M'sia LIVE
2016

Hilton Kuala Lumpur | 28th – 30th July 2016

Organised by:
Collaboration:
Live Transmission Site:
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Dear colleagues,

Welcome to Interventional Cardiovascular Society of Malaysia annual interventional meeting, MYLIVE 2016.

This is our 13th annual conference, chaired by Prof Wan Azman, has put together an exciting two and a half day program that will promise a good blend of international and local perspectives in application of the latest advances in interventional cardiology.

This conference is for cardiologists, physicians who specialised in interventional cardiology, vascular surgeons, fellows and other medical professionals interested in cardiovascular disease.

One of the highlight of this year’s meeting is the partnership of MYLIVE with Endovascular and Cardiac Complications Conference. We are proud to have world renowned expert collaboration with Prof. Eric Eeckhout and hope that this would translate into future Asia ECC partnership.

We are confident that this conference will be a valuable and enjoyable experience to you and the comprehensive program would provide opportunities for professional development and networking.

I would like to thank all of you for coming to MYLIVE 2016.

Dr Ng Wai Kiat, FNHAM
President of The National Heart Association of Malaysia
Dear colleagues and friends,

On behalf of the organising committee, it is my pleasure to invite you to attend MYLIVE 2016 to be held from 28th-30th July 2016 in Hilton Hotel, Kuala Lumpur, Malaysia. This is the Interventional Cardiovascular Society of Malaysia (ICSM) annual conference with Live Transmission. ICSM has undergone remarkable growth and achievement over the last decade. This meeting offer a unique opportunity for cardiovascular fraternity and people in the related field to meet, to discuss and networks with colleagues from the region and abroad to share the best practices and know-how for the betterment of cardiovascular care in the region.

MYLIVE 2016 will again showcase the best of cardiac and other vascular intervention and the challenges surrounding the treatment. In this two and half days meeting we will have many symposiums, case sharing, how to treat sessions addressing each important topics-left main disease, bifurcation, chronic total occlusion, long and small vessel, saphenous vein graft, STEMI intervention, structural and peripheral intervention, learning to integrate the right techniques and devices for optimal management of our patients. Live Transmission for MYLIVE 2016 will be from University Malaya Medical Centre and there will be how to treat session by the Masters.

Another highlight in 2016 meeting is to start a new chapter, MYLIVE with Endovascular and Cardiac Complications (ECC) Conference which is held in CHUV Hospital Lausanne by Prof Eric Eeckhout. This collaboration would be able to form a strong partnership in future especially the birth of Asia ECC. This will be one and a half day programme sharing complications from the west and the region.

There will be an exhibition of the latest devices and technologies, imaging modalities, new innovation and hand on session on the use of these devices and technologies.

We thank you for your support and look forward to your presence in this exciting MYLIVE 2016. Your presence will certainly add value to the meeting and very much appreciated.

SELMAT DATANG to Kuala Lumpur.
Let me take this opportunity to extend a very warm welcome to all participants attending MyLIVE 2016.

Once again, we are privileged to host this annual meeting that is designed to showcase world renowned interventional cardiovascular treatments and procedures. MyLIVE 2016 will present an expertly designed series of scientific programme with case based sessions, for guiding delegates in various aspects of cardiology practice.

This year, we are proud to also host the inaugural ECC session that will see the formation of the Asia ECC. The Asia ECC will create a renewed awareness and provide educational value to our esteemed participants about cardiovascular complications which occur in the Asian region. I am confident that this establishment will create a sustainable platform for healthy discourse and expert contributions to enable and direct future research and collaborative efforts in the field of cardiovascular treatments.

As it has been with every year, MyLIVE will once again bring to the delegates the much anticipated “How To Treat” sessions which will utilise essential case-based teaching sessions and an exchange of expert opinion in the approach and delivery of cardiovascular treatment methods. With our expert panellists, speakers and participants from all over the globe, this year’s MyLIVE promises to be a rich information repository and dialogue in the further education for all professionals involved in the specialty of cardiovascular care.

Thank you and I look forward to your support and participation at MyLIVE 2016.

Dr. Ramesh Singh VERIAH, FNHAM
Scientific Chairman MYLIVE 2016
ORGANISING COMMITTEE

Organising Chairman
Wan Azman WAN AHMAD \textit{FNHAM}

Treasurer
TIANG Soon Wee \textit{FNHAM}
LAM Kai Huat \textit{FNHAM}

Scientific Chairman
Ramesh Singh VERIAH \textit{FNHAM}

Scientific Co-Chairman
Al Fazir OMAR \textit{FNHAM}

Live Transmission Committee
CHEE Kok Han \textit{FNHAM}
Azmee MOHD GHAZI \textit{FNHAM}

Trade & Exhibition
NG Wai Kiat \textit{FNHAM}
Shaiful Azmi YAHAYA \textit{FNHAM}

Audio Visual
CHOO Gim Hooi \textit{FNHAM}

Souvenir Programme Committee
Sazzli KASIM \textit{FNHAM}

ICSM Immediate Past Chairman & NHAM President
ROSLI Mohd Ali \textit{FNHAM}

President of NHAM
NG Wai Kiat \textit{FNHAM}

MYLIVE 2016 Advisor
Robaayah ZAMBAHARI \textit{FNHAM}
Rosli Mohd Ali \textit{FNHAM}
INTERNATIONAL FACULTY

BANGLADESH
Mir Jamal UDDIN
Muhammad Murshed UDDIN

EUROPE
Christoph Kurt NABER
Eric EECKHOUT
Franz Xaver KLEBER
Michael HAUDE
Pieter STELLA
Upendra KAUL
William WIJNS

HONG KONG
Michael LEE
Stephen LEE Wai Luen
William HAU

INDIA
Ashok SETH
Debabrata DASH
Mathew Samuel KALARICKAL
NN Khanan
Raman CHAWLA
Rishi GUPTA
Rajinikanth RAJAGOPAL

INDONESIA
A Fauzi YAHYA
Nikolas WANAHITA
Sunarya SOERIANATA
Teguh SANTOSO

JAPAN
Fumitaka HOSAKA
Hironori KITABATA
Toshiya MURAMATSU

MYANMAR
KYAW Soe Win

PHILIPPINES
Jose Nicolas CRUZ

SINGAPORE
HO Hee Hwa
Joshua LOH
KOH Tian Hai
LIM Soo Teik
LOH Poay Huan
Paul ONG Jau Leung
TAN Huay Cheem
Timothy James WATSON

THAILAND
Wasan UDAYACHALERM

UNITED STATE
Alan YEUNG
Renu VIRMANI

VIETNAM
Huy Duc DINH
Abdul Kahar ABDUL GHAPAR FNHAM
Abdul Wahab UNDOK FNHAM
Ahmad Faris ADDENAN
Ahmad Fazli ABDUL AZIZ FNHAM
Ahmad KHAIRUDDIN FNHAM
Ahmad Syadi MAHMOOD ZUHDI FNHAM
Aizai Azan ABDUL RAHIM FNHAM, FAsCC
Alan FONG Yean Yip FNHAM
Alexander LOCH FNHAM
Al Fazir OMAR FNHAM
Amin ARIFF NURUDDIN FNHAM
Anuar MASDUKI FNHAM
Asri Ranga ABDULLAH RAMAIYAH
Azhari ROSMAN FNHAM, FAsCC
Azmee MOHD GHAZI FNHAM
Balachandran KANDASAMY
CHEE Kok Han FNHAM
CHOO Gim Hooi FNHAM, FAsCC
CHOONG Choon Hooi FNHAM
CHAN Chong Guan FNHAM
David CHEW Soon Ping FNHAM, FAsCC
Emily TAN Lay Koon FNHAM
Firdaus MOHD ALI KANABATHI
Ganiga Srinivasasaih SRIDHAR
Haizal Haron KAMAR FNHAM
Hamat Hamdi CHE HASSAN
Imran ZAINAL ABIDIN FNHAM
Kamaraj SELVARAJ
Kannan PASAMANICKAM FNHAM
Kenneth CHIN FNHAM
KOH Kok Wei
LIEW Chee Tat FNHAM
LIEW Houng Bang FNHAM
LAM Kai Huat FNHAM, FAsCC
Mansor YAHYA

MA Soot Keng FNHAM
Mohd Rabani ROSMAN
Mohd Nasir MUDA FNHAM
Muhamad Ali SK ABDUL KADER FNHAM
Muhammad Dzafir ISMAIL FNHAM
NG Wai Kiat FNHAM, FAsCC
NEOH Eu Rick
Nik Halmey NIK ZAINAL ABIDIN FNHAM
Noor Rathnavathy MAHADIR NAIDU
Noraminah AEDRUS
Norizam MOIS
Omar ISMAIL FNHAM
ONG Tiong Kiam FNHAM
Oteh MASKON FNHAM
Rajesh PRAVINCHAND SHAH FNHAM
Ravinderjit SINGH
Ramesh SINGH VERIAH FNHAM
Razali OMAR FNHAM
Robaayah ZAMBAHARI FNHAM, FAsCC
ROSLI Mohd Ali FNHAM, FAsCC
Sazzli KASIM FNHAM
Shaiful Azmi YAHAYA FNHAM
Simon LO FNHAM
Sanjiv JOSHI FNHAM
Siti Khairani ZAINAL ABIDIN FNHAM
Surinder KAUR
Suzanna Hani HUSSEIN
Tamil Selvan MUTHUSAMY
Thavarasa NAVARATNAM
TIANG Soon Wee FNHAM, FAsCC
Wan Azman WAN AHMAD FNHAM
Yazmin YUSOFF
Zubin IBRAHIM
Zulkifli MUSTAPHA
Zurkurnai YUSOF FNHAM
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<td>0900-0930</td>
<td>MyLive 15: 1 year outcomes of cases AL Fazir OMAR</td>
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<td>0930-1000</td>
<td>Welcome Address, Opening Ceremony and Sponsors’ Award Presentation Wan Azman WAN AHMAD</td>
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<td>1000-1030</td>
<td>Latest in Interventional Cardiology William WIJNS</td>
<td>1030-1200</td>
<td>STEMI SYMPOSIUM</td>
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<td>Rajinikanth RAJACOPAL</td>
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<td>LIVE SESSION 1 – Left main</td>
<td>1030-1045</td>
<td>STEMIM Network: Getting to where we are today and meeting challenges ahead. CHOO Gim Hooi</td>
<td>1030-1045</td>
<td>1. Antegrade Approach WASAN UDAYACHALERM</td>
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<td>ALVIMEDICA</td>
<td>1045-1100</td>
<td>2. Thrombectomy – to aspirate or not HO Hee Hwa</td>
<td>1045-1100</td>
<td>2. Retrograde Approach Toshiya MURAMATSU</td>
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<td>CASE 1</td>
<td>Operators:</td>
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<td>1100-1115</td>
<td>3. Japanese vs American way of CTO intervention LIM Soo Teik</td>
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<td>1. Robaayah ZAMBAHARI</td>
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<td>CASE 2</td>
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<td>1115-1130</td>
<td>4. Starting a CTO PCI Program Fumitaka Hosaka</td>
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<td>1. Wan Azman WAN AHMAD</td>
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<td>OCT/IVUS - William HAU</td>
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<td>1115-1130</td>
<td>3. Culprit Only vs Complete Revascularization in STEMI TAN Huay Cheem</td>
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<td>1130-1145</td>
<td>4. No reflow phenomenon Paul ONG Jau Leung</td>
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<td>1145-1200</td>
<td>Q&amp;A</td>
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<td>1220 -1240</td>
<td>ZAMBAHARI Lecture 1: Leaders Free Robaayah</td>
<td>1145-1200</td>
<td>6. Shock in STEMI Mir Jamal UDDIN</td>
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<td>1240 -1300</td>
<td>ZAMBAHARI Lecture 2: Leaders Free - ACS Ramesh Singh</td>
<td>1200-1400</td>
<td>Lunch Symposium 2: MEDTRONIC Managing Complex Coronary Interventions with Resolute Onyx (2.0mm to 5.0 mm) <em>Chairpersons:</em> 1. Amin Ariff NURUDDIN 2. Al Fazir OMAR</td>
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<tr>
<td>1300 -1310</td>
<td>VEKIAM Case 1</td>
<td>1210 - 1214</td>
<td>Opening and Introduction by Chairperson Amin Ariff NURUDDIN</td>
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<td>1310 -1320</td>
<td>Alan FONG Yeon Yip Case 2 Asri Ranga ABDULLAH</td>
<td>1215 -1230</td>
<td>Complex XLV: Extra Large Vessel cases with Resolute Onyx 4.5-50 Sazzli KASIM</td>
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<td>1320 -1330</td>
<td>RAMAIAH Case 3</td>
<td>1230-1245</td>
<td>DAPT interruption after 1 month of DES implantation Al Fazir OMAR</td>
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<td>1330 -1350</td>
<td>Kamaraj SELVARAJ Q &amp; A</td>
<td>1245 - 1300</td>
<td>Onyx: Going to where none has gone before CHOO Gim Hooi</td>
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<td>1300 - 1315</td>
<td>Simplifying CTO: the right device selection is critical for success Wan Azman WAN AHMAD</td>
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<td>1315 - 1330</td>
<td>Next generation FFR technology: Catheter based FFR device RXI in the setting of complex PCI ONG Tiong Kiam</td>
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<td>1330 - 1400</td>
<td>Panel discussion and Closing by <em>Chairperson</em> Al Fazir OMAR</td>
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<td>1500-1510</td>
<td>OCT/IVUS - William HAU</td>
<td>1500-1515</td>
<td>BOM 6: The Perfect Storm Jayakhanthan KOLANTHAIVELU</td>
<td>1500-1515</td>
<td>5. Utilising OCT to Optimize stenting Hironori KITABATA</td>
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<td>1530-1600</td>
<td>Q &amp; A</td>
<td>1530-1600</td>
<td>BOM 8: The Trifurcation Dilemma Jayakhanthan KOLANTHAIVELU</td>
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<td>1530-1600</td>
<td>TEA BREAK</td>
<td>1600-1730</td>
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<td>1645-1700</td>
<td>Case 1: Side branch wire entrapment CHOOR Chee Ken</td>
<td>1645-1700</td>
<td>Case 2: Fishing for an ostial RCA dislodged stent Nicholas CHUA</td>
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<td>1700-1715</td>
<td>Case 3: Catheter associated thrombosis Erwin MULIA</td>
<td>1700-1715</td>
<td>Case 4: Saved By The Stingray! NG Min Yeong</td>
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<td>1715-1730</td>
<td>Q &amp; A</td>
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## DAY 2: FRIDAY 29th July 2016

### BALLROOM C

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<th>TIME</th>
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| 0745-0830 | Breakfast Symposium 1: ABBOTT  
*Chairpersons:*  
1. Robaayah ZAMBAHARI  
*Moderators:*  
1. ONG Tiong Kiam  
2. LIEW Houng Bang  
3. Ramesh Singh VERIAH  
4. Hasral Noor HASNI |
| 0745-0750 | Opening and Introduction by Chairperson |
| 0750-0805 | European Experience of BVS: Dr Naber’s Perspective  
Christoph Kurt NABER |
| 0805-0820 | Live Session 4: Bifurcation  
*Chairpersons:*  
1. CHOO Gim Hooi  
2. William WIJNS  
*Panelists:*  
1. Pieter STELLA  
2. A Fauzi YAHYA  
3. LOH Poay Huan  
4. Ramesh Singh VERIAH  
5. Alan FONG Yean Yip |
| 0820-0830 | Panel discussion and Closing by Chairperson |
| 0830-1000 | ASIA ECC SYMPOSIUM 2  
*Chairpersons:*  
1. Upendra KAUL  
2. Michael LEE  
*Panelists:*  
1. Sunarya SOERIANATA  
2. TAN Huay Cheem  
3. Nick CRUZ  
4. David CHEW  
5. Rajesh PRAVINCHAND SHAH |

### BALLROOM B

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Teguh SANTOSO |
| 0830-1000 | New Generation Stents and balloon SYMPOSIUM  
*Chairpersons:*  
1. Stephen LEE  
2. Renu VIRMANI  
*Panelists:*  
1. Azmee MOHD GHAZI  
2. Rishi GUPTA  
3. Abdul Kahar ABDUL GHAPAR  
4. Omar ISMAIL  
5. MANSOR YAHYA |

### SENTRAL BALLROOM

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| 0805-0845 | Newer generation DEB – what are the benefits  
Franz KLEBER |
| 0845-0900 | Dedicated Bifurcation stent  
Wasan UDAYACHALERM |
| 0900-0915 | Polymer free (DCS) vs durable polymer DES. Difference and implication on DAPT  
Robaayah ZAMBAHARI |
| 0915-0930 | BRS Update: what the future holds  
Christoph NABER |
| 0930-0945 | Self-expanding stents  
Asri Ranga ABDULLAH RAMAIAH |
| 0945-1000 | Q & A |

### TEA BREAK

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### DAY 2: FRIDAY 29th July 2016

#### SCIENTIFIC PROGRAMME

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<td>1030-1200</td>
<td>LIVE SESSION 5 – MISC</td>
<td>1030-1200</td>
<td>ASIA ECC SYMPOSIUM 3: PERIPHERAL/STRUCTURAL COMPLICATIONS</td>
<td>1030-1200</td>
<td>HOW DO I TREAT SESSION</td>
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<td><strong>Chairpersons:</strong></td>
<td>1. TAN Huay Cheem</td>
<td><strong>Chairpersons:</strong></td>
<td>1. Shaiful AZMI YAHYA</td>
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<td>4. Robaayah ZAMBAHARI</td>
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<td>2. KYAW Soe Win</td>
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<td>3. Rishi GUPTA</td>
<td>3. Eric EECKHOUT</td>
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<td>5. Abdul Kahar ABDUL GHAPAR</td>
<td>5. NN KHANNA</td>
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<td>Commentator: Robaayah ZAMBAHARI</td>
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<td>Operators:</td>
<td>1. Alan YEUNG</td>
<td>1. Case 1: Two shots to the heart and a life is saved</td>
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<td>2. Sazzli Kassim</td>
<td>Kantha RAO</td>
<td><strong>Complications during structural interventions</strong></td>
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<td>Operators:</td>
<td>1. Ashok SETH</td>
<td>Raman CHAWLA</td>
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<td><strong>Presenter:</strong> Imran ZAINAL ABIDIN</td>
<td><strong>Presenter:</strong> Joshua LOH</td>
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<td>2. Azhari ROSMAN</td>
<td><strong>Case 2:</strong></td>
<td><strong>Case 1:</strong> Complications during structural interventions</td>
<td><strong>Commentator:</strong> Sunarya SOERIANATA</td>
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<td>OCT/IVUS - William HAU</td>
<td><strong>Case 3:</strong> Complication in peripheral vascular intervention</td>
<td><strong>Case 1:</strong> Complications during structural interventions</td>
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<td><strong>How Did I do it:</strong> Imran ZAINAL ABIDIN</td>
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<td>1110-1125</td>
<td>Case 3: Complication in peripheral vascular intervention</td>
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<td><strong>Presenter:</strong> Azmee MOHD GHAZI</td>
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<td>CHEE Kok Han</td>
<td><strong>Case 4:</strong> Iliac perforation</td>
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<td><strong>Commentator:</strong> Muhammad Ali SK ABDUL KADER</td>
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<td>2. ROSLI Mohd Ali</td>
<td>Shaiful AZMI YAHAYA</td>
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<td><strong>How Did I do it:</strong></td>
<td><strong>How Did I do it:</strong> Azmee MOHD GHAZI</td>
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<td>1230-1325</td>
<td>Opening Remarks &amp; Introduction CHEE Kok Han</td>
<td>1140-1155</td>
<td>Case 5: An unexpected twist to aortoiliac occlusion FOO Yoke Loong</td>
<td>1130-1150</td>
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<td><strong>LIEW Houng Bang</strong></td>
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<td><strong>Are All Modern DES the Same? From Pathology to In Vivo Coronary Imaging</strong></td>
<td><strong>Case Presentation:</strong></td>
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<td>3. Panas KANGTONG</td>
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<td>Case Presentation 2: Cre8 in Left Main H O H Hee Hwa</td>
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<td>Does Lesion Preparation Matter? Ramesh Singh VERIAH</td>
<td>1400-1415</td>
<td>FFR: believer or non believer CHOO Gim Hooi</td>
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<td>1423-1436</td>
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<td>Case 4 KOH Tian Hai</td>
<td>1500-1515</td>
<td>Approaching a Complex Bifurcation lesion LIM Soo Teik</td>
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<td>Case 3 Michael LEE</td>
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<td>Case 5 Sunarya SOERIANATA</td>
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<td>1600-1730</td>
<td>Case 1: Where we went wrong – the mortality Raman CHAWLA</td>
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<td>Case 2: Rotawire fracture associated with perforation of left circumflex coronary artery LOH Poay Huan</td>
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<td>Cardiac Catheterization – Haemodynamic Left &amp; Right Mohd Rabbani ROSMAN</td>
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<td>1615-1630</td>
<td>Case 2: Rotawire fracture associated with perforation of left circumflex coronary artery LOH Poay Huan</td>
<td>1630-1645</td>
<td>Case 3: Sponatneous coronary artery dissection – an ongoing challenge Rajinikanth RAJAGOPAL</td>
<td>1620-1640</td>
<td>ECG – SVT Firdaus Mohd ALI KANABATHI</td>
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<td>1645-1700</td>
<td>Case 4: BVS complication: A case of a growing vessel Nikolas WANAHITA</td>
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<td>Case 5: Acute stent thrombosis Mohan RAMACHANDRAN</td>
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<td>Cardiac Imaging – HEART in HEART Ahmad Faris ADDENAN</td>
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<td>1700-1715</td>
<td>Case 5: Acute stent thrombosis Mohan RAMACHANDRAN</td>
<td>1715-1730</td>
<td>Q &amp; A</td>
<td>1720-1730</td>
<td>Q &amp; A</td>
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## How to Treat: Expert’s Session 1

**Chairpersons:**
1. Eric EECKHOUT
2. Asri Ranga ABDULLAH RAMAIAH

**Panelists:**
1. CHEE Kok Han
2. Alexander LOCH
3. Toshiya MURAMATSU
4. KOH Tian Hai

### How to treat a CTO in three vessel disease

*Presenter:* Debabrata DASH  
*Commentator:* CHEE Kok Han  
*How I Did It:* Debabrata DASH

### How to treat a diabetic patient

*Presenter:* Pieter STELLA  
*Commentator:* Alexander LOCH  
*How I Did It:* Pieter STELLA

### The Complex of Complexities

*Presenter:* Muhammad Dzafir ISMAIL  
*Commentator:* Toshiya MURAMATSU  
*How I Did It:* Muhammad Dzafir ISMAIL

### No Flow After Stenting

*Presenter:* Wan Azman WAN AHMAD  
*Commentator:* KOH Tian Hai  
Wan Azman WAN AHMAD

## Q & A

## How to Treat: Expert’s Session 2

**Chairpersons:**
1. Ramesh Singh VERIAH  
2. ROSLI Mohd Ali

**Panelists:**
1. Ahmad Syadi MAHMOOD ZUHDI  
2. Mathew SAMUEL  
3. LIM Soo Teik  
4. Hamat Hamdi CHE HASSAN

### Severe calcific 3 vessel disease with left main bifurcation

*Presenter:* Timothy JAMES WATSON  
*Commentator:* Ahmad Syadi MAHMOOD ZUHDI  
*How I Did It:* Timothy JAMES WATSON

### A persistant leak after percutaneous post MI VSD closure

*Presenter:* Eric EECKHOUT  
*Commentator:* Hamat Hamdi CHE HASSAN  
*How I Did It:* Eric EECKHOUT

### Summary of Malaysia Live 2016

Muhammad Dzafir ISMAIL / Ganiga SRINIVASAIAH SRIDHAR

### Closing Ceremony & Prize Award Presentation

Wan Azman WAN AHMAD
BEST OF MALAYSIA CASES
Date:  28th July 2016
Venue:  Ballroom B, Level 6, Hilton Kuala Lumpur

BOM 1  Time: 1400-1410 hr
MOTHER OF ALL CHRONIC TOTAL OCCLUSIONS
Alan Koay Choon Chern
Institute Jantung Negara

BOM 2  Time: 1410-1420 hr
ROLLER COASTER RIDE OF DISLODGE STENT
Dr Nor Halwani Habizal
Hospital Pulau Pinang

BOM 3  Time: 1420-1430 hr
TROUBLED WITH A TREBLE
Dr Ng Yau Piow
Institute Jantung Negara

BOM 4  Time: 1430-1440 hr
SAVED BY THE STINGRAY!
Dr Ng Min Yeong
Institute Jantung Negara

BOM 5  Time: 1440-1450 hr
COMPLETE PERCUTANEOUS REVASCULARISATION
Dr Sri Raveen Kandan
Hospital Raja Permaisuri Bainun

BOM 6  Time: 1450-1500 hr
THE PERFECT STORM
Dr Jayakhanthan Kolanthaivelu
Institute Jantung Negara

BOM 7  Time: 1500-1510 hr
NOT ALL THOSE WHO WANDER ARE LOST
Dr Dharmaraj Karthikesan
Hospital Sultanah Bahiyah

BOM 8  Time: 1510-1520 hr
THE TRIFURCATION DILEMMA
Jayakhanthan Kolanthaivelu
Institute Jantung Negara
BOM 1

Time: 1400-1410 hr

MOTHER OF ALL CHRONIC TOTAL OCCLUSIONS
Dr Alan Koay Choon Chern
Institute Jantung Negara

INTRODUCTION
A 65-year-old gentleman was referred for further management following complaint of bilateral intermittent claudication (claudication distance: 30m) for the past 3 months. Ankle-brachial index (ABI) on the right was 0.37 and on the left was 0.47. CT Aortography revealed aortoiliac total occlusion immediately distal to the renal arteries with reconstitution of both external iliac arteries from the mesenteric arteries.

Premorbid medical history includes:
1) NSTEMI in 2014 – multivessel PCI performed for 3VD, EF 33%
2) Dyslipidemia

OBJECTIVE
1) Describing the techniques employed in percutaneous reconstruction of the aortoiliac bifurcation using the antegrade and retrograde approaches.
2) Describing the complications encountered and bailout techniques employed during the complications.

DESCRIPTION OF THE PROBLEM, PROCEDURE, TECHNIQUE & EQUIPMENT USED
Access: Right brachial, right and left femoral arteries approaches

Guide: Heartrail II-STO1 5Fr, Glidecath Multipurpose 4Fr & MPA1 6Fr

Antegrade approach was first attempted via right brachial artery approach using Terumo stiff wire on Heartrail II-STO1 catheter. Multiple attempts failed to cross lesion as wire kept going into false lumen. The antegrade approach was then switched to retrograde approach (right femoral artery), which also failed. Switched back to antegrade approach (right brachial artery) using V18 wire on Progreat microcatheter.

Finally, managed to cross aortic occlusion into right common iliac artery and V18 was snared out through right femoral artery. Glidecath Multipurpose 4Fr was advanced over the V18 wire via right femoral artery and changed to Terumo wire. Predilated distal aorta with Evercross 5x60mm and flow was established from aorta to right common iliac artery.

Attempted to cross lesion in left common iliac artery via antegrade and retrograde approaches with Terumo wire on Glidecath Multipurpose 4Fr but failed. V18 and Conquest Pro 8-20 wires on Progreat microcatheter were also attempted but kept going into false lumen.

Long sheath was replaced on left femoral artery and reattempted retrograde approach using Conquest Pro 8-20 wire but to no avail. Decision was made to abandon PTA left common iliac artery, stent the aorto-right common iliac artery and send patient for femoral-femoral bypass.

After stenting, noted BP dropped to 90/50mmHg and shot taken showed perforation of left common iliac artery (possibly due to long sheath advancement). Evercross 5x60mm balloon was quickly advanced up left common iliac artery and inflated for 5 minutes to seal off the perforation.

V18 wire through the right femoral artery (crossover approach via Glidecath) eventually managed to cross the lesion in left common iliac into the left femoral sheath (tip-in technique). Right-left common iliac bifurcation was predilated with Foxcross 4.0x60mm balloon. Left common iliac artery was predilated further with Evercross 5x60mm (retrograde) and Foxcross 4.0x60mm (antegrade) balloons simultaneously; and stented with Atrium V12 8x59mm, 6x22mm and 5x38mm covered stents. Perforation was successfully sealed. BP improved to 172/61mmHg.

Aortoiliac bifurcation was stented simultaneously with Omnilink 7x59mm and 8x59mm. Finally, right common iliac artery was stented with Innova 8x100mm.

RESULTS
Aortoiliac bifurcation was successfully reconstructed percutaneously and iatrogenic perforation of the left common iliac artery was successfully sealed. Patient was well in subsequent follow-ups with resolution of intermittent claudication.
BOM 2

Time: 1410-1420 hr

ROLLER COASTER RIDE OF DISLODGE STENT
Dr Nor Halwani Habizal
Hospital Pulau Pinang

INTRODUCTION
Percutaneous coronary intervention (PCI) using stent, has been established to improve in patient’s symptoms and clinical outcome. Stent dislodgement is a rare complication of PCI and may be fatal. Patient may complicate into coronary embolization, hence requiring emergent coronary artery bypass surgery and sometimes may lead to death. Equipment design has been improved for the last few decades, thus reduce this complication.

OBJECTIVE
This case will illustrate to us the measures that had been done to our unfortunate patient who went for elective PCI and developed stent dislodgement.

PROCEDURE
Our patient, 58 years old gentleman with underlying diabetes mellitus and hypertension, who had positive exercise stress test and proceeded with coronary angiogram on October 2015. He was diagnosed to have two vessels disease and was planned for elective PCI to left circumflex (LCX) artery on the 6th April 2016.

Right radial artery was punctured and 6Fr sheath was inserted. EBU 3.5 6Fr guide catheter was engaged to left main (LM). Estimated of 52mm significant lesion was recognized in LCX artery and our strategy to deploy and to overlap two stents. LCX artery was wired with Runthrough NS without difficulty. Distal lesion was predilated with Sprinter Legend 2.0 x 20 at 14atm and stent Terumo Ultimaster 2.5 x 28 at 12atm was deployed. The second stent for the proximal lesion, Terumo Ultimaster 3.0 x 24 was introduced and unfortunately slipped from its balloon at the LM.

Small Minitrek balloon 1.2 x 8 was deployed distal to the stent and attempted to pull into the guider but failed. Another Minitrek balloon 2.0 x 8 was deployed distal to the stent. Initially the stent was able to pull from the LM but unable to withdraw into the guider due to flawed stent. We were decided to pull out the balloon-stent-guider together into the right radial artery 6Fr sheath but failed.

Subsequently, right femoral artery 14Fr sheath was inserted and Mullin 10Fr sheath was advanced into ascending aorta. Then the stent was pushed retrogradely using MPA 1 5Fr but failed and EBU 6Fr guide was used to push back the stent into the Mullin sheath. The stent was successfully pushed into Mullin sheath and the stent was successfully withdrawn together with the sheath.

RESULT
The stent was successfully taken out through 14Fr right femoral artery sheath. The left circumflex artery was eventually stented with TERUMO Ultimaster 2.75 x 24 with good final TIMI 3 result.
INTRODUCTION & OBJECTIVE
We described a case of procedural and clinically successful unprotected LMCA intervention including trifurcation branches with triple balloon inflation and utilization of buddy balloon technique in stent delivery through LM stent strut into an angulated ostial Lcx lesion.

46 year old gentleman with hypertension, hypercholesterolemia, smoking presented with typical exertional angina CCS class III.

Coronary angiogram showed - LMS : severe distal stenosis 80 %, ostial LAD stenosis 80 %, distal LAD 90% stenosis, dominant ostial Lcx stenosis 70 %, Intermedia ostial stenosis 80 % RCA is non dominant and mildly diseased.

He was advised for CABG repeatedly by two tertiary center but declined and was referred to IJN for elective PCI. 2D Echo : EF 60 % good LV function, valves normal. Syntax score : 33. He was consented for high risk LMS PCI.

DESCRIPTION OF THE PROBLEM
Procedure was done via RFA. LFA 5Fr sheath inserted anticipating need for IABP. Strategy of single LMS-LAD provisional stenting decided at the outset. 8Fr JL3.5 guiding catheter engaged LCA, 3 wires passed down into distal LAD(RTF), distal Lcx(BMW), Ramus intermedia(Sion Blue). Distal LM and Ostial LAD was predilated with Sapphire II 2.5/12mm 6 atm. Distal LAD predilated with Sapphire 2.0/12 10atm then stented with Ultimaster 2.25/18 at 18atm. Stent balloon was used to measure length of LM lesion. Stented LMS into LAD with Ultimaster 3.5/18 at 10atm. Wire from ramus and Lcx was re-crossed/flip flop technique into both artery from within the stent strut. Triple kissing inflation of LAD/Lcx/Ramus was done with Saphire 2.0(Intermedia), Saphire 3.0(Lcx), Lacrosse 3.0 (LAD). Ostial diagonal noted pinched and kissing inflation done with Saphire 3.0(LAD) & Saphire 2.0(D1). POTS done to LM stent. Ostial Lcx was noted to be hazy and was decided to proceed for TAP stenting. Ostial Lcx was predilated with Saphire 2.0/12 at 12 atm. Faced great difficulty in delivering stent into Lcx due to 90 degree angulation from LM into Lcx and presence of stent covering ostial Lcx. Again predilated with Lacrosse 3.0, still unsuccessful in delivering stent down into Lcx. More predilatation with NC Trek 3.5/12 still failed to deliver stent into target lesion. Finally employed buddy balloon technique-Sapphire 2.0/12 which managed to deliver stent into Lcx artery. Careful removal of buddy balloon to prevent trapped balloon or stent deformation. Promus premier 3.0/12 deployed at ostial Lcx with small protrusion into distal LM with balloon positioned in LM. Final kissing inflation LM/LAD/Lcx done with Sapphire 4.0/12(LM-LAD) & NC Trek 3.5/12(Lcx). Final results good, with good flow and no chest pain.

RESULTS
An interesting successful PCI in a complex distal LMCA and trifucation stenosis with 3 DES with triple balloon inflation, provisional TAP and buddy balloon technique. Patient, equipment and lesion preparation with multiple careful predilatation is crucial in increasing chances of success in complex PCI.
BOM 4

Time: 1430-1440 hr

SAVED BY THE STINGRAY!
Dr Ng Min Yeong
Institute Jantung Negara

INTRODUCTION & OBJECTIVE
We described a case of Stingray Catheter CTO Re-entry System was used to overcome a not uncommon situation while treating CTO whereby the guidewire persistently went into subintimal space that created by guide wire.

CASE HISTORY
51 year old gentleman, presented to us for second opinion after his recent MSCT angiogram in other hospital revealed total occlusion proximal LAD and distal RCA disease. He has no known medical illness but presented with typical angina pain with exertion.

Coronary angiogram showed normal LM and LAD occluded proximally. Left circumflex: mild disease at OM1. RCA dominant, moderate distal segment stenosis and severe RPL stenosis. Retrograde filling of mid and distal LAD observed.

PCI to RCA lesion was done with good result but failed to cross CTO LAD.
Staged PCI to CTO LAD during CTO workshop arranged.

DESCRIPTION OF THE PROBLEM
The procedure was done with bilateral punctures. JR 3.5 /6F via the right radial and engaged to RCA whereas EBU 3.5/7F via right femoral and engaged to LAD RCA-LAD retrograde view taken.

Anterograde approach attempted with micro catheter FINECROSS MG with Guide Wire FIELDER XT and GAIA 2 subsequently. The wire persistently entering into subintimal space despite multiple attempts. We decided to change strategy to overcome the problem thus Stingray Catheter was used.

We predialte the subintimal space with SAPPHIRE 1.0 balloon and subsequently 1.5 x10mm balloon upto 10ATMS to prepare the vessel to accommodate the catheter. Stingray catheter 3.7F/135cm was advanced to the subintima space and approximated with the true lumen. Stingray wire was used to puncture the intimal layer and exchanged with GAIA 2 wire later.

Guide Wire crossed the lesion and Predilate with SAPPHIRE 2.0x15 and 2.5/15mm sequentially upto 12ATMS. Lesions stented with tapered stent BIOMIME MORPH 3.0-2.5/60MM. Stent postdilate with NC EUOHORA 3.0/20mm 10 to 20ATMS. Final result was good with good flow achieved.

RESULTS
This is an interesting experience of using Stingray catheter CTO Re-entry System. As we know the difficulty to treat chronic total occlusion will increased when the lesion was complicated by false lumen that we created during attempts. Stingray catheter seems very useful in the cases like this.
BOM 5

Time: 1440-1450 hr

COMPLETE PERCUTANEOUS REVASCULARISATION
Dr Sri Raveen Kandan
Hospital Raja Permaisuri Bainun

INTRODUCTION
A 62-year-old man undergoing coronary angiography for unstable angina and severe left ventricular impairment (ejection fraction 25%) was found to have significant distal left main stem (LMS) bifurcation disease and double chronic total occlusions (CTO) of his left anterior descending (LAD) artery and dominant right coronary artery (RCA). In addition, his last remaining vessel (circumflex) had a 90% proximal lesion.

OBJECTIVE
We describe a percutaneous strategy for complete revascularisation of this patient with very complex coronary disease and poor ejection fraction.

DESCRIPTION OF THE PROBLEM, PROCEDURE, TECHNIQUE AND EQUIPMENT USED
The patient was initially referred for coronary artery bypass grafting. A cardiac MRI confirmed viability in all 3 coronary territories but he was felt to have poor distal targets for surgery.

A staged percutaneous approach was therefore undertaken with initial PCI to his RCA CTO. Successful antegrade crossing was achieved with a Gaia 3 wire. Following extensive pre-dilatation, the RCA was stented with overlapping 3.0-2.5x50mm BIOMIME MORPH (distal), 3.5-3.0x50mm BIOMIME MORPH (mid) and 3.5x23mm EUCALIMUS (ostial-proximal) drug eluting stents (DES) and post-dilated to high pressure with 2.5mm-3.5mm non-compliant (NC) balloons.

The patient returned 6 months later for complete revascularisation. The LAD CTO was crossed with a Fielder XTR wire. Following extensive pre-dilatation an IVUS run was performed to size the LMS and LAD. The mid-LAD was stented with a 2.25x40mm ORSIRO DES.

A Double-Kissing Crush (DK-Crush) strategy was chosen to treat the distal LMS/ LAD/Circumflex bifurcation. The circumflex was stented first with a 3.0x30mm ORSIRO DES, crushed in the LMS with a 3.5mm balloon, re-wired and first kissing inflations were performed. The LMS to mid-LAD was then stented with a 3.5-3.0x50mm BIOMIME MORPH DES and post-dilated with 3.0mm-4.0mm NC balloons to high pressure. Final kissing inflations were performed with 4.0mm (LAD) and 3.0mm NC balloons. A post PCI IVUS run showed well-expanded and well-opposed stent struts with satisfactory minimal stent area.

RESULTS
At clinic follow-up 3 months later, the patient reported no further angina and an improvement in his exercise capacity from NYHA Class III to Class II. A repeat echocardiogram showed improvement in LV function.
INTRODUCTION
We describe a case of a 60 year old retiree, who is a diabetic. He presented with anginal pains and shortness of breath on exertion. Coronary angiogram on 2nd February 2016 revealed severe diffuse calcified stenosis from ostial to distal LAD, mild proximal LCX stenosis and small diffusely diseased RCA. Patient was not keen for a surgical option.

The objective of this case will be about managing high risk PCI in a patient with poor ejection fraction. Also to learn to manage complications arising from angioplasty to calcified and diffusely diseased vessels.

DESCRIPTION OF THE PROBLEM, PROCEDURE, TECHNIQUE AND EQUIPMENT’S USED
He was planned for stage PCI to LAD. Right radial approach initially using AL 1.0/7Fr. However due to high origin LAD when attempting to cross LAD with wire, the catheter occluded LCX flow and patient became hypotensive and began trashing around. Quick decision was made to change to right femoral approach. Attempted with AL 1.0/7Fr and JL 4.0/6Fr. However both catheters did not give good approach or support to cross LAD. Decided to use AL 1.0/6Fr. RTF was passed down LCX for support. We managed to pass Sion Blue down LAD without microcatheter support.

Pre-dilated LAD with a semi compliant balloon 2.0/20mm and further with NC balloon 2.5/20mm up to 28 atm. Attempted to pass stent Biomime Morph 3.0-2.5/60mm, however failed to pass proximal LAD. Further pre-dilation done with NC balloon 3.0/20mm up to 26atm. However the long stent refused to pass to distal LAD. Further pre-dilation done with NC balloon 3.5/20mm up to 28atm. We were still unable to pass the stent down. We decided to use Guideliner 6Fr for support. However we had great difficulty in passing the guideliner down the LAD as well.

We used NC 3.5mm balloon as anchor at mid LAD to advance guideliner. NC 3.5mm was inflated at low pressure and while inflated, guideliner advanced towards balloon. This was done sequentially till guideliner passed to mid LAD. NC balloon was removed. With guideliner secure in mid LAD the Biomime Morph 3.0-2.5/60mm was pushed down to distal LAD. Once the stent was passed down, the guideliner was pulled back into LM and Biomime Morph deployed at proximal LAD. The stent was then post-dilated with NC balloon 3.5/20mm. Despite this the stent remained under. Decided to use OPN NC balloon 3.5mm, post dilated stent and pre-dilated ostial LAD up to 35 atm.

At this juncture, the OPN balloon was stuck to the LAD wire and had to be pulled out. We managed to re-wire LAD with a prolapsed Sion Blue. We noted a perforation at ostial LAD. We then stented ostial LAD with Resolute Integrity 3.5/15mm hoping that will seal the perforation. Unfortunately the perforation was persistent, despite long balloon inflations. As perforation had not sealed off we used a single layered covered stent Papyrus 3.5/20mm to ostial LAD. Covered stent was deployed at 14atm with a 2.5/15mm balloon at LM-LCX (at 10atm). With this the perforation had sealed. No re-accumulation of contrast seen.

However we noted haziness at ostial LCX instead. We waited for 5 minutes and repeated shots were similar. IVUS was done to LCX. Noted plaque shift with calculated stenosis at 77% on CSA. Decided to stent ostial LM-LCX with Resolute Onyx 3.0/18mm. Rewired LAD with a new Sion Blue wire. We then post dilated LM-LCX with NC balloon 4.0/8mm. LM-LAD initially dilated with 2.0mm balloon to open up the stent struts. Then final kissing was done with NC balloon 4.0/8mm in LM-LAD and NC balloon 3.5/20mm in LM-LCX. IVUS done post stenting to LAD and LCX, showing stent well opposed. Urgent ECHO shows very minimal pericardial effusion. Right femoral puncture was closed with angioseal 8Fr. Patient recovered well and repeat ECHO reveals minimal pericardial effusion and EF of 30%.

RESULTS
We managed to successfully complete high risk PCI despite encountering multiple complications from the beginning right up to the end of the procedure.
NOT ALL THOSE WHO WANDER ARE LOST
Dr Dharmaraj Karthikesan
Hospital Sultanah Bahiyah

INTRODUCTION
We present a case of a 54-year-old man with symptoms of exertional angina. Exercise stress test (EST) was positive and echocardiogram showed good left ventricular function. Coronary angiography revealed chronic total occlusion (CTO) of mid left anterior descending artery (LAD) and proximal right coronary artery (RCA). His percutaneous coronary intervention (PCI) involved a two-step approach. Ad hoc PCI was first attempted to the CTO LAD which was successfully implanted with a single drug eluting stent.

OBJECTIVE
1) To demonstrate perceived difficult initial approach may turn out to be the safest approach to successful CTO intervention.
2) To demonstrate various techniques to improve guide support during CTO intervention with challenging ostial lesions.

DESCRIPTION OF THE PROBLEM, PROCEDURE, TECHNIQUE AND EQUIPMENT USED:
Staged PCI to RCA (First attempt) Bilateral femoral arteries were punctured and 7Fr Sheath inserted. A 7Fr EBU 3.5 guide for LAD was used. Difficulty was encountered when engaging the RCA due to the ostial lesion. Started with AL 1.0, then XB RCA and finally JR 4.0. The initial strategy was an antegrade approach with Finecross microcatheter support. Attempted to wire with Runthrough NS but failed. Changed to Fielder XTA and subsequently attempted parallel wire technique using Gaia First which also proved unsuccessful. The plan was changed to retrograde approach via the LAD mid-septal collateral channels. This was made possible using Finecross microcatheter and Sion Blue through the septal collateral but unable to wire into the right posterior descending artery (RPDA) due to the angulation. Changed to Fielder XTA as it was already available and was able to wire easily into proximal RPDA but caused perforation into the right ventricle (RV) cavity. Stat echocardiogram showed no evidence of pericardial effusion and the retrograde attempt was abandoned. Reattempted antegrade approach with Gaia Second and finally upgraded to Conquest Pro but due to poor guide support and wire tracking into false lumen causing dissection, second attempt at antegrade approach also failed. We planned for a staged PCI to CTO RCA via retrograde approach 1 month later once dissection and perforation healed.

STAGED PCI TO RCA (SECOND ATTEMPT)
Retrograde RCA CTO approach was commenced. A 7FR EBU 3.5 guide for LAD and 6F JR 3.5 guide to RCA was used. Using Finecross microcatheter with selective contrast injection to second, third and fourth septal branch, we noted no interventional collaterals. This was probably due to occlusion of interventional collaterals from the previous perforation. Reattempted antegrade approach. In view of significant ostial RCA lesion and poor guide support, anchor balloon technique to conus branch was used which enabled excellent guide support. With Finecross support and Fielder XTA, we were able to cross the CTO successfully and wire to posterior left ventricular branch (PLV). The lesion was predilated and the vessel was prepared accordingly from distal to ostial RCA. Diffuse distal RCA disease was intervened with DEB Sequent Please Neo 2.0 x 35 (6 atm) for 1 minute. With strong guide support, distal to ostial RCA lesion was stented with overlapping Orsiro 2.5 x 40 mm and Orsiro 3.0 x 30 mm. The stents were postdilated with Sapphire NC 3.0 x 15.

RESULT
Final angiography results were excellent. He was discharged well and remains asymptomatic.
BOM 8

Time: 1510-1520 hr

THE TRIFURCATION DILEMMA
Dr Jayakhanthan Kolanthaivelu
Institute Jantung Negara

INTRODUCTION
We describe a case of a 54 year old gentleman, who has dyslipidaemia and hypertension. He presented with NSTEMI. Coronary angiogram on 1st February 2016 revealed severe ostial LAD stenosis, CTO LAD at midsegment after D2, severe intermediate stenosis, moderate ostial LCX stenosis and mild RCA stenosis. He had failed adhoc PCI to CTO LAD.

The objective of this case will be about managing bifurcating and trifurcating lesion that supply a sizeable area of myocardium.

DESCRIPTION OF THE PROBLEM, PROCEDURE, TECHNIQUE AND EQUIPMENT’S USED
He was planned for stage PCI CTO LAD with aim to protect D2, septal and intermediate artery. Right radial and right femoral approach as this was a CTO. Optitorque 5Fr to RCA and EBU 3.5/6Fr to LAD. RTF wired to D2 and Sion Blue to septal. Pre-dilated proximal LAD with semi compliant 2.0/20mm and NC 2.5/10mm.

We managed to cross the CTO LAD with Mizuki microcatheter support and Fielder XTA. We then removed the RTF from D2 and wired to LAD. Proceeded to pre-dilate LAD with semi compliant balloon 2.0/20mm and NC balloon 2.5/10mm up to 22atm. We managed to pass a new Sion Blue wire to D2 with great difficulty pass proximal LAD dissection. Pre-dilated ostial D2 with semi compliant balloon 2.0/15mm. However we were unable to pass Biomime Morph 3.0-2.5/60mm down LAD. Further pre-dilatation done with semi compliant balloon 2.5mm/25mm. However we still could not get the stent down to distal LAD. We then wired down LAD with the Sion Blue wire from septal as buddy wire. Used semi compliant balloon 2.5mm balloon as anchor distally (deployed at 4atm). Managed to push down long stent and anchor balloon pulled back into LM.

Stented from dLAD with Biomime Morph 3.0-2.5/60mm. The buddy wire was trapped, but managed to remove with balloon support and wired back into septal (Sion blue). Post dilated distal LAD with NC 2.5/10mm up to 24atm. Flip-flopped wires, RTF into D2 and Sion Blue (from D2) into LAD. Unable to pass 2.0mm balloon into D2. Proximal optimization technique ‘POT’ done at mid LAD with NC balloon 3.25/18mm at 18atm. Managed to pass 2.0/20mm balloon into D2. Kissing mid LAD with NC balloon 3.25mm and D2 with 2.0mm balloon was done. As there was TIMI III flow down D2, wire in D2 (RTF) was removed and passed down to LCX.

We then stented from ostial LM to mid LAD with Biomime 3.5/48mm. Thereafter RTF removed and rewired into LCX. We attempted to cross pinched septal with fielder XTA and microcatheter but failed. During this time the Sion blue in septal was accidently pulled out. Proceeded to post dilate LM to proximal LAD with NC balloon 4.0/8mm up to 22 atm (with POT at septal). Post dilated mid LAD with NC balloon 3.5/15mm up to 28atm. Finally managed to cross pinched septal with fielder XTA and microcatheter support. Ostium of septal dilated with semi compliant 2.0/20mm up to 16atm. Kissing at LAD with NC balloon 4.0/8mm and septal with 2.0mm balloon. Both these balloon pulled back and post diluted LM with these parallel balloons at 10atm.

Good final results with TIMI III flow. Pinched Intermediate artery was left alone as patient had no angina post procedure. Right femoral puncture was closed with angioseal 8Fr.

Patient recovered well and was discharged the following day. He was seen again in clinic after 1 month and has remained angina free.

RESULTS
We had managed to angioplasty a diffusely diseased CTO LAD and salvaged sizeable bifurcating arteries with TIMI III flow.
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MYLIVE 2016 Faculty Lounge is located at Suite 1&2, Level 7, Hilton Kuala Lumpur. This lounge is reserved for use of faculty members. Beverages and light snacks will be served at the foyer.

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Operating hours
28th July 2016 | 0600hr – 1800hr
29th July 2016 | 0600hr – 1800hr
30th July 2016 | 0630hr – 1400hr

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Operating hours:
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29th July 2016 | 0600hr – 1800hr
30th July 2016 | 0630hr – 1400hr

Delegate Registration
Date : 28th July 2016
Time : 0600hr – 1800hr
Venue : Sentral Exchange, Level 6, Hilton Kuala Lumpur

Date : 29th July 2016
Time : 0600hr – 1800hr
Venue : Sentral Exchange, Level 6, Hilton Kuala Lumpur

Date : 30th July 2016
Time : 0700hr – 1400hr
Venue : Sentral Exchange, Level 6, Hilton Kuala Lumpur

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• Admission to the Trade Exhibition
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NHAM MOBILE APPS

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