



Laubry Gets Very Calcified; A Difficult Approach of Coronary Artery Disease

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Clinical Image

We present the case of a 66-year-old male diagnosed with Laubry-Pezzi syndrome with mechanical aortic valve replacement and ventricular septal defect closed by surgery, hypertension, myelomonocytic leukemia, smoker, gout and chronic kidney disease. He had a history of one week with shortness of breath and chest pain with efforts and went to the emergency room diagnosed with NSTEMI. The coronary angiography revealed the left main with distal calcified lesion; in proximal and mid segment of Left Anterior Descending artery (LAD) with diffuse lesions involving the first diagonal, also lesion in distal circumflex artery (Figure 1). We evaluated with IVUS the Left Main (LM) and LAD with a moderate calcification of 270°, minimum luminal area 5.5 mm² and severely calcified lesion of 360°, minimum lumen area 3.7 mm² respectively (Figure 1).

The patient was treated with intracoronary lithotripsy using a Shockwave balloon device in LM and also the proximal segment of LAD. We performed double kissing crush technique with proximal optimization technique for the bifurcation of LAD with first diagonal and the lesion in the mid segment of LAD was treated with provisional stenting (Figure 2). The adequate coronary stent expansion was confirmed with IVUS at the end of procedure (Figure 3). The patient was discharge with dual antiplatelet therapy and asymptomatic.

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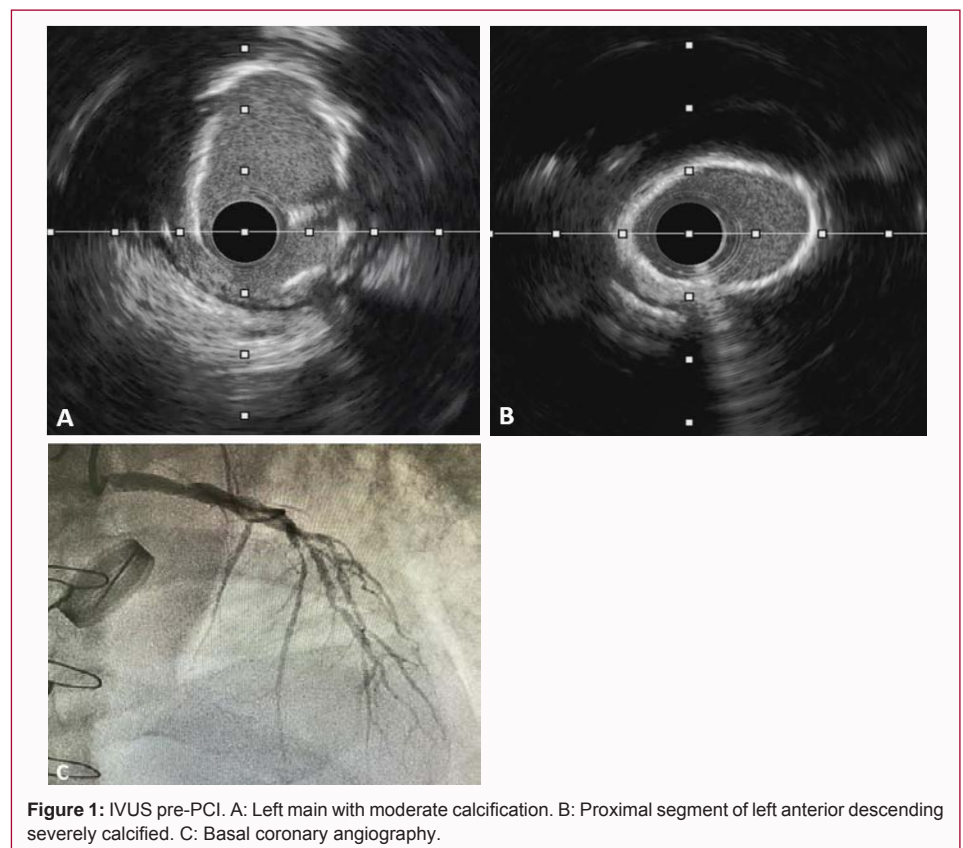


Figure 1: IVUS pre-PCI. A: Left main with moderate calcification. B: Proximal segment of left anterior descending severely calcified. C: Basal coronary angiography.

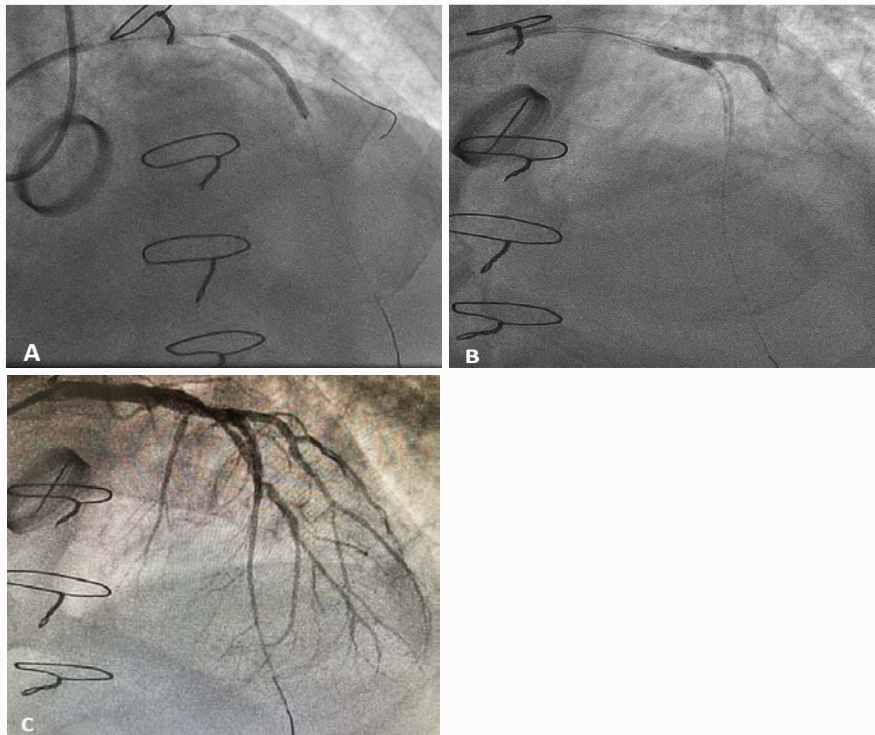


Figure 2: A: Provisional stent in mid segment LAD. B: Coronary angiography with kissing balloon inflation in left main with first bifurcation. C: Final assessment.

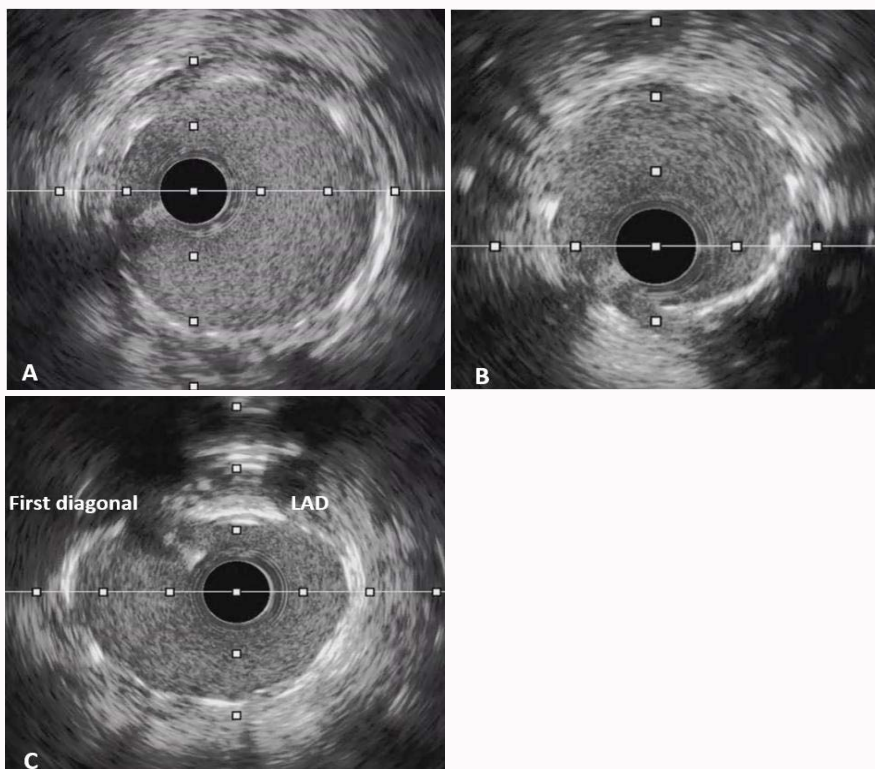


Figure 3: IVUS post-PCI. A: Stent expansion in the mid segment of LAD. B: Left main with stent expansion. C: Left Anterior Descending artery (LAD) with first diagonal.