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FFR-OCT IN LEFT MAIN

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The angiographic evaluation of left main (LM) disease can present challenges and requires use of additional devices (intravascular imaging/coronary physiology) to make the correct decision regarding revascularization. There is a lot of anatomical and functional mismatch in the LM implying that even 40% to 50% stenosis can be functionally significant.

Fractional flow reserve (FFR) evaluation of the LM depends not only on the lesion characteristics but also on the territory supplied by the vessel. FFR is very reliable in the presence of isolated LM disease. It is accepted that an FFR in the LM <0.8 or an minimum luminal area (MLA) $<6 \text{ mm}^2$ is the threshold for revascularization. FFR is a potential tool for assessing the hemodynamic significance of an LM stenosis.

A poor correlation has been noted between quantitative coronary angiography and FFR, which points to the shortcomings of relying on angiography alone in evaluating LM lesions. Angiographically intermediate LM lesions with an FFR of ≥ 0.80 can have revascularization deferred with favorable long-term outcomes.

Optical coherence tomography (OCT) provides precise information very quickly and helps treat cardiovascular diseases, including LMCA disease. OCT can help assess atherosclerotic plaque and visualize thrombus. It can also assist in evaluating the lumen area with accurate automated measurements. OCT is indispensable in patients where the LM disease is present along with disease in left anterior descending (LAD) and left circumflex artery (LCx).

During percutaneous coronary intervention (PCI), it can help in assessing lesion morphology and measuring the diameter and plaque burden in both LCx and LAD. It formulates the stenting strategy and will guide whether the lesion can be treated with single-stent or two-stent strategy. Post-stenting the OCT helps in optimizing the

stent as there is a lot size mismatch between the LM and its daughter vessels.

There is a benefit in integrating FFR and OCT technologies for evaluating coronary artery disease (CAD). FFR helps identify significant lesions which can then be precisely treated with coronary stents using OCT. OCT-guided stenting is associated with good long-term results and very low rates of stent failure. This is most important in the LM segment as it supplies a big chunk of myocardium and stent failure in this segment can be catastrophic.

HOW WILL WE APPROACH CORONARY ARTERY DISEASE IN 2033?

Dr Patrick W Serruys, Ireland

In a lifespan, we will see a tremendous evolution of lipid-lowering and anti-inflammatory therapies. Nowadays, CAD phenotype on noninvasive imaging is a sufficient argument to initiate primary preventive pharmacotherapy.

PCSK9 is an endogenous regulator of low-density lipoprotein (LDL) receptor levels by facilitating the destruction of the LDL receptor. Inclisiran is a small interfering or silencing RNA, silencing the gene that encodes mRNA responsible for the production of PCSK9, with a consequence of an increase in activity in LDL receptor, now recycled, thereby lowering your LDL cholesterol to a very low level. CT is a safe alternative to cardiac catheterization for patients with suspected CAD that will likely change clinical practice worldwide by replacing invasive testing in patients with stable chest pain with an intermediate pretest probability for obstructive disease. The value of multislice CT as a diagnostic “one-stop shop” (coronary CT angiogram, finite element analysis, computational fluid dynamics, tissue characterization analysis, perivascular fat attenuation analysis, wall shear stress and wall strain, etc.) is currently emerging as the most promising, cost-effective and best-reimbursed approach to identify coronary disease throughout the lifespan.



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