

Ischemia versus vulnerability: the dilemma when the patient is a cardiologist's father

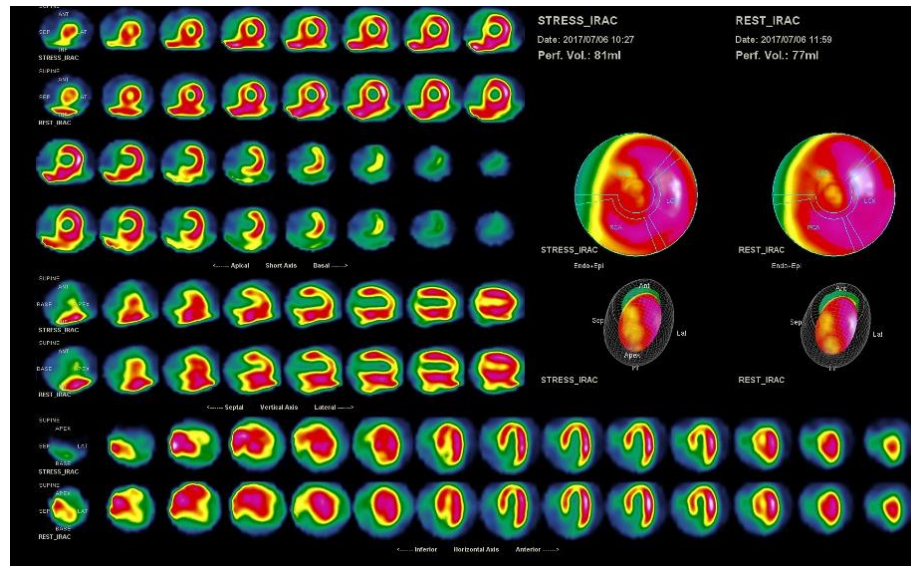
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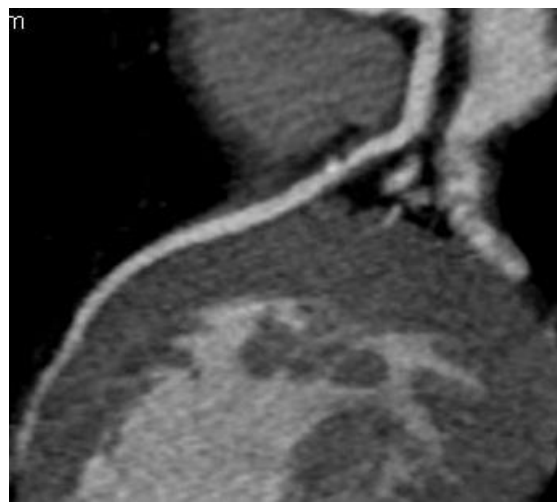
I do not have any potential conflict of interest to declare

- Male, 70 y.o.
- **Cardiovascular Risk Factors:** former smoker, Dyslipidemia.
- **Background:** in 2013, primary angioplasty for inferior STEMI with D.E.S. implantation to RCA.
- **Clinical Presentation:** Asymptomatic. New LBBB at EKG.
- **Myocardial perfusion SPECT** with dipyridamole: mild “fixed defect” septal and apical. EF: 55%

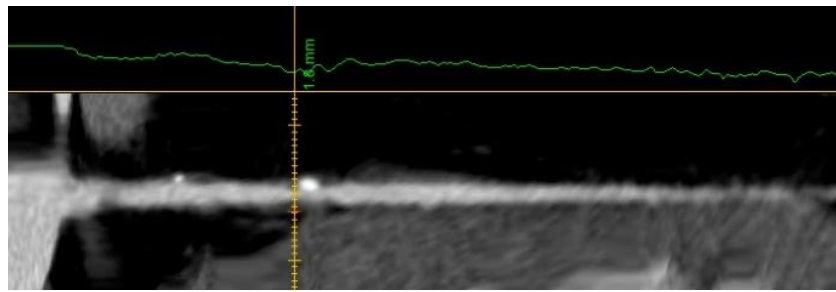
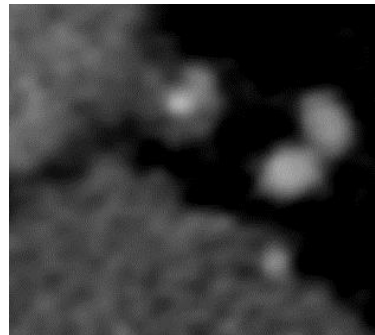


CT Angiography: vulnerable plaque

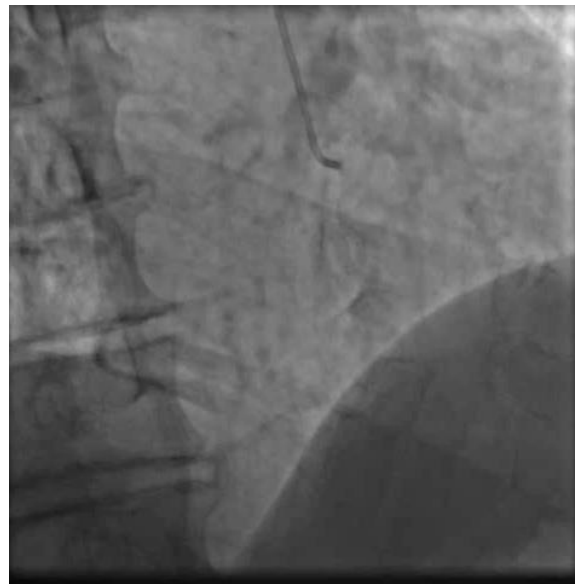
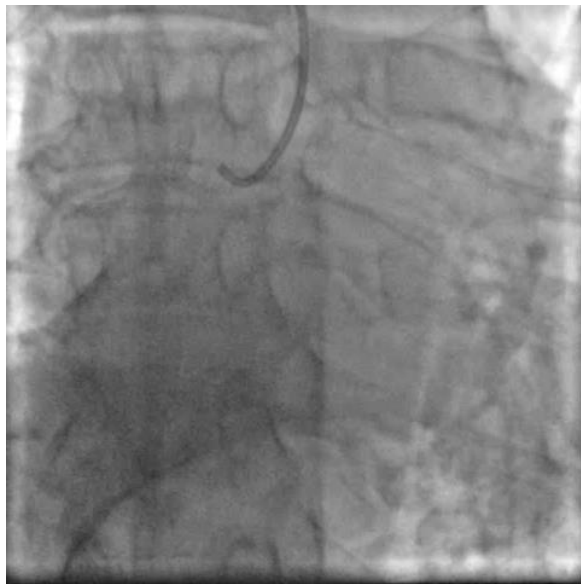
Intermediate severity
LAD stenosis: 50-70%



Low-density plaque with
positive remodeling and
spotty calcification

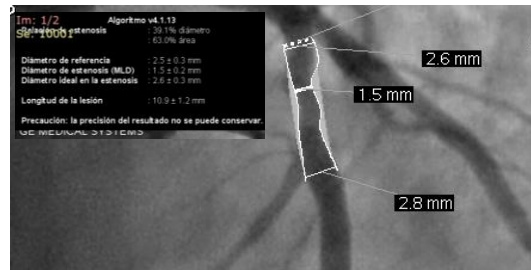
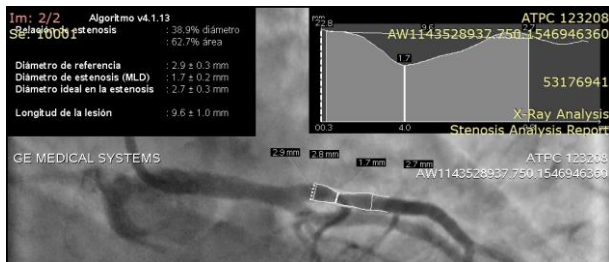
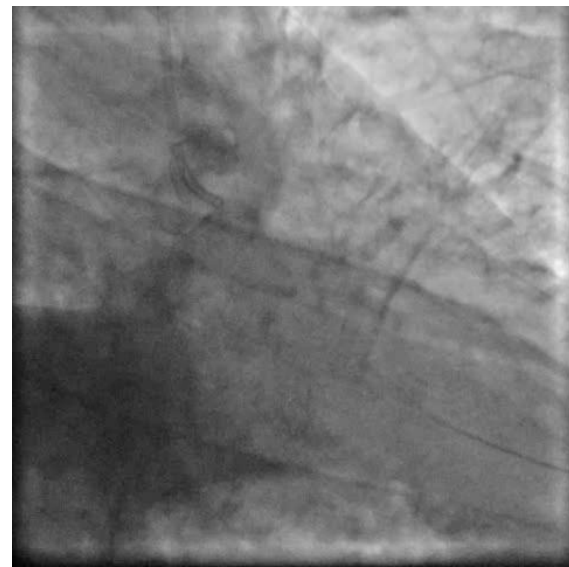
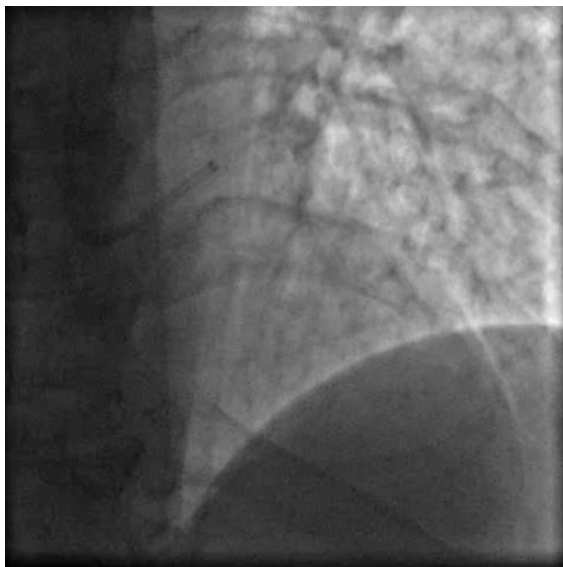


- At this point, I had my first contact with the patient. I recommended an invasive coronary angiography plus FFR evaluation to the LAD lesion.

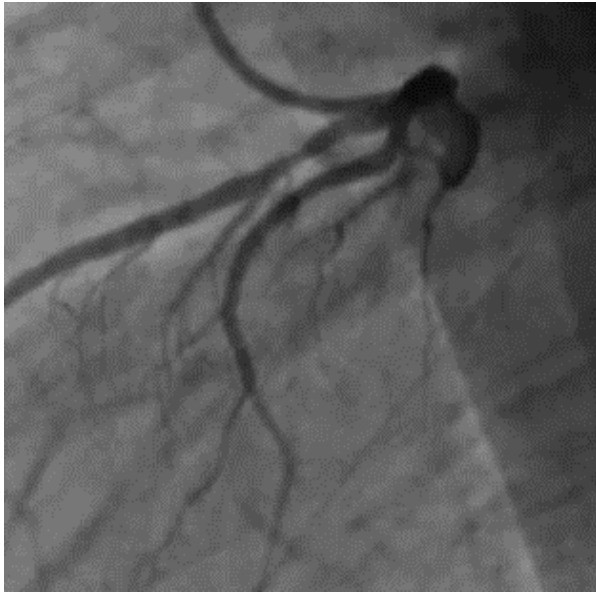


Left Circumflex and Right coronary arteries without significant lesions

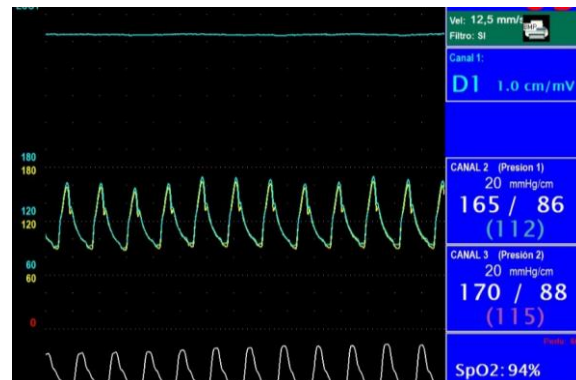
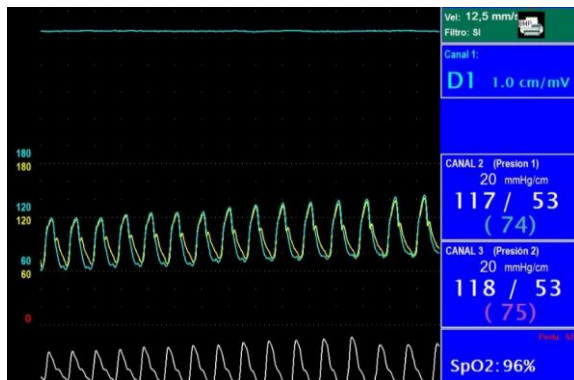
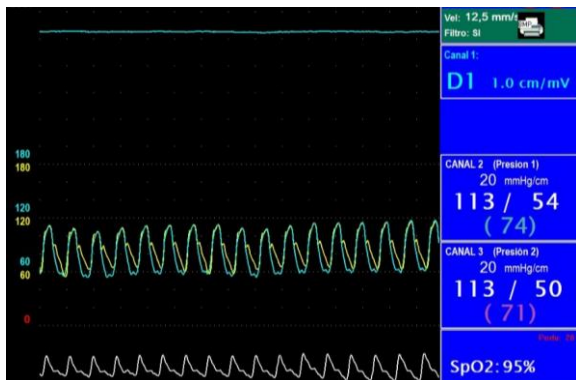
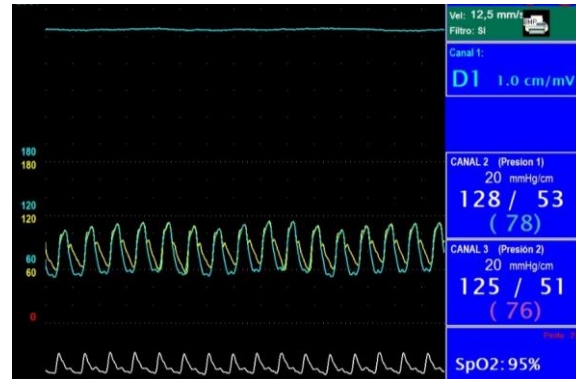
LAD angiography: intermediate lesion



LAD angiography: intermediate lesion

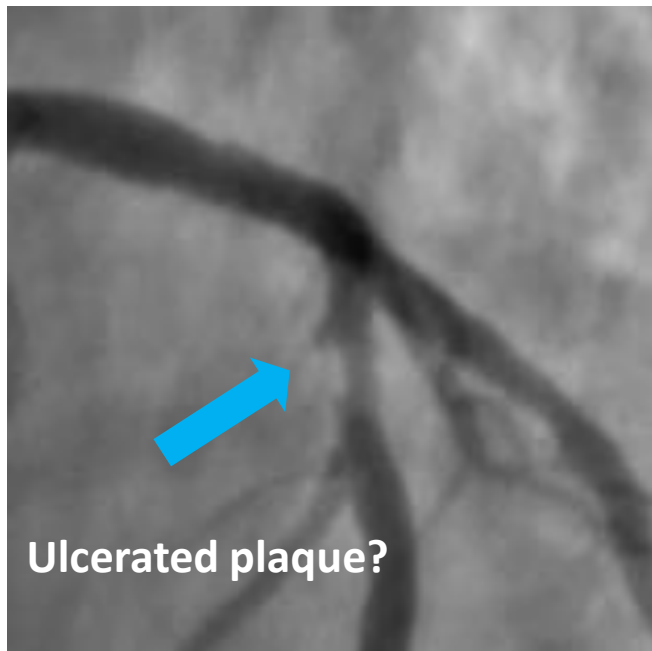


FFR: 0.96

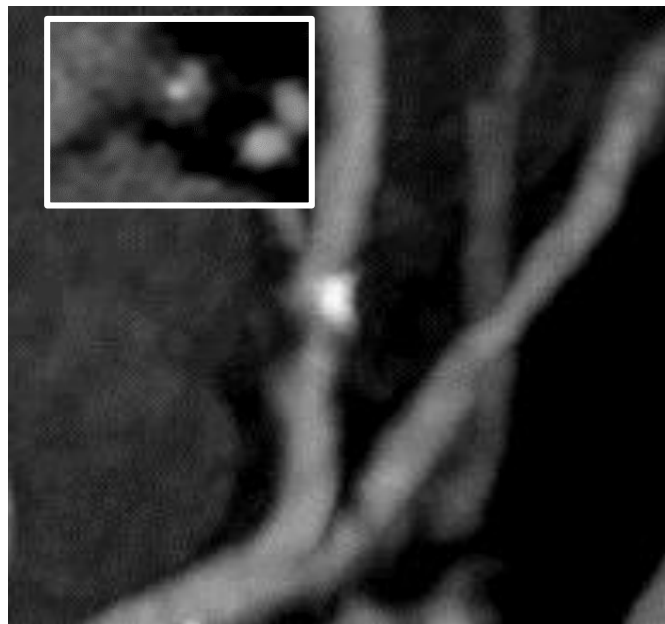


The FFR was normal but...

I didn't like this:



and this:

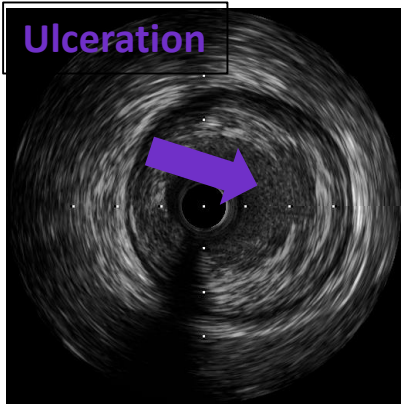
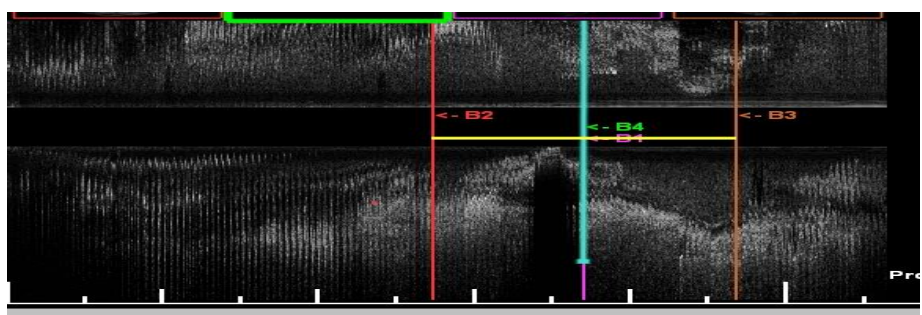
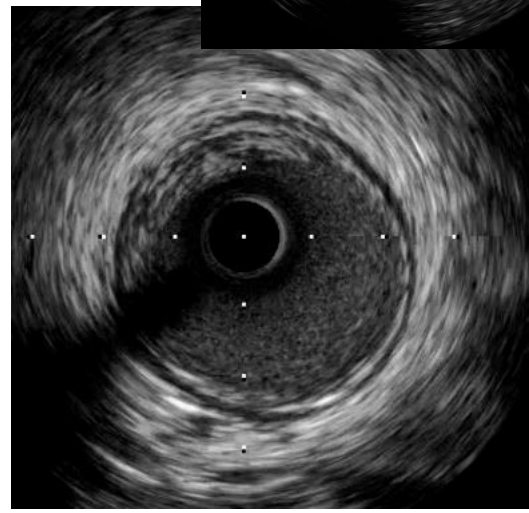
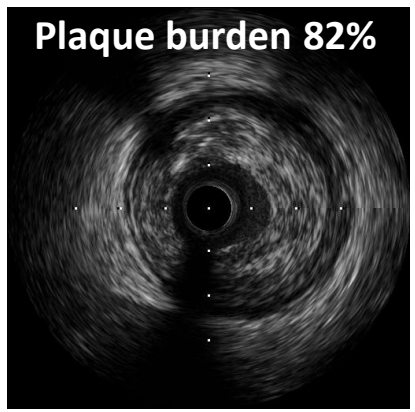
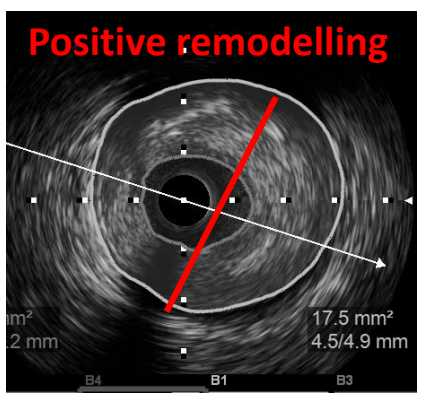
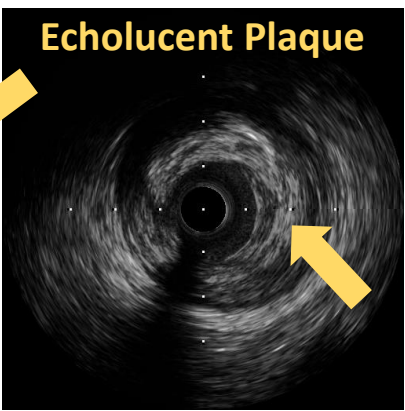
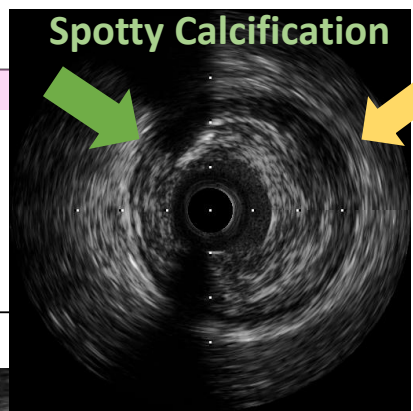


So... why don't to take a look with IVUS? (and remember, he was a colleague's father)

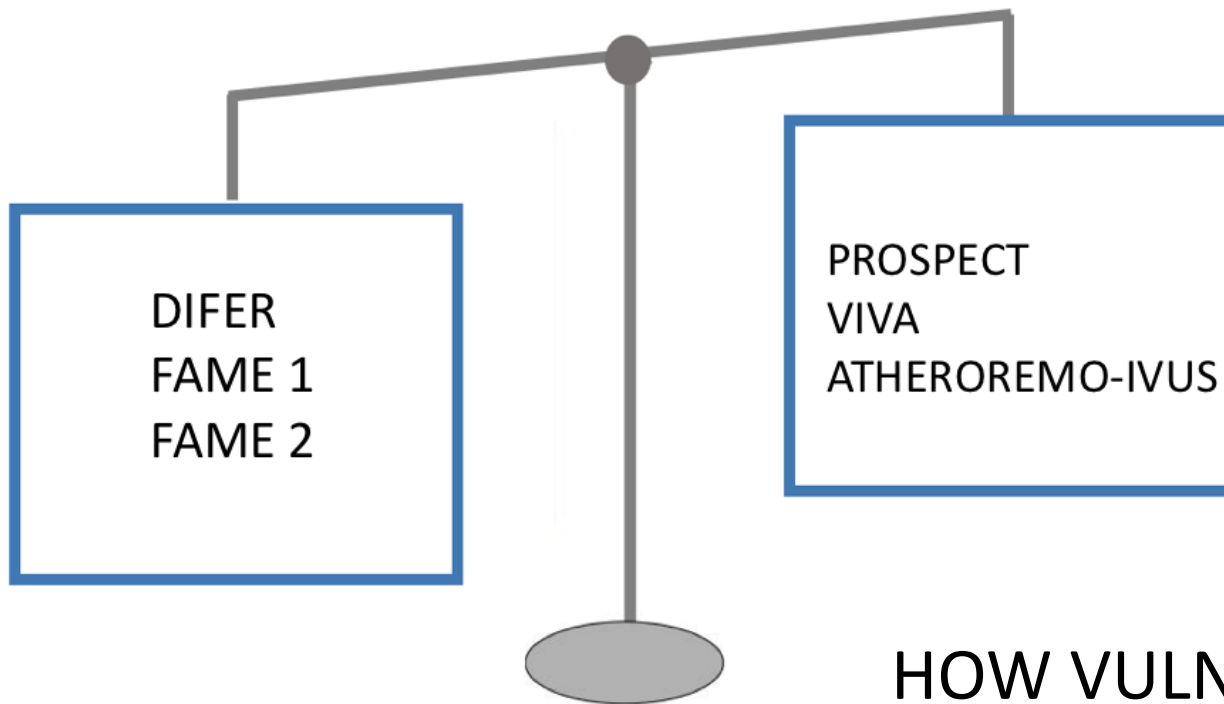
IVUS: Vulnerable Plaque

MLA < 4 mm²

Measure	MAP	VOL
A1 TA 3.08 mm ²		Area
1.76 mm / 2.19 mm		82%
A2 TA 17.49 mm ²		
4.45 mm / 4.94 mm		
L1 LV 0.30 mm		
L2 LV 19.49 mm		

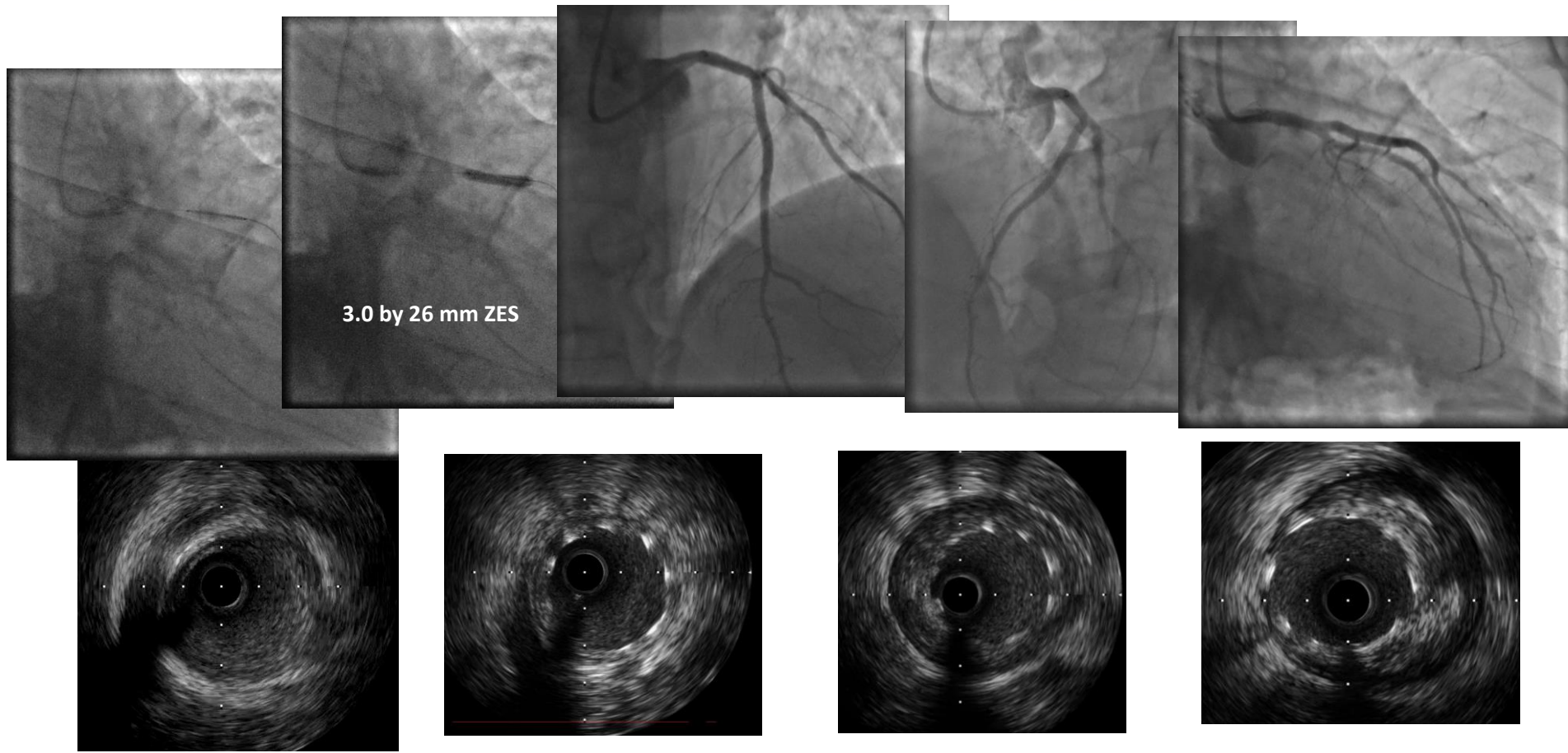


NON-SEVERE / NON-ISCHEMIC VULNERABLE PLAQUE

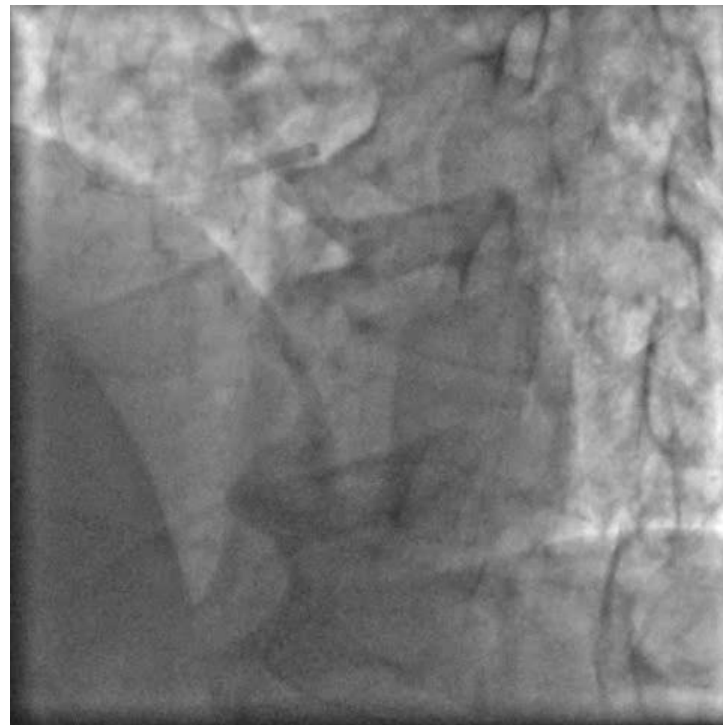
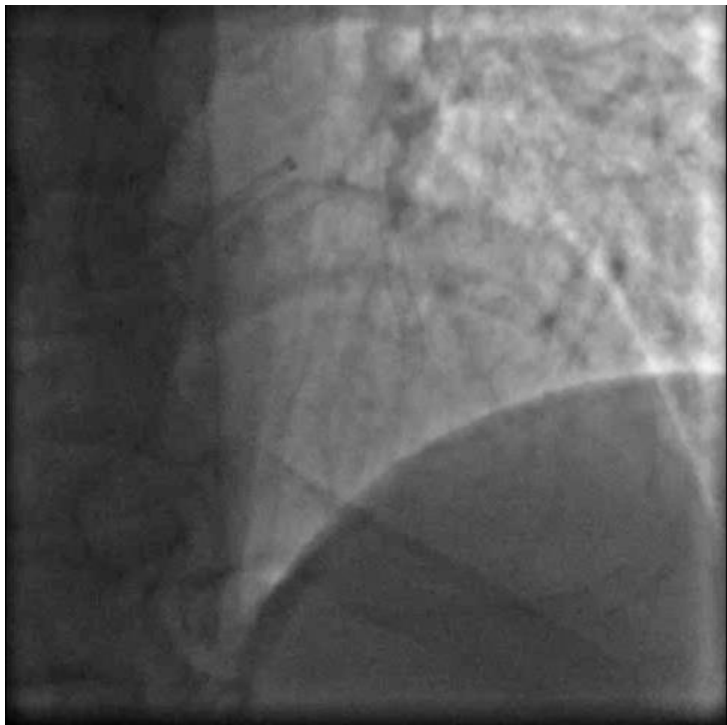


HOW VULNERABLE?

Of course, I decided PCI to the LAD with DES implantation



Final result



My dilemma

- The patient was discharged 24 hours after the procedure, medicated with aspirin, ticagrelor, and rosuvastatin (40 mg).
- He's still asymptomatic at almost one year follow up, with normal functional tests
- The dose of rosuvastatin had to be reduced due to myalgias
- I recognized to have had some bias because of the patient's relationship with my colleague
- For half of my working group, FFR > 0.80 was enough evidence to assign this patient to optimal medical treatment (OMT) alone.
- I am still thinking... but I'm positive about the patient's evolution. Quiet. With such a kind of vulnerable plaque, do OMT have enough evidence to make me feel that way?