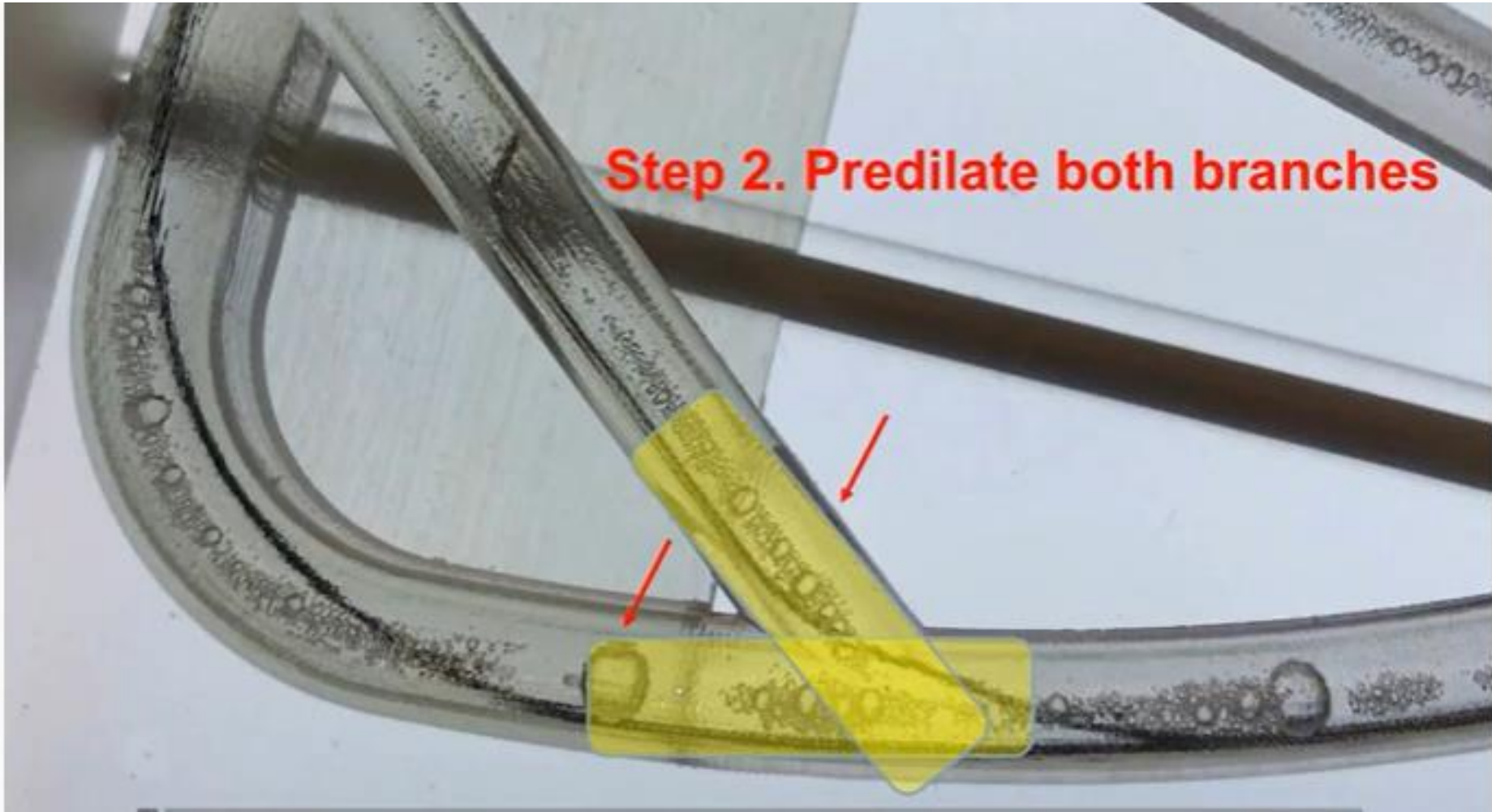


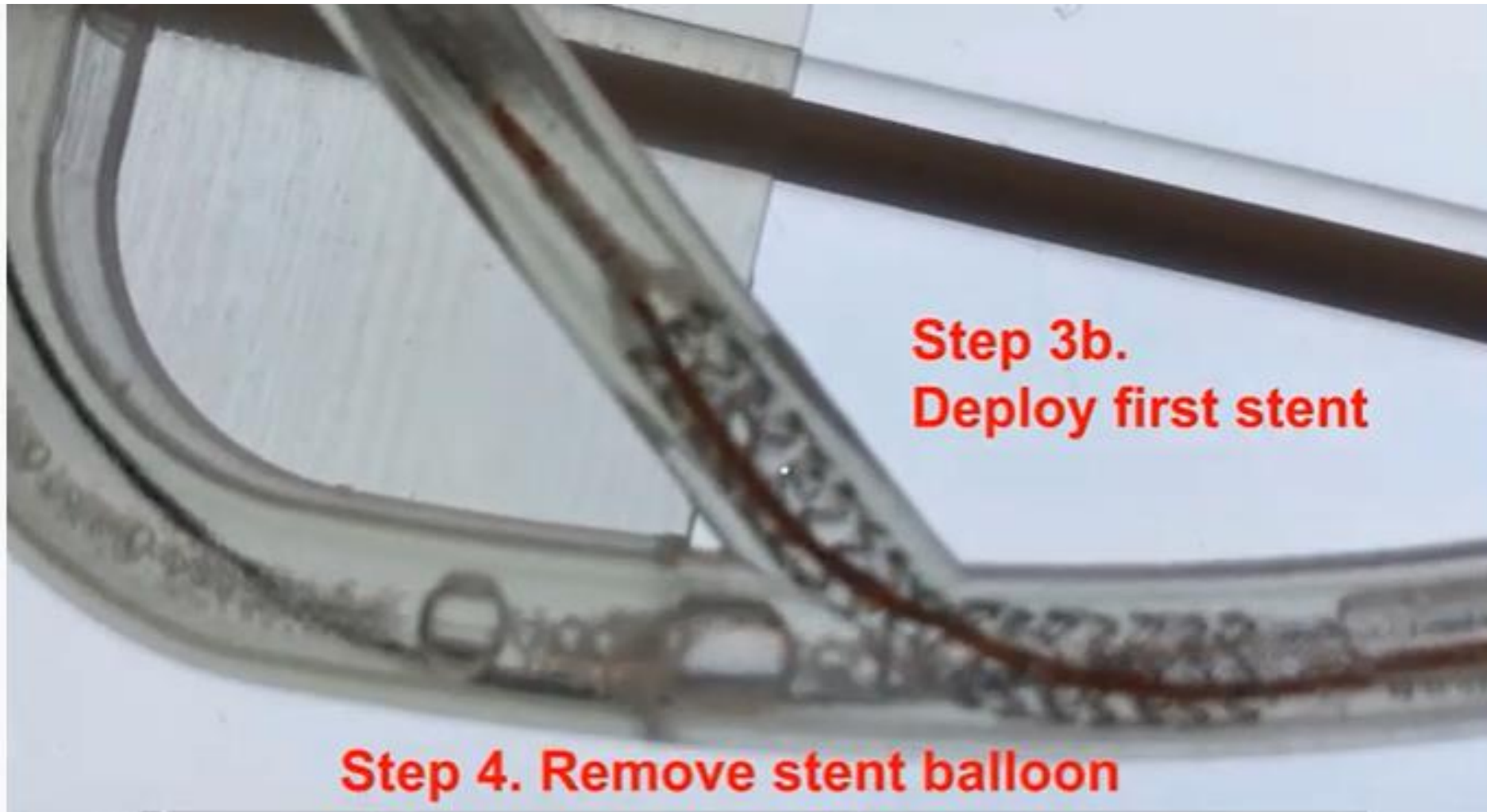
**Step 1. Wire both branches**





**Step 2. Predilate both branches**



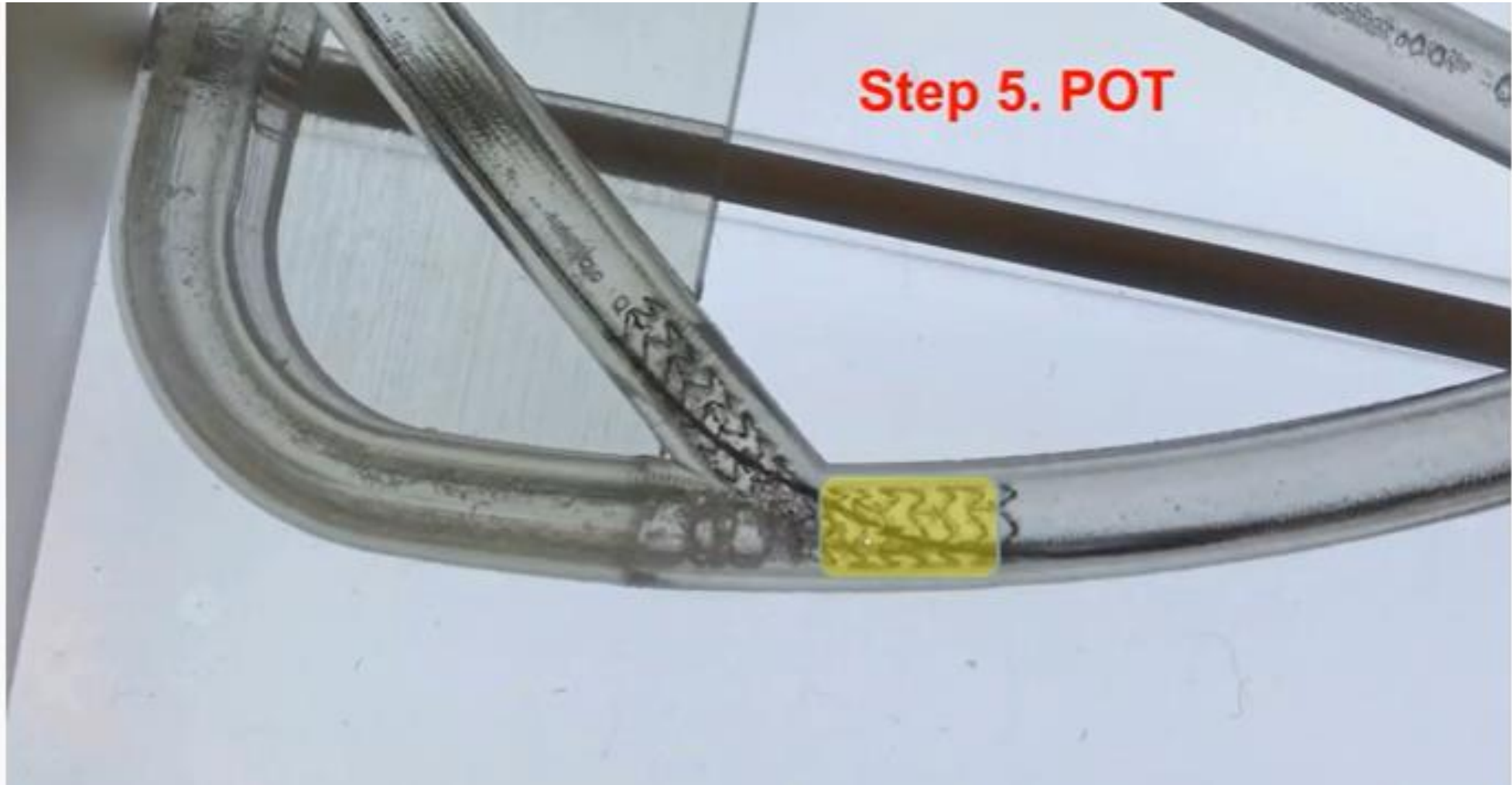


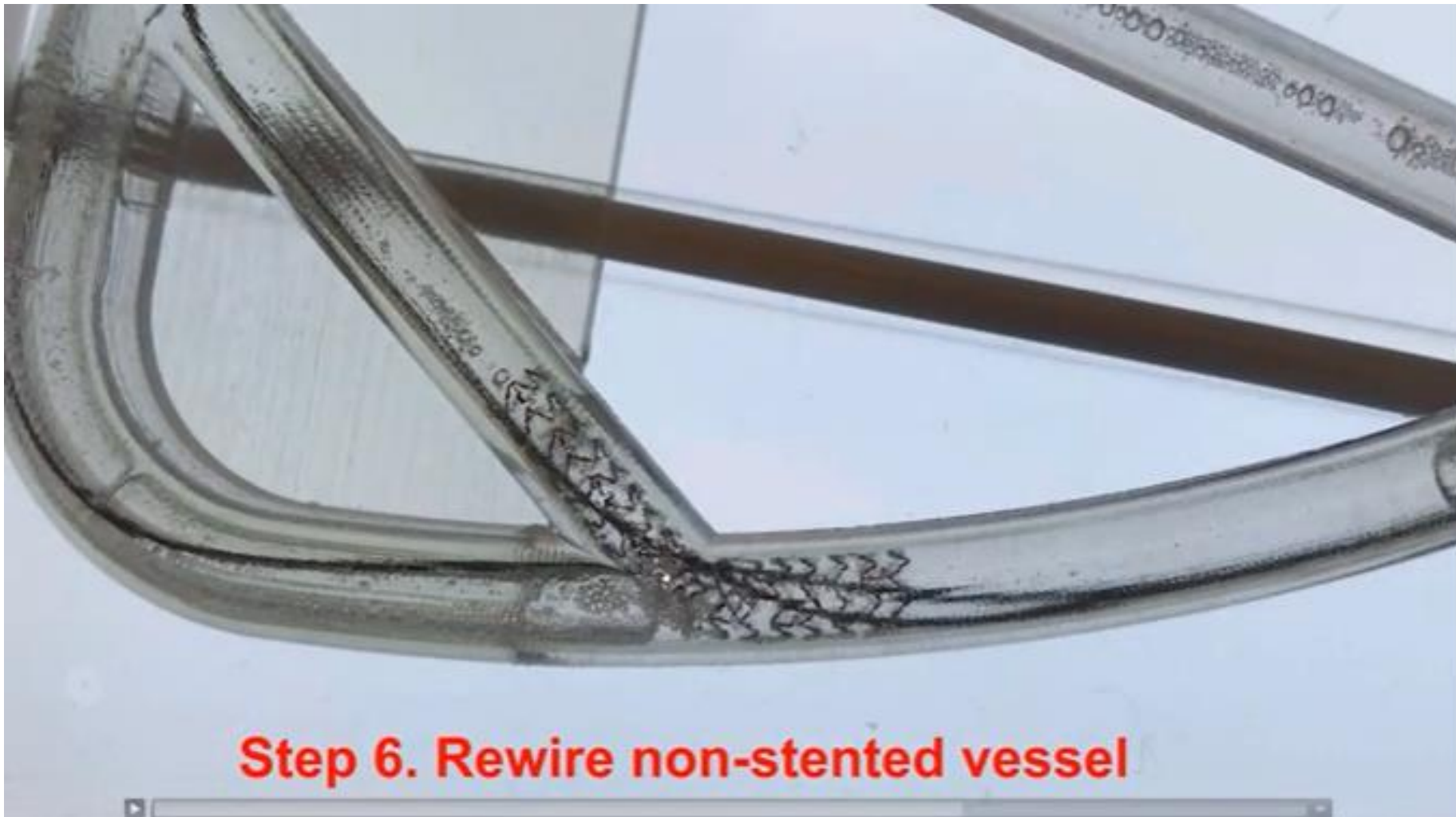
**Step 3b.  
Deploy first stent**

**Step 4. Remove stent balloon**



**Step 5. POT**





**Step 6. Rewire non-stented vessel**



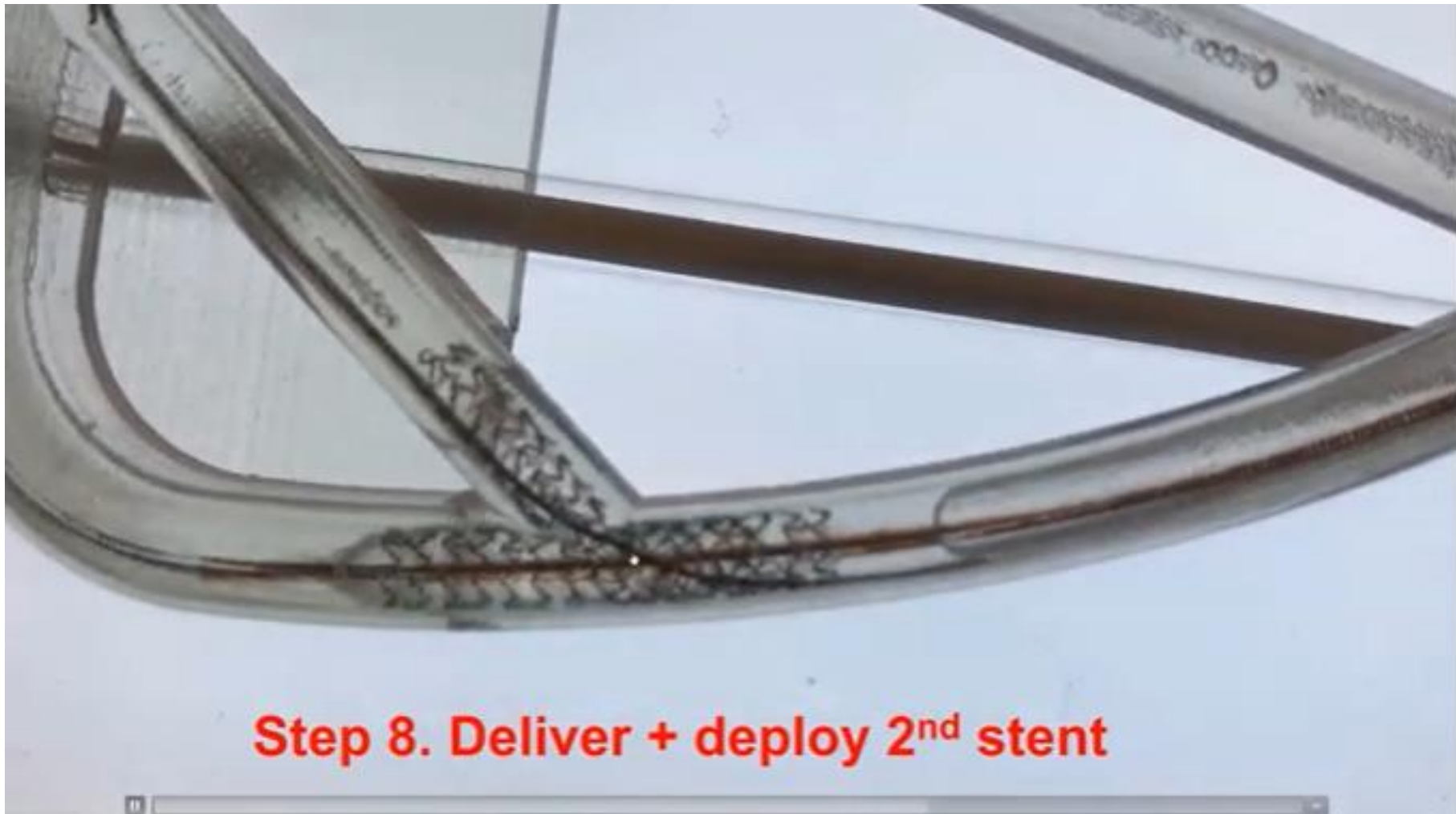




**Step 7. Dilate struts into non-stented branch**

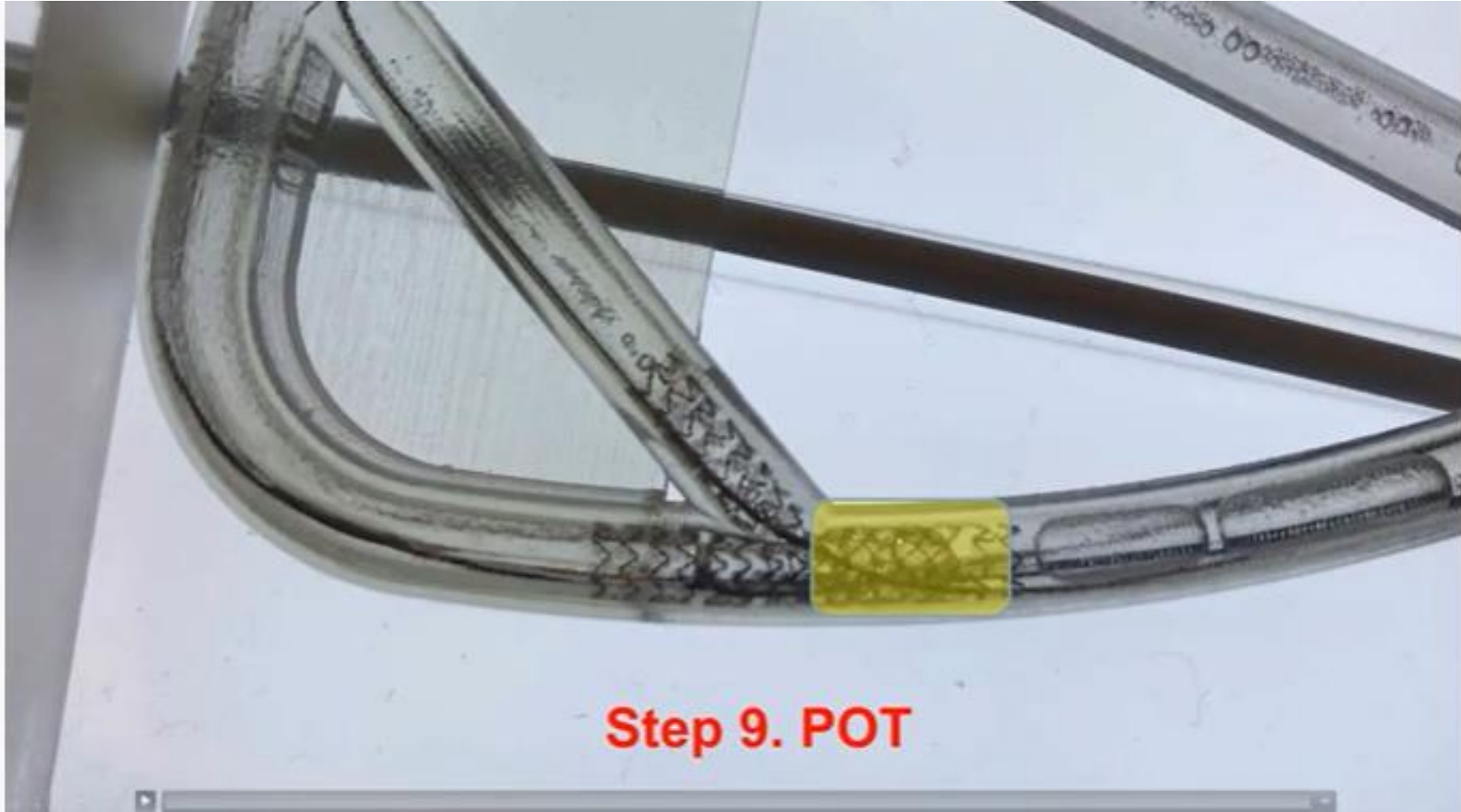






**Step 8. Deliver + deploy 2<sup>nd</sup> stent**







**Step 10. Rewire initially stented branch  
+ remove jailed wire**





**Step 11. Kissing balloon**



# Cas pratique

- H 73 ans
- DB2, DLP
- Dyspnée d'aggravation progressive depuis 2 mois
- OAP
- ECG: BAV 1<sup>er</sup> degré, BBG
- FEVG 20%, hypokinésie globale, RAC serré Sao 0.7cm<sup>2</sup>, gdt moy 40mmHg

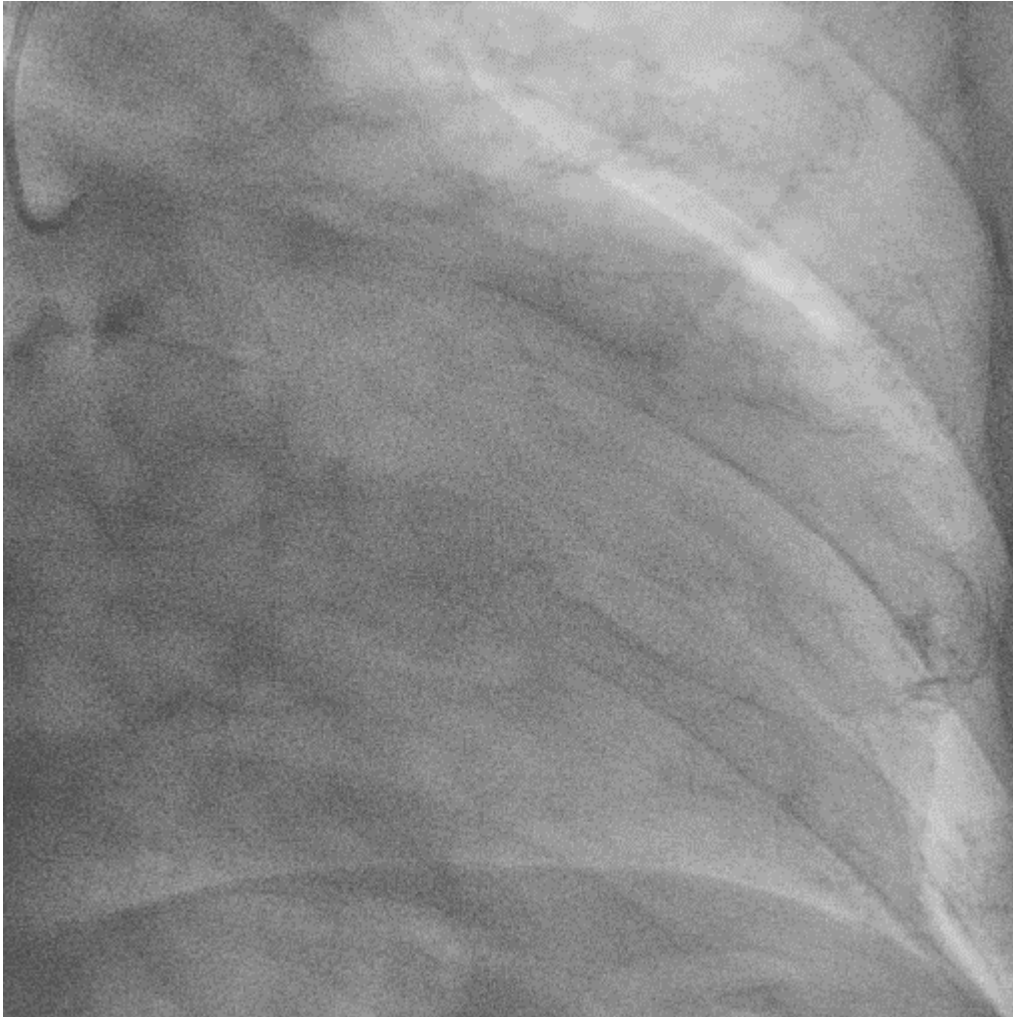




# Coronarographie



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# Coronarographie

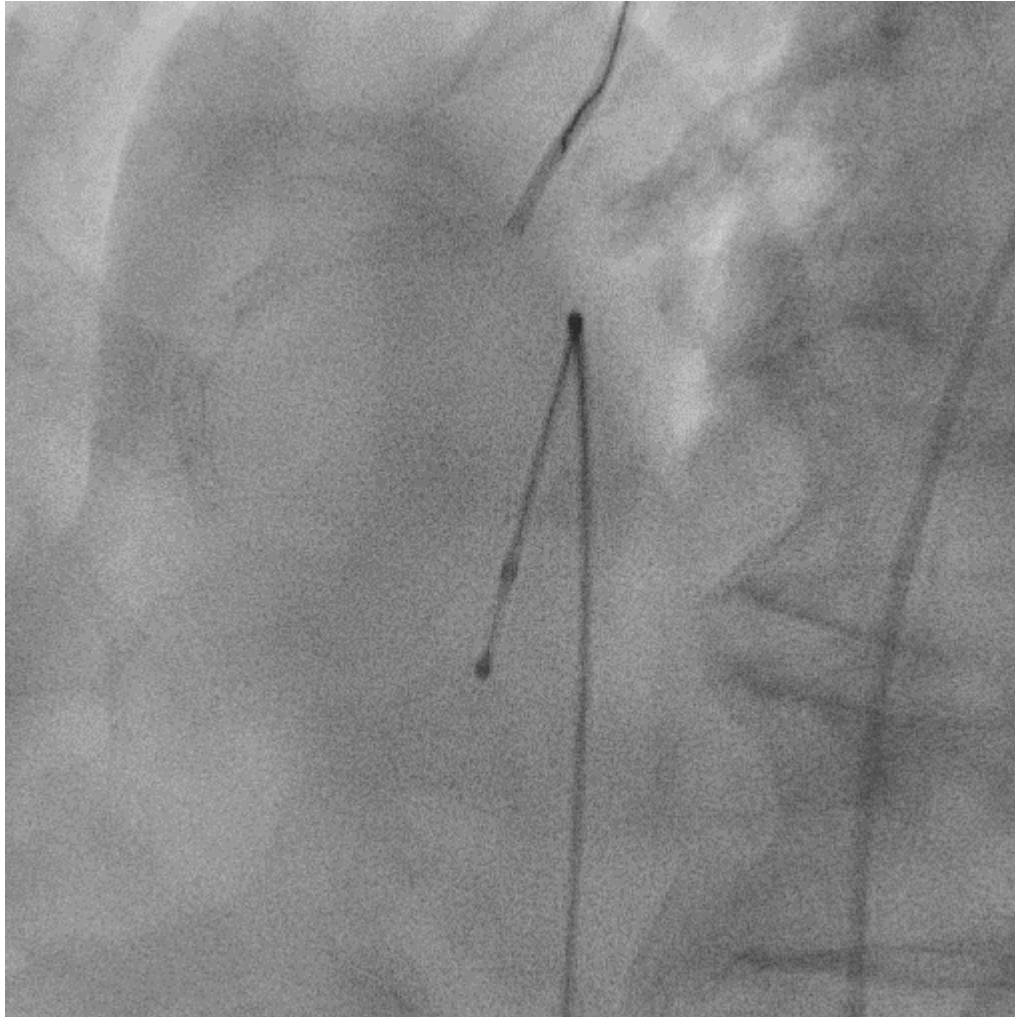


# Staff médico-chirurgical

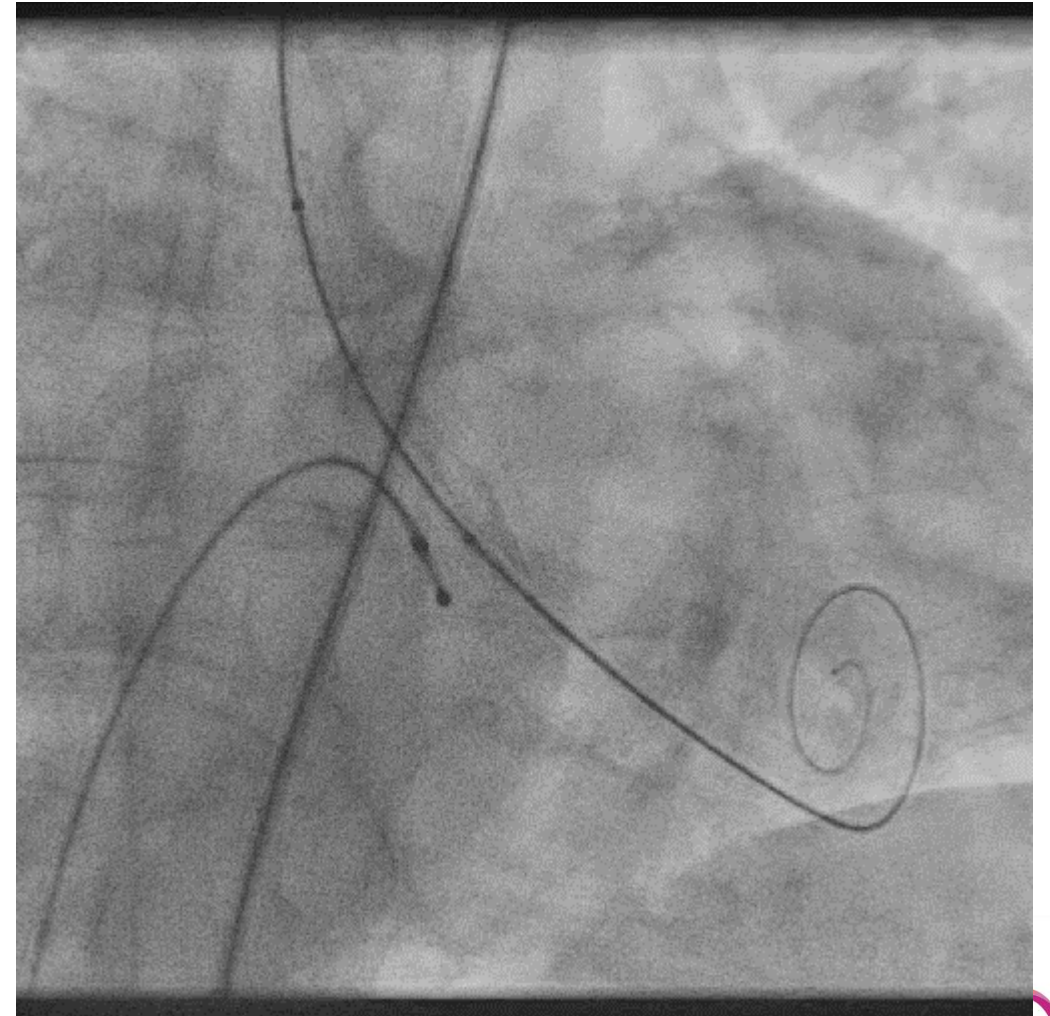
- Patient récusé de la chirurgie
- Angioplastie à haut risque (en 2 temps)
- +/- TAVI



# 1<sup>er</sup> temps: ATC CD + Valvuloplastie



ATC CD par 3 DES

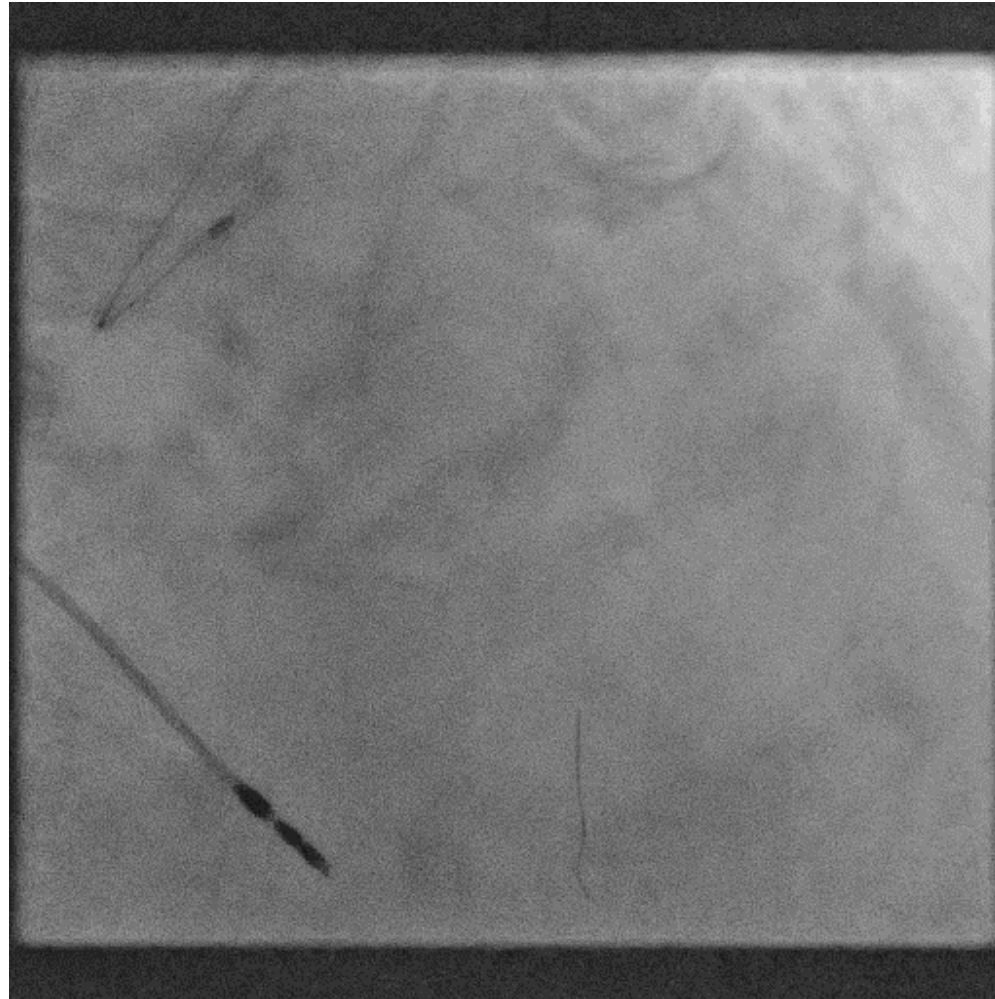


Valvuloplastie (ballon 20mm)





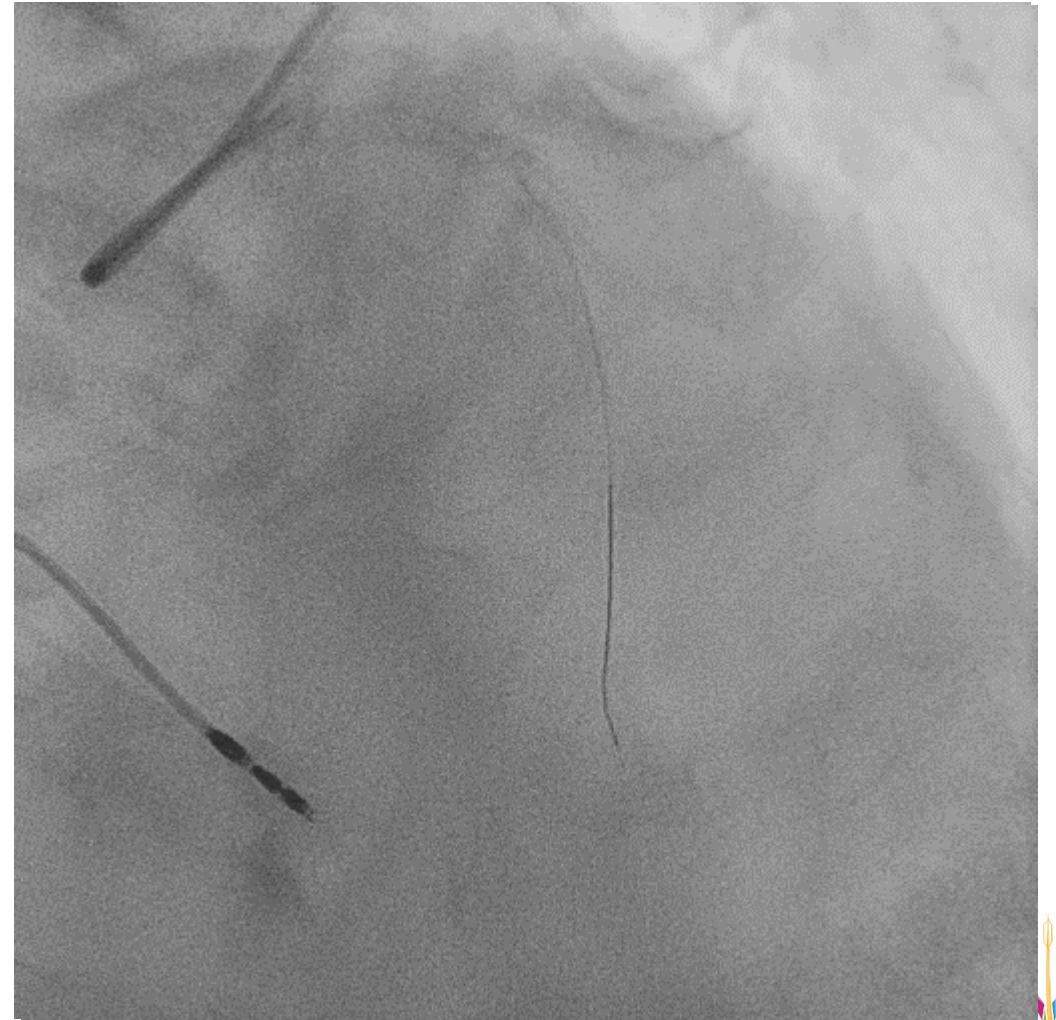
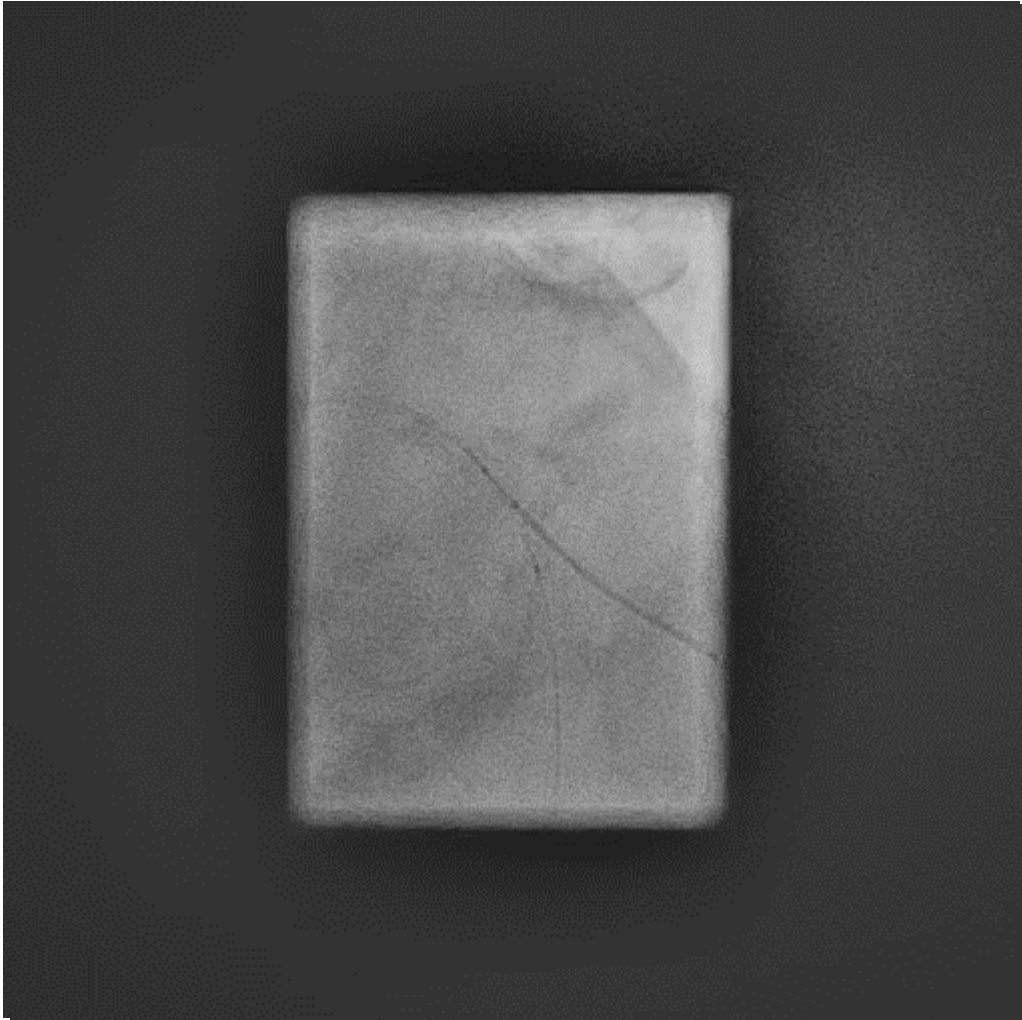
# 2<sup>e</sup> temps: ATC du réseau gauche



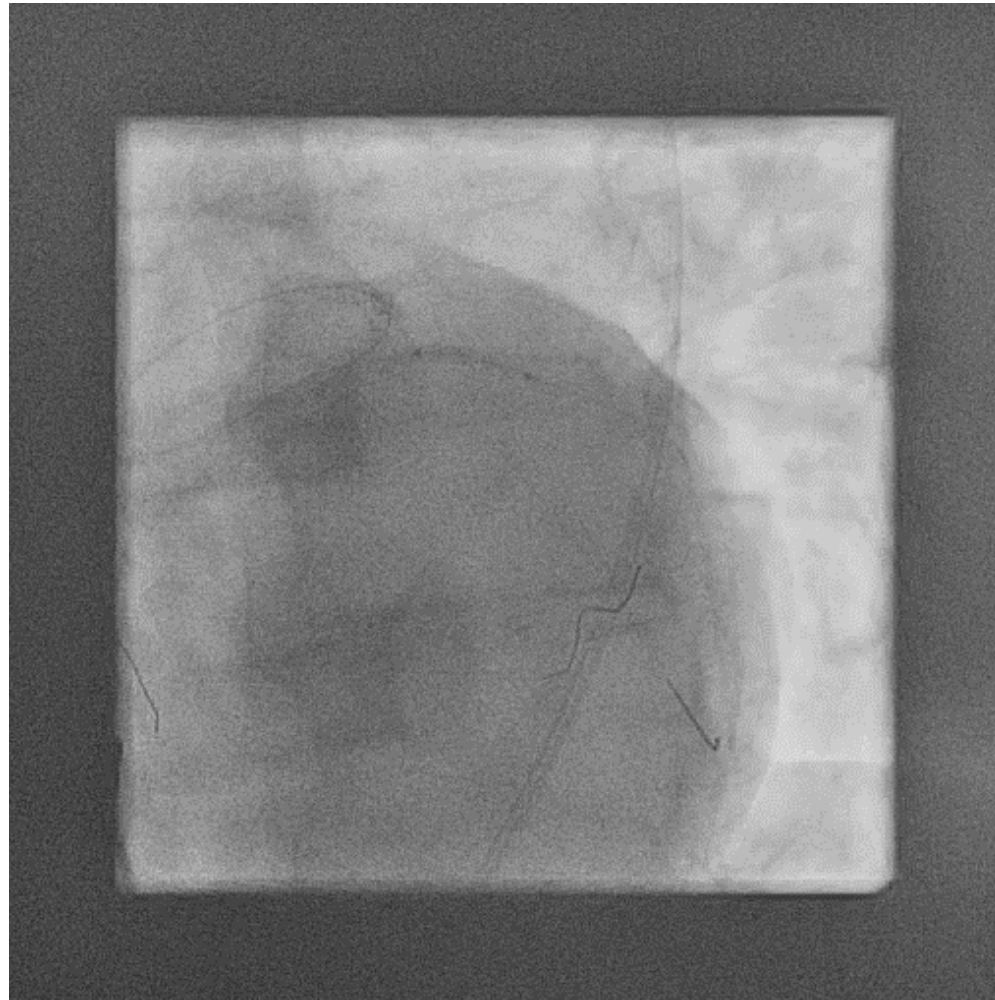
Rota TC vers IVA burr 1.5 x 3 passages



# TAP inversé pour la bifurcation IVA – D1



# DEB pour la Bx

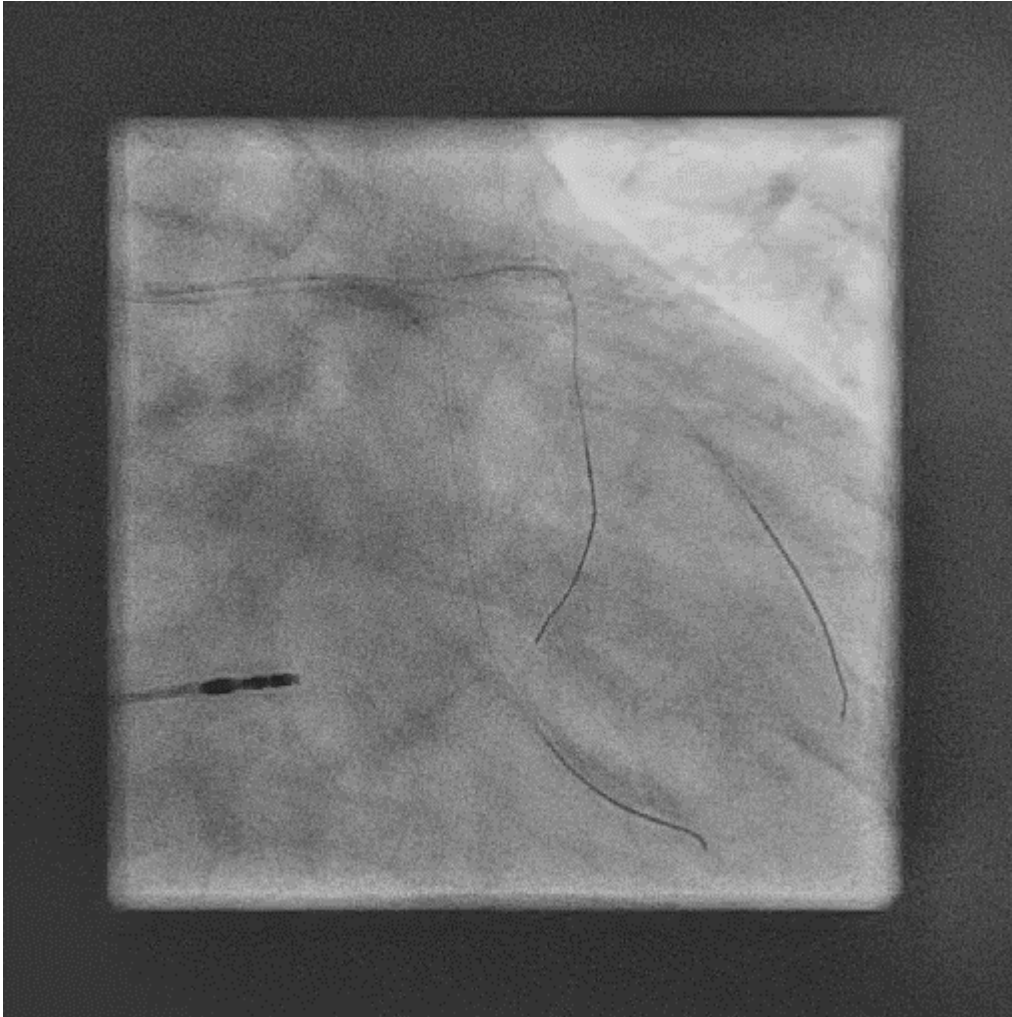


DEB 2.5 x 20 x 60 s

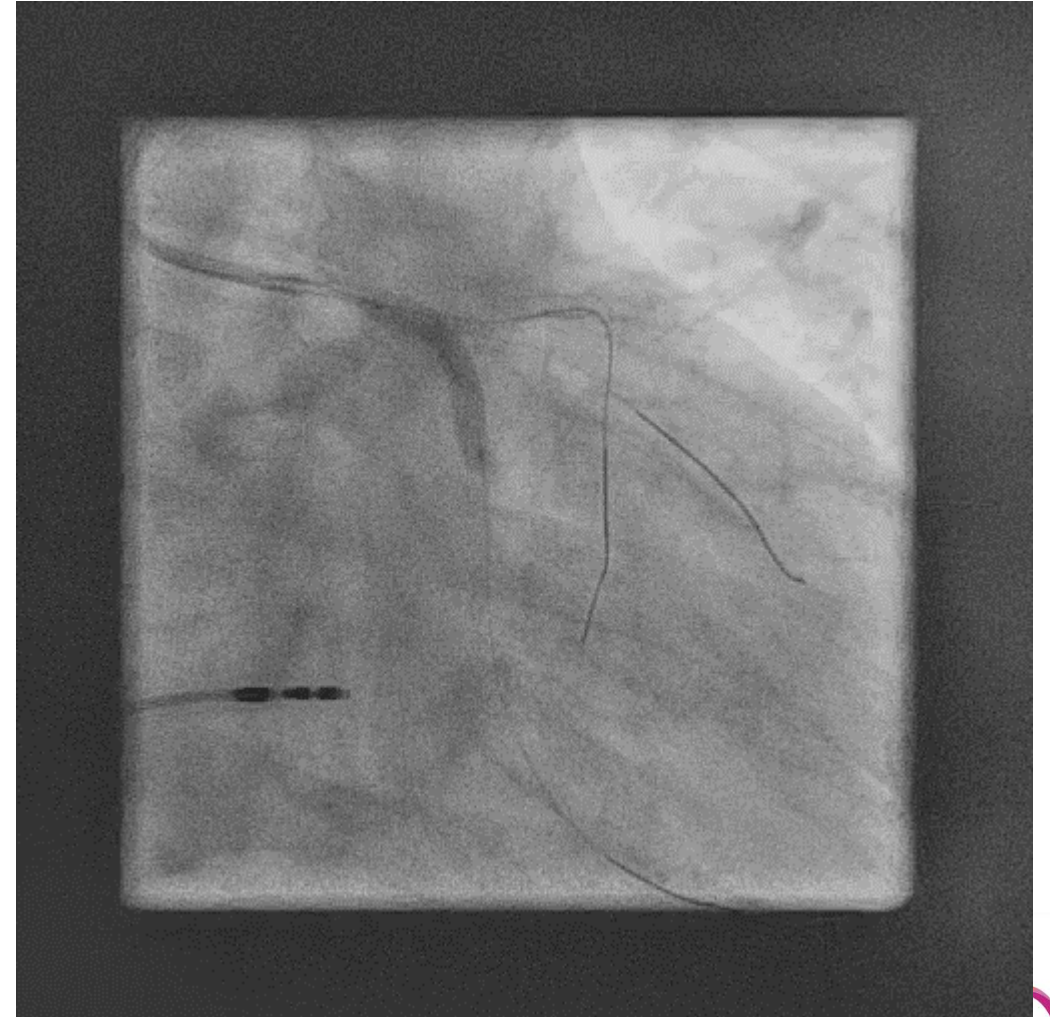




# Culotte pour la trifurcation du TC



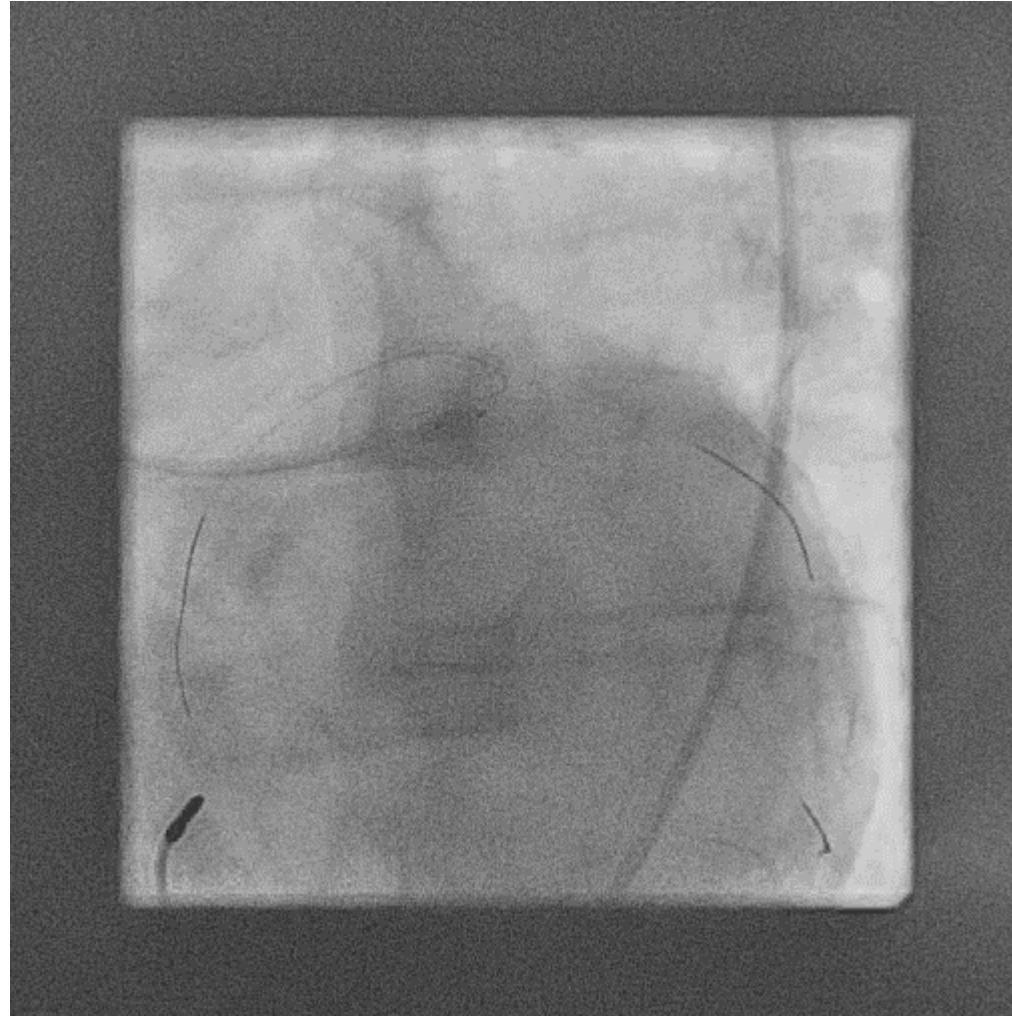
Prédil 3.5 puis 4.0



DES 4.0 x 26 mm



# Culotte pour la trifurcation du TC

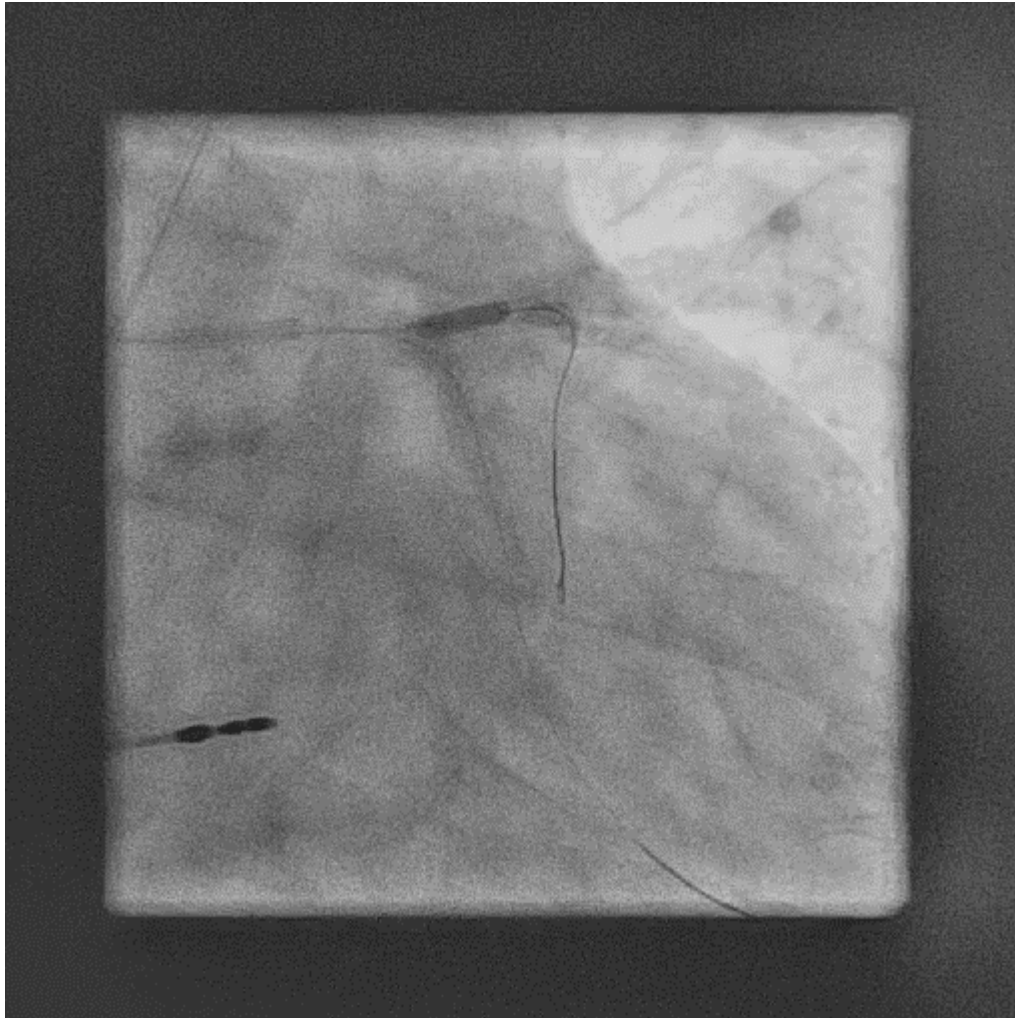


POT 4.5 NC





# Culotte pour la trifurcation du TC



Ouverture des mailles vers l'IVA



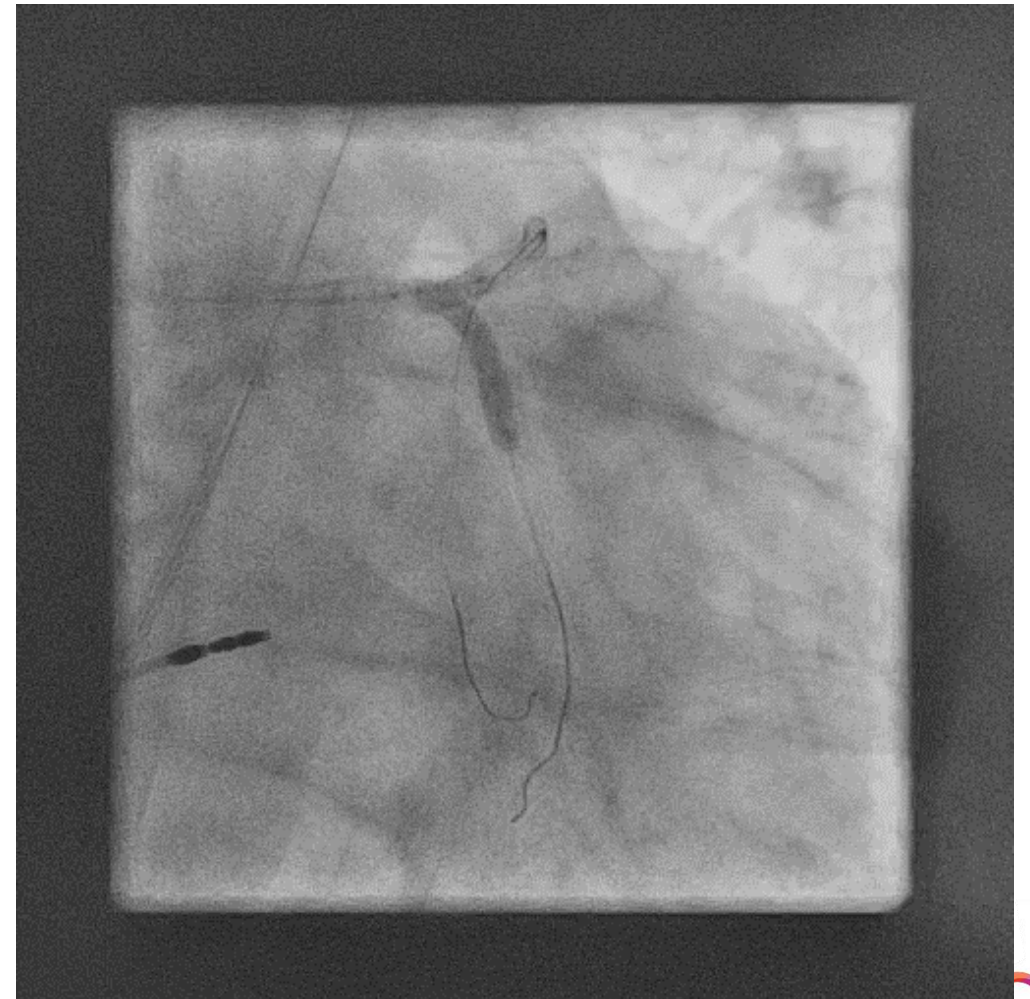
DES 3.5 x 18mm



# Culotte pour la trifurcation du TC



2° POT 5.0

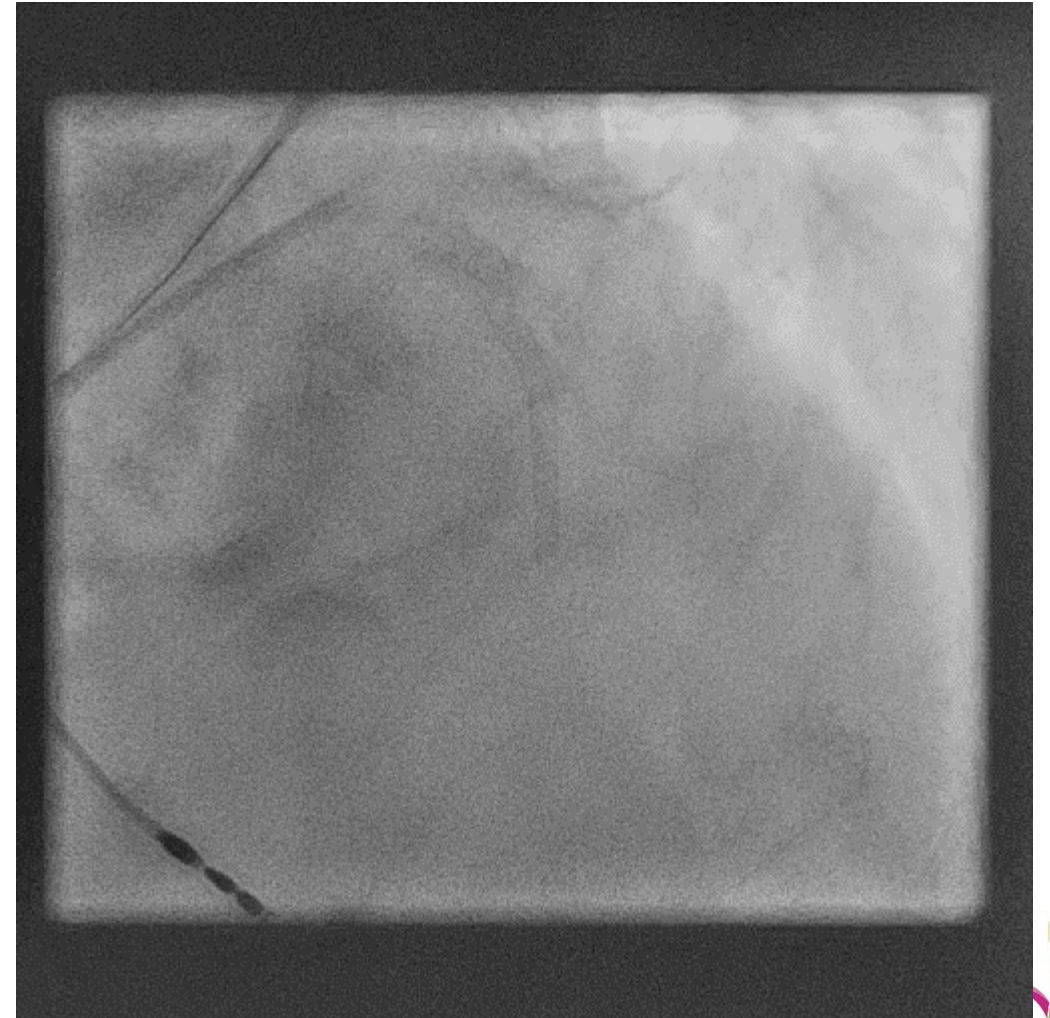
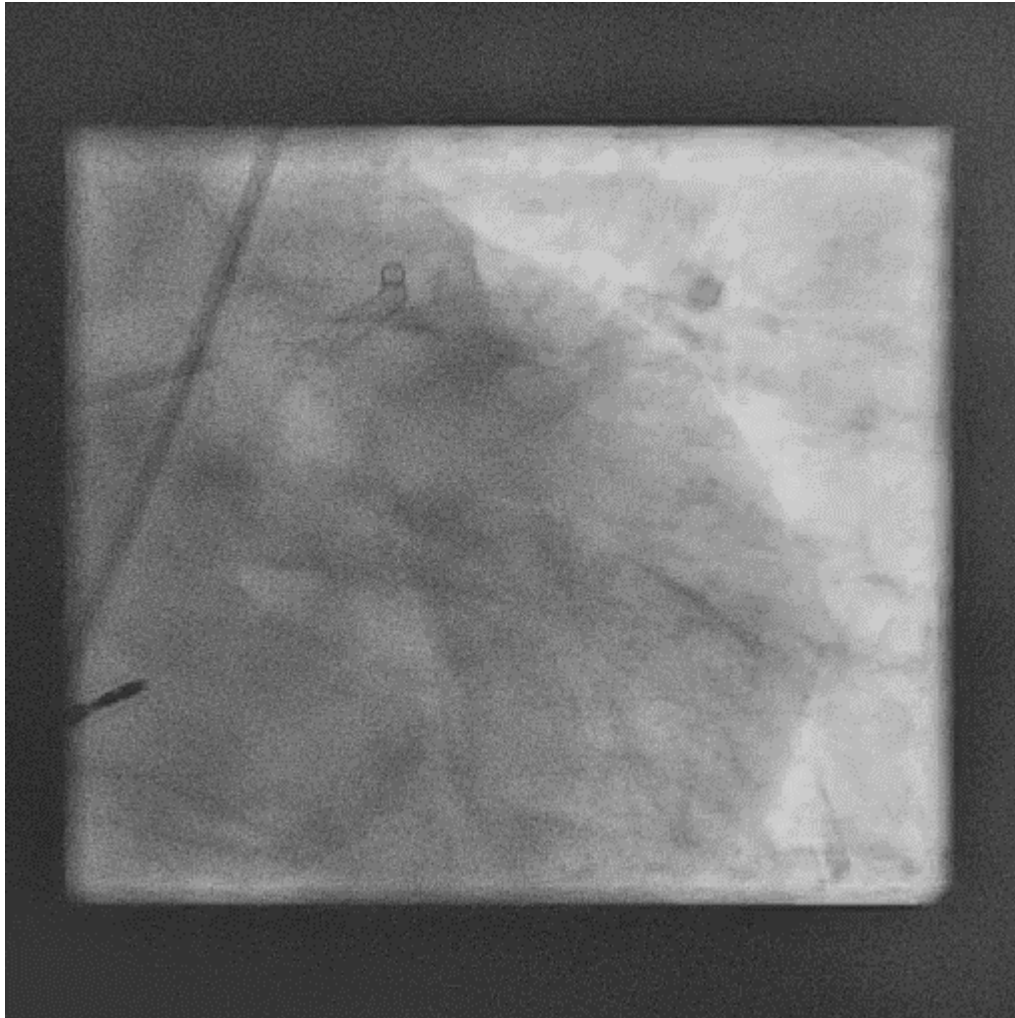


Kissing balloons 4.0 et 3.5

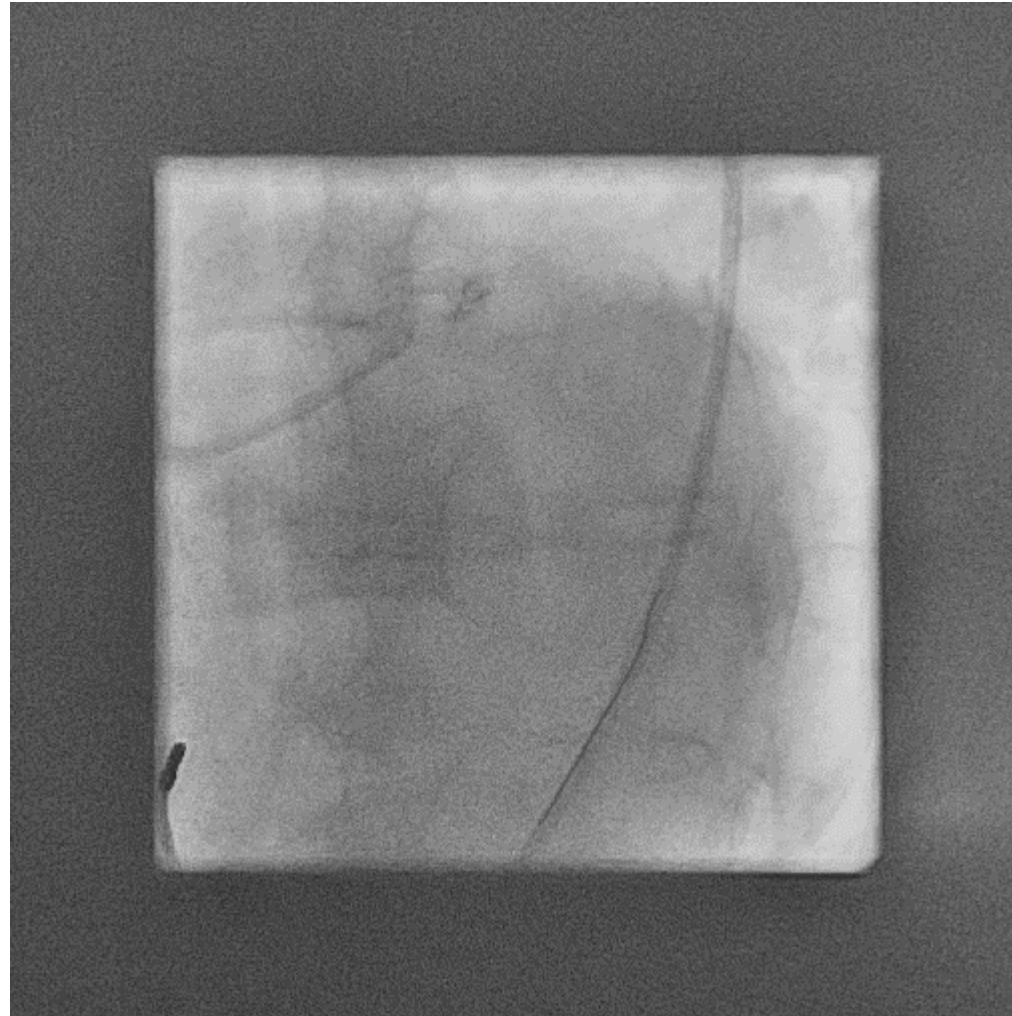




# Résultat final



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# Evolution

- Implantation d'une CRT
- Amélioration de la FEVG 48%
- TAVI le 18/10/2022 avec une Corevalve Evolut Pro R 29mm





Merci de votre attention

