

CASE SPOTLIGHT

DIRECT STENTING



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R STENT™

Direct Stenting with the R stent is a Safe and Effective Solution

CASE DETAILS:

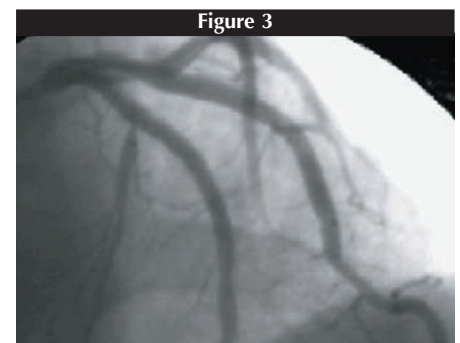
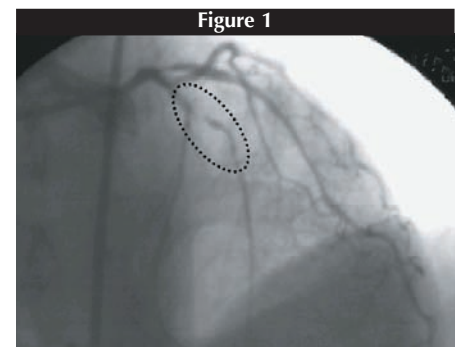
The patient is a 65 year old woman with dyslipemic symptoms and hypertension and with a previous cardiac history of chest pain. She had an acute coronary syndrome troponin T elevation. The physical exam was normal and the TIMI risk score was 3/7.

Two days before the PTCA, the patient began to take AAS, Clopidogrel, Atenolol, Enalapril, and Sinvastatin. During the angiography, there was a critical lesion in the LAD distal to the origin of the first branch and another lesion of 15 mm was distal to the first one (Figure 1). The lesion was type C (AHA/ACC) with TIMI III flow. Before the procedure a subtotal occlusion with TIMI II flow was observed in the middle part of the LAD after the take off of the septal branch.

A femoral approach was used with a 6Fr JL 3.0 catheter and the lesion was crossed with a high torque floppy wire. A direct stenting technique with a 3.0 x 23 mm **R stent Evolution 2** was deployed at 12 ATM and completely covered the two lesions without obstructing the septal branch. No more post dilatation was required (Figure 2).

The stent was easily delivered through the lesion and there were no difficulties to position it near the septal branch without occlusion (Figure 3). The procedure was successful and improved the TIMI flow. The patient remained asymptomatic and was discharged without any complication.

The **R stent's** excellent delivery and ease of advance allowed the angioplasty to proceed without predilating the critical lesion. No snow plow effect to the septal branch was observed. The **R stent Evolution 2** was the accurate choice to treat the subocclusive lesion with direct stenting and covered the two lesions without complication.



"The R stent's thin struts and flexible dual helix design are an ideal combination for direct stenting," said Doctor Bettinotti.