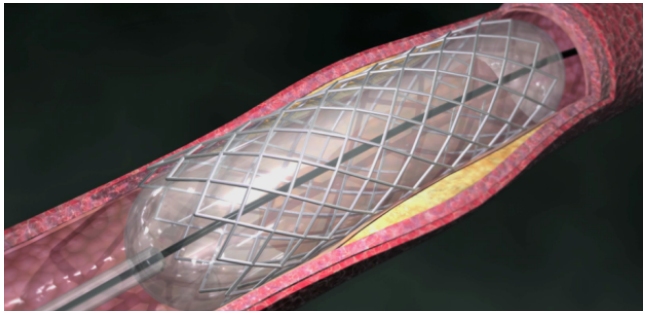
Stent couvert : état des lieux



Guillaume CAYLA
Service de cardiologie CHU de Nîmes
Groupe ACTION Pitié Salpêtrière

Les questions?

1- Différents types de stent couvert

2-Traitement perforation coronaire

3-Traitement des anévrysmes coronaires

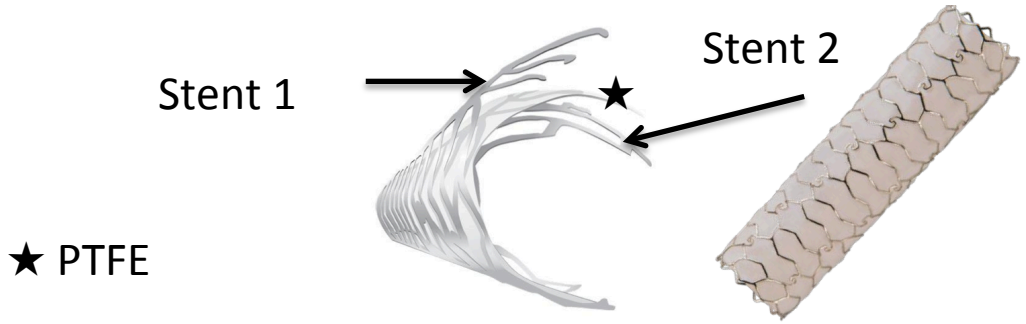
4-Conclusion

Stent couverts

Definition: stent non permeable

Différents types

Abbott Grafmaster: double couche de stent (Jostent) avec membrane en PTFE (polytetrafluoroEthylene) entre les deux stents



Stent couverts périphériques

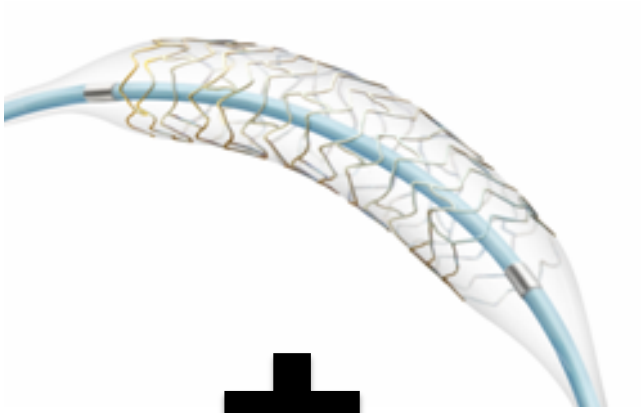
Maquet advanta V12 (compatible 6F)

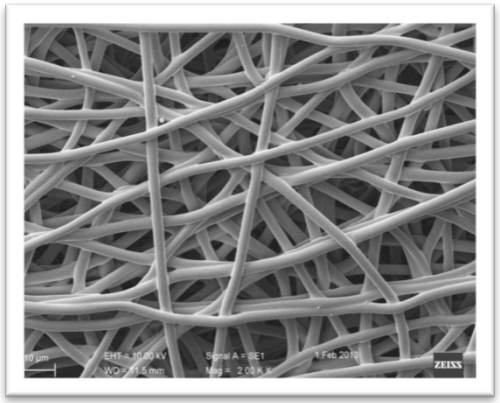
Begraft Peripheral stent Graft (compatible 6F)

Stent couvert PK Papyrus

PK Papyrus

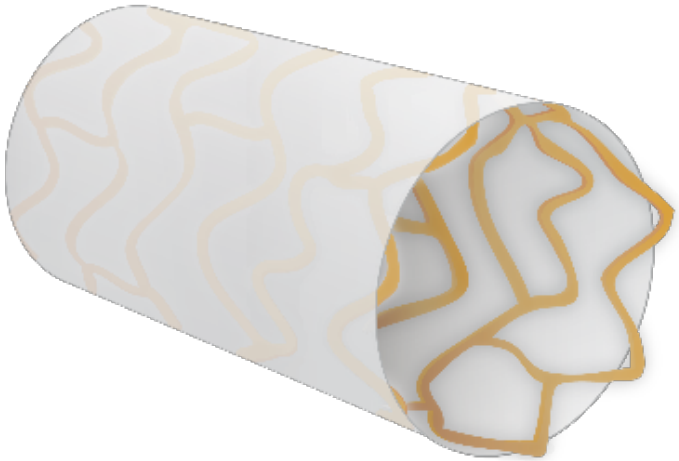
Stent Prokinetic CrCo L605 (60-120 µm)



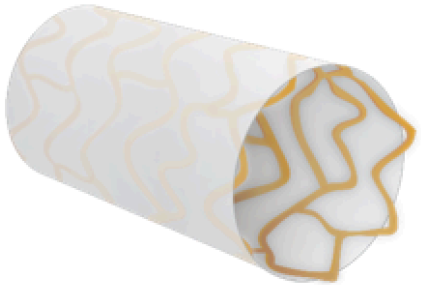


Polyuréthane Electrofilé (90 µm)

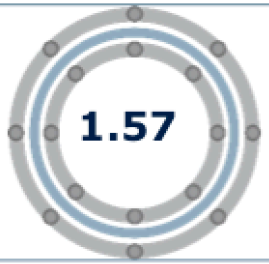
Stent PK Papyrus



PK Papyrus

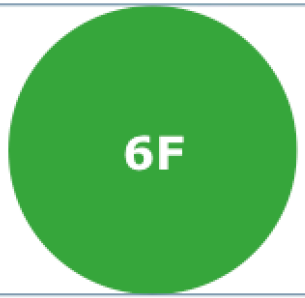


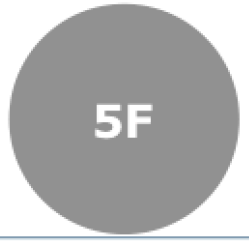
Profile de franchissement
[mm]



Reduction de 24%

Compatibilité Catheter Guide*





Données Biotronik

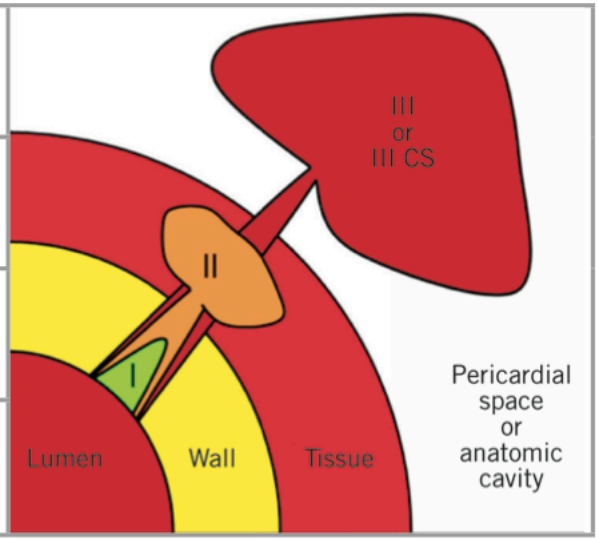
Perforation coronaire

Complication rare (0.43%) des angioplasties

Mortalité très élevée (20%)

Classification Ellis

Type I	Extraluminal crater without extravasation
Type II	Pericardial or myocardial blush without contrast jet extravasation
Type III	Extravasation through frank (>1 mm) perforation
*Type III cavity spilling (CS)	Perforation into an anatomic cavity, chamber, coronary sinus, etc.



Perforation coronaire

Facteurs prédictifs de perforation

Clinical	Procedural
Complex lesions	Atheroablative devices
Age	Cutting balloons
Female gender	Hydrophilic guidewire
Chronic total occlusion	Stiff guidewire
Presence of coronary calcification	Use of IVUS
Hypertension	Oversized device
Acute coronary syndrome	Femoral approach
Heart failure	

EuroIntervention 2014;10:646-647

Gestion perforation

Etape 1: inflation prolongée ballon (2-6 ATM)

Etape 2:
Evaluation Echocardiographique
Drainage Tamponnade/Remplissage
Antagonisation héparine/HBPM : sulfate (1mg/100 unités héparine)
Transfusion plaquettaire (GPI)

Etape 3: obturation brêche coronaire

Perforation distale

- Microcoil
- Inflations répétées
- Thrombine

Perforation non distale

Stent couvert
Limites: accessibilité , occlusion branche latérale

Voir presentation P commeau Jeudi A 17H20

Anévrysme coronaire

Cas clinique

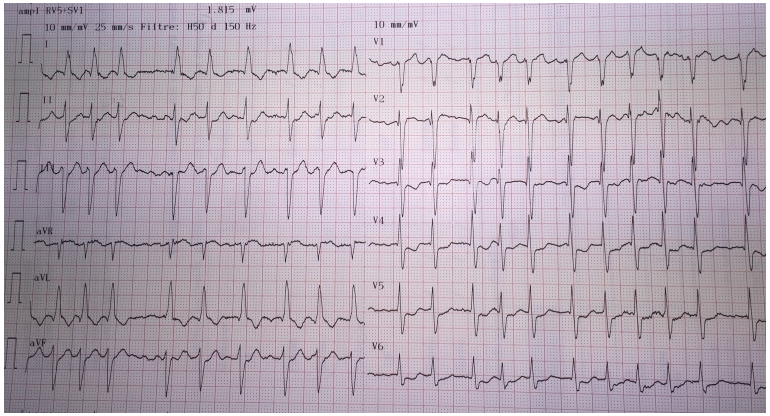
Mr B. F., 75 ans: admis pour NSTEMI avec ischémie antérieure (juin 2014).

FdR: HTA, tabagisme actif.

ATCD:
CMI : 2 stents fin IVA 1 et Diagonale en 2010
FA permanente sous AVK.

Autres ATCD maladie de Parkinson évoluée.

ETT: FEVG 25% sur large akinésie ASA

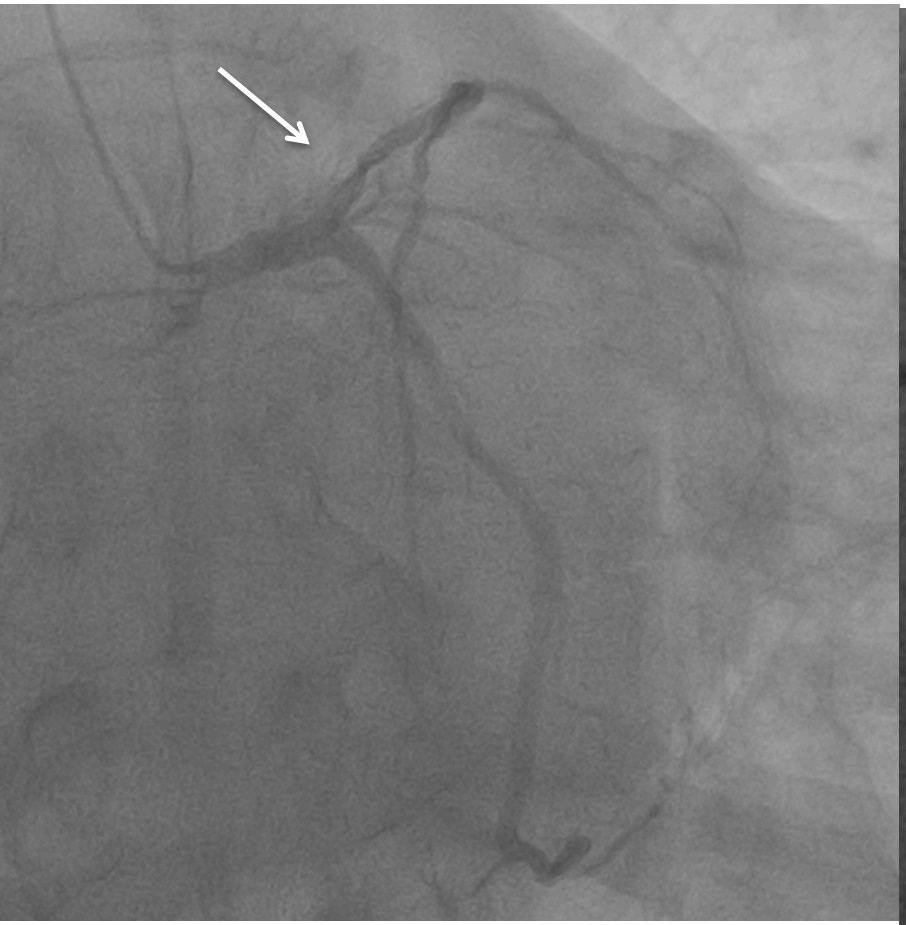


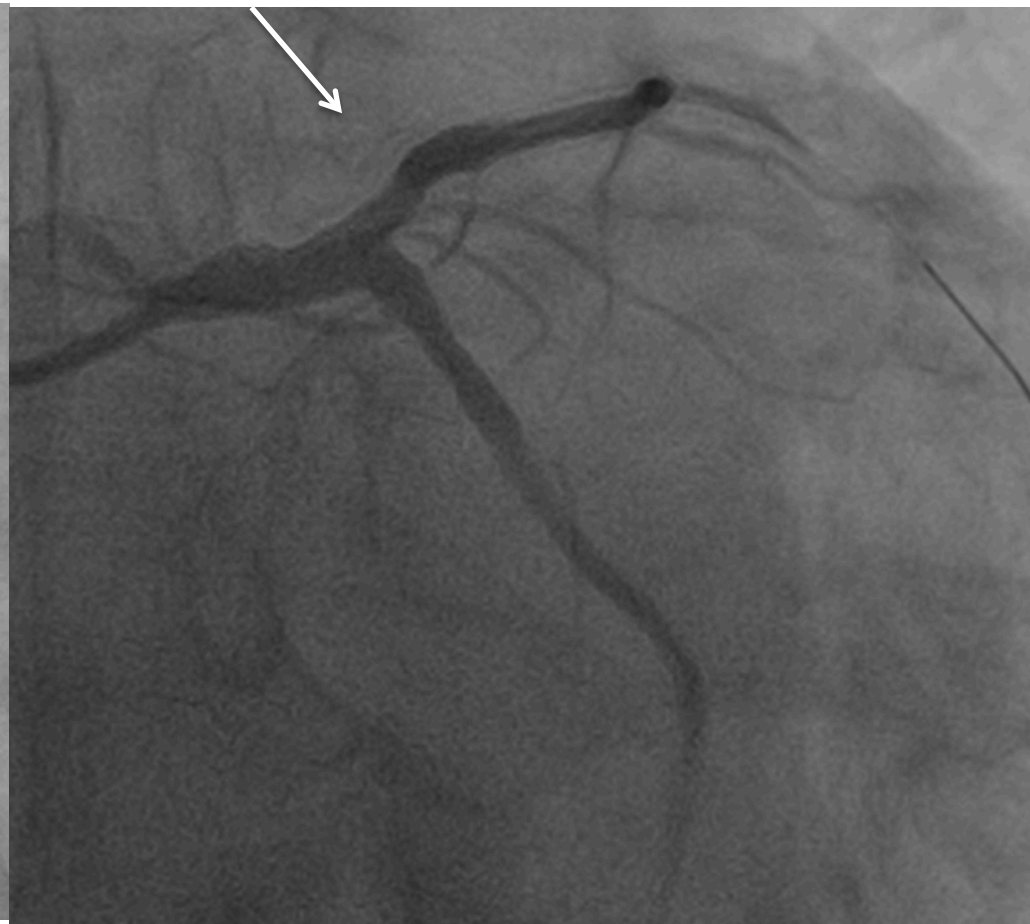
Cas clinique

Sténose serrée IVA1
Sténose distale IVA3

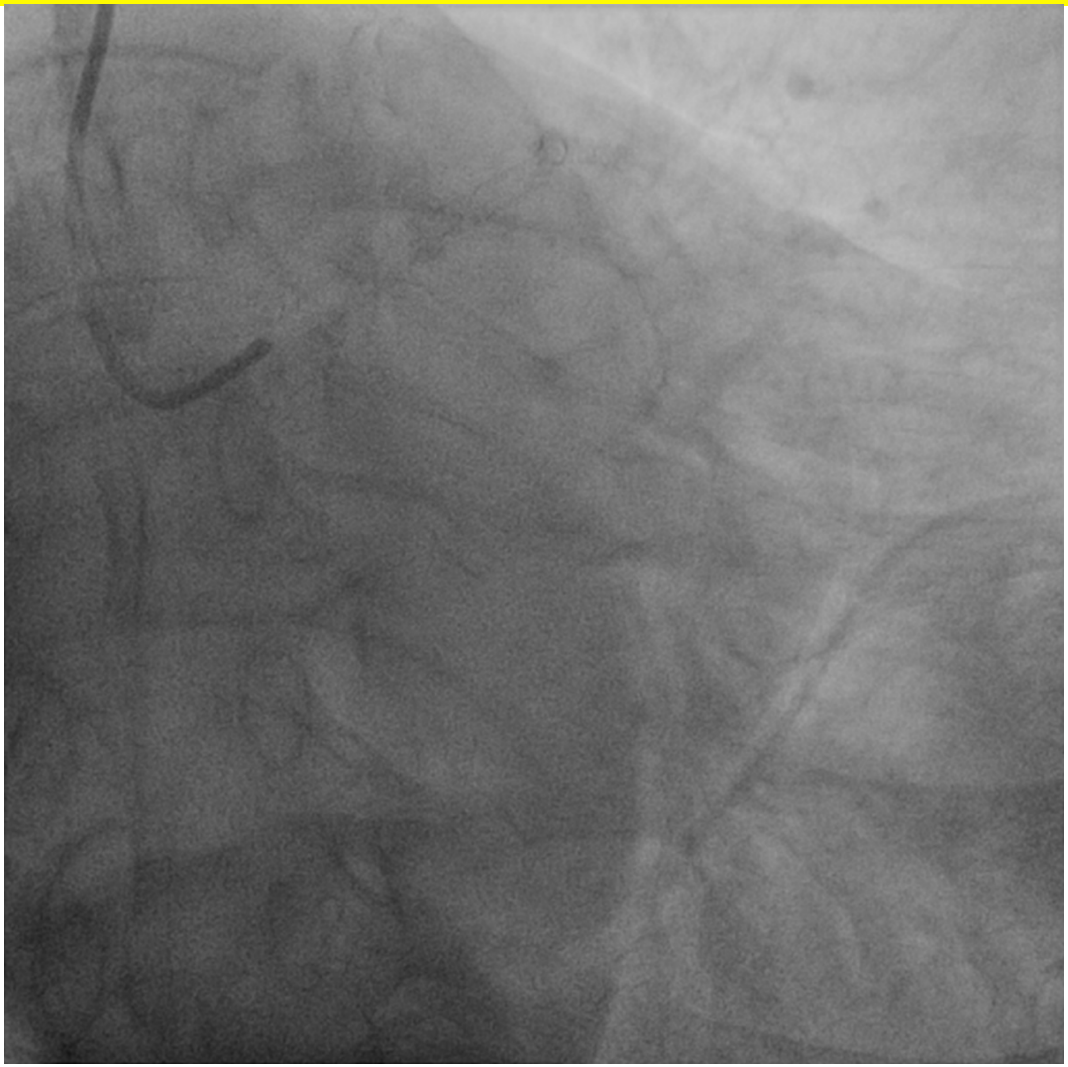
Stent nu 3.5/13 mm

Sortie AVK/clopi



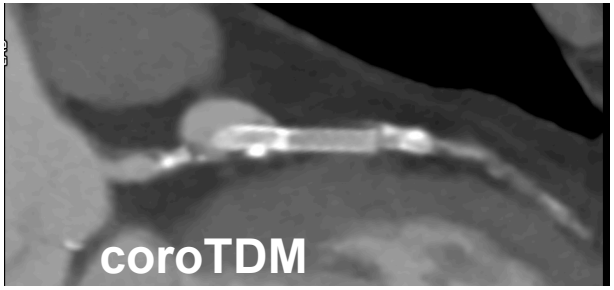


3 mois plus tard NSTEMI

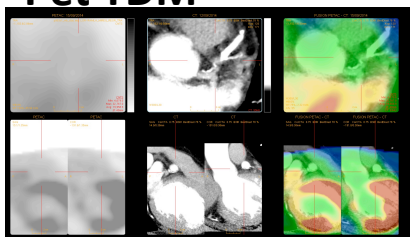


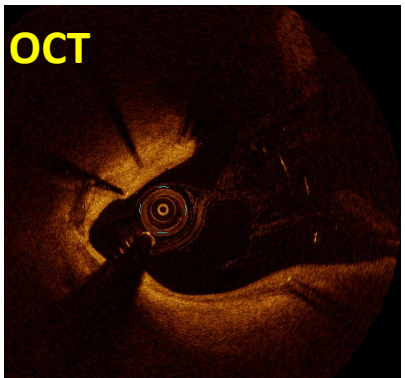
Que proposez-vous?

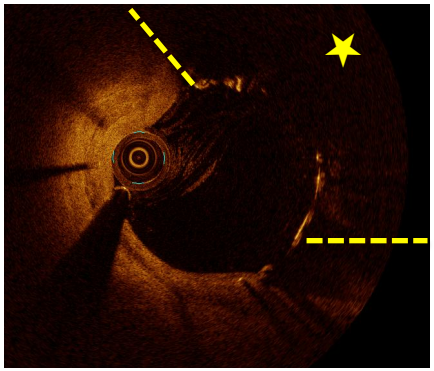
Diagnostique



Pet TDM







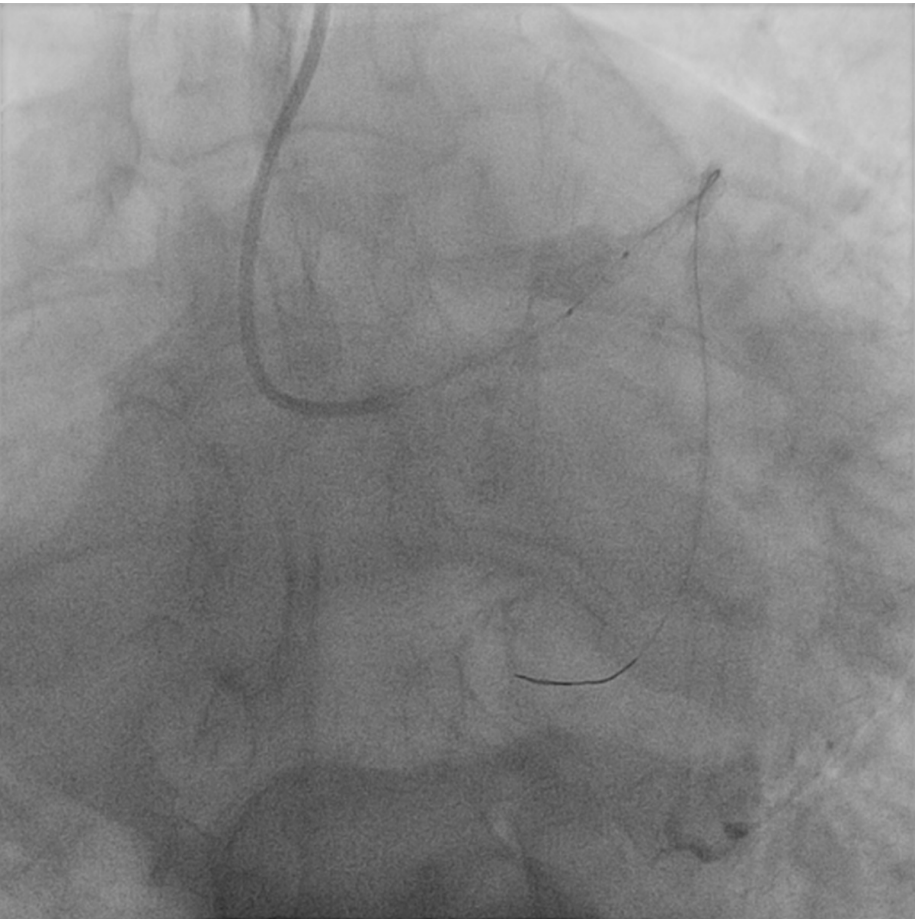
Thérapeutique

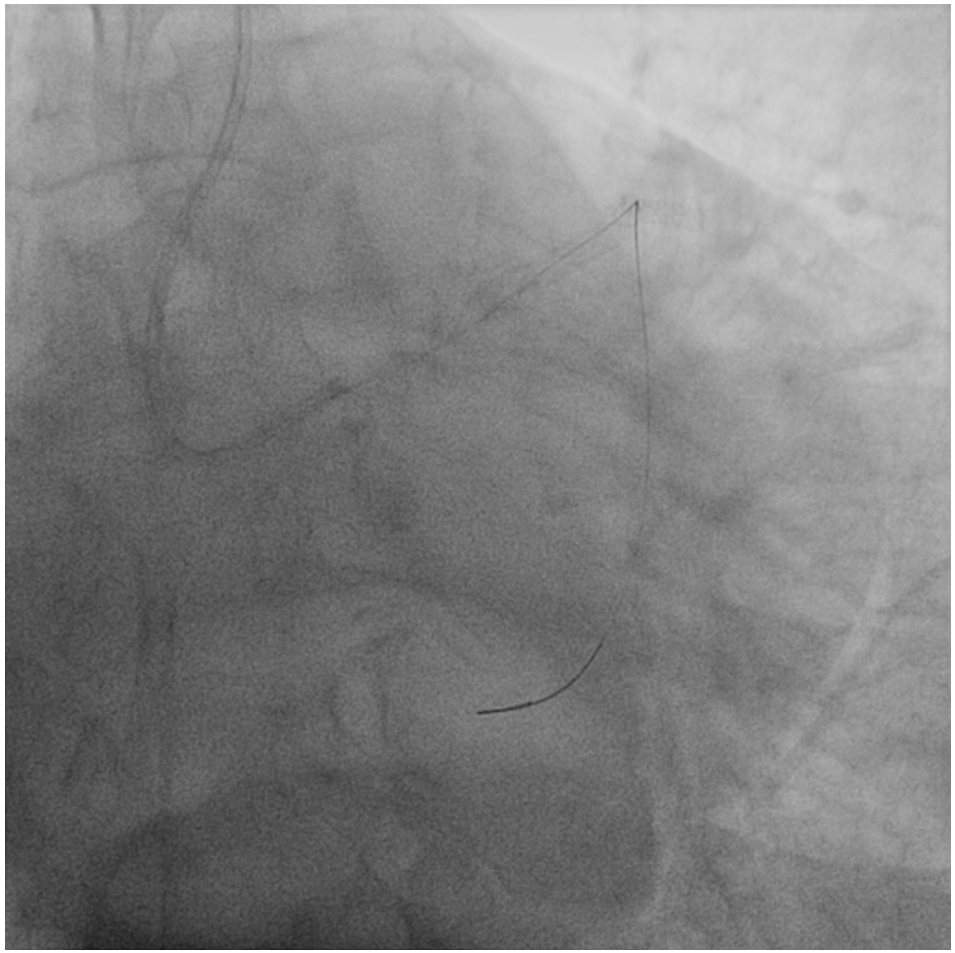
Chirurgie? Heart Team refusée car maladie de PK

Angioplastie avec utilisation stent couvert?

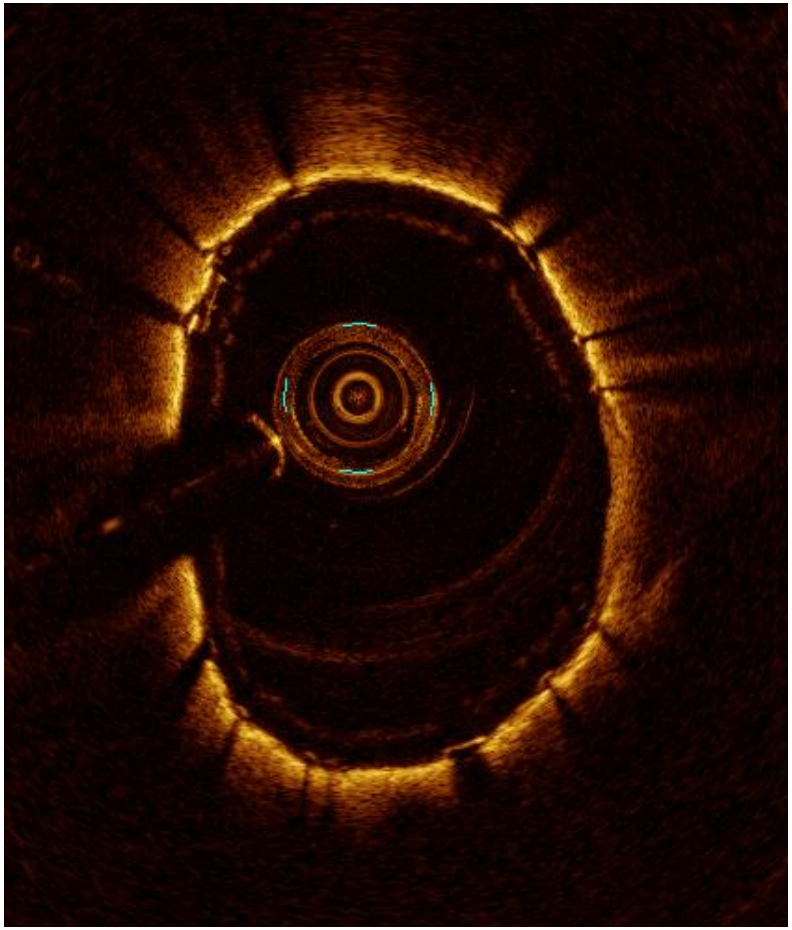
Angioplastie stent couvert

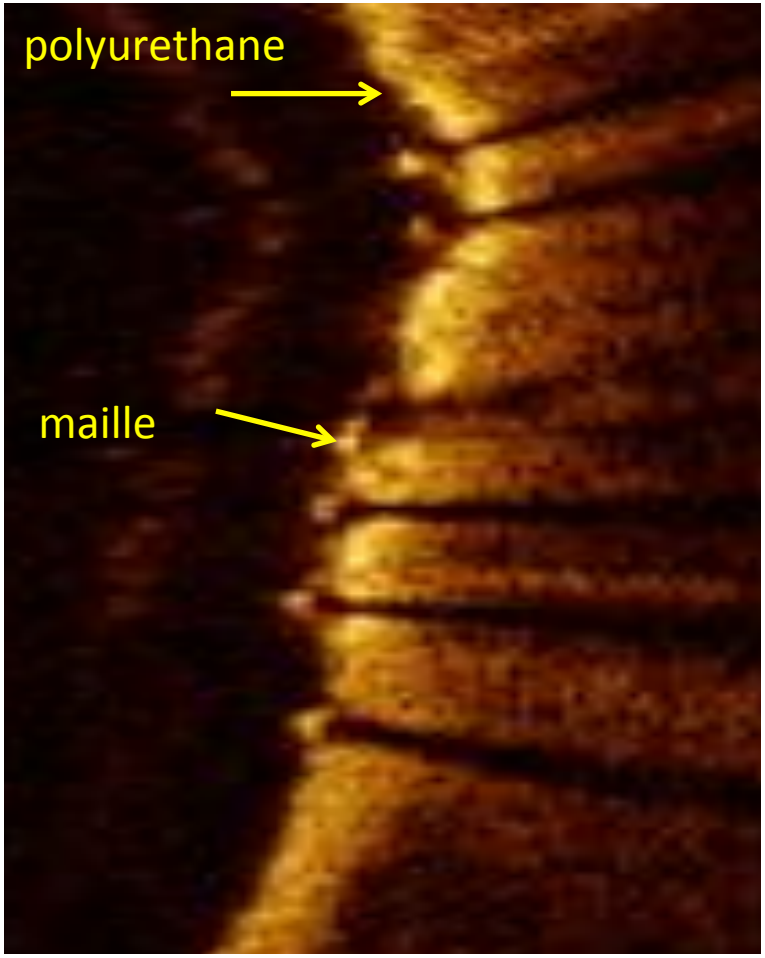
Angioplastie stent PK Papyrus 3x20 mm





OCT post implantation

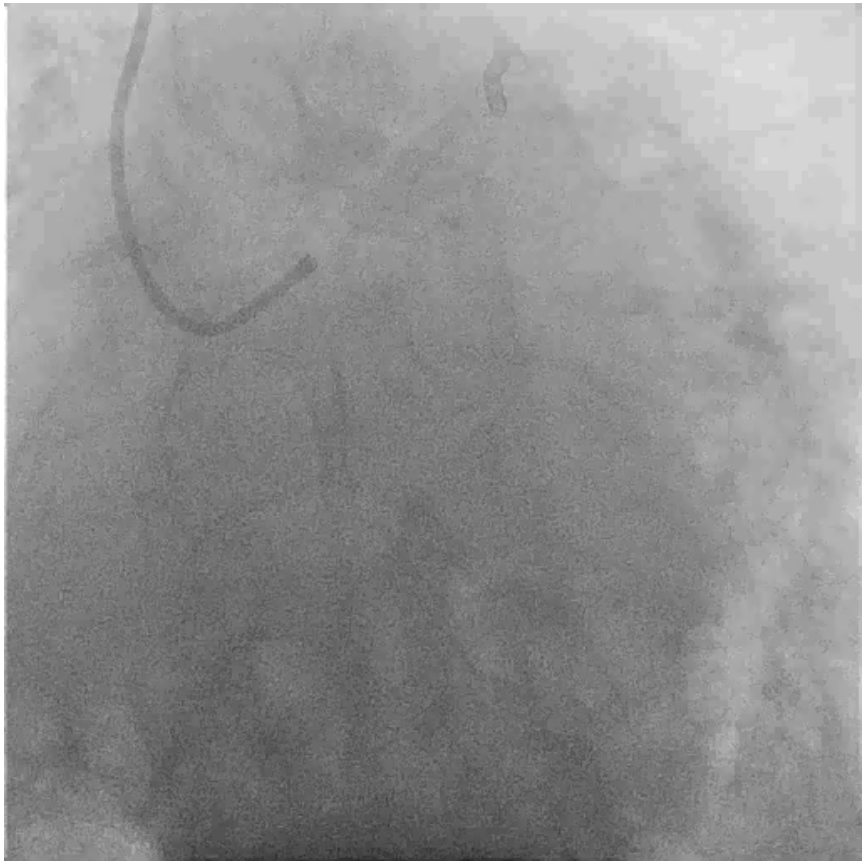


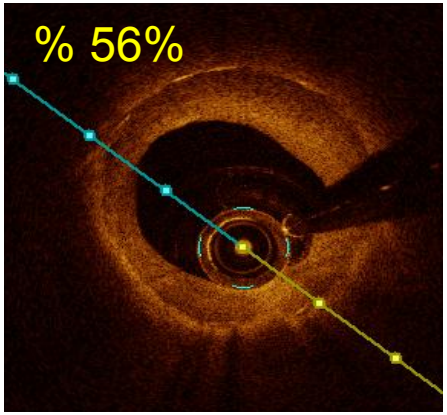


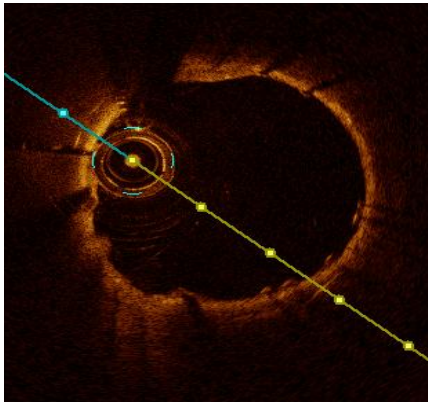
Sortie sous Triple thérapie

Contrôle coro systématique à 3 mois

Contrôle 3 mois

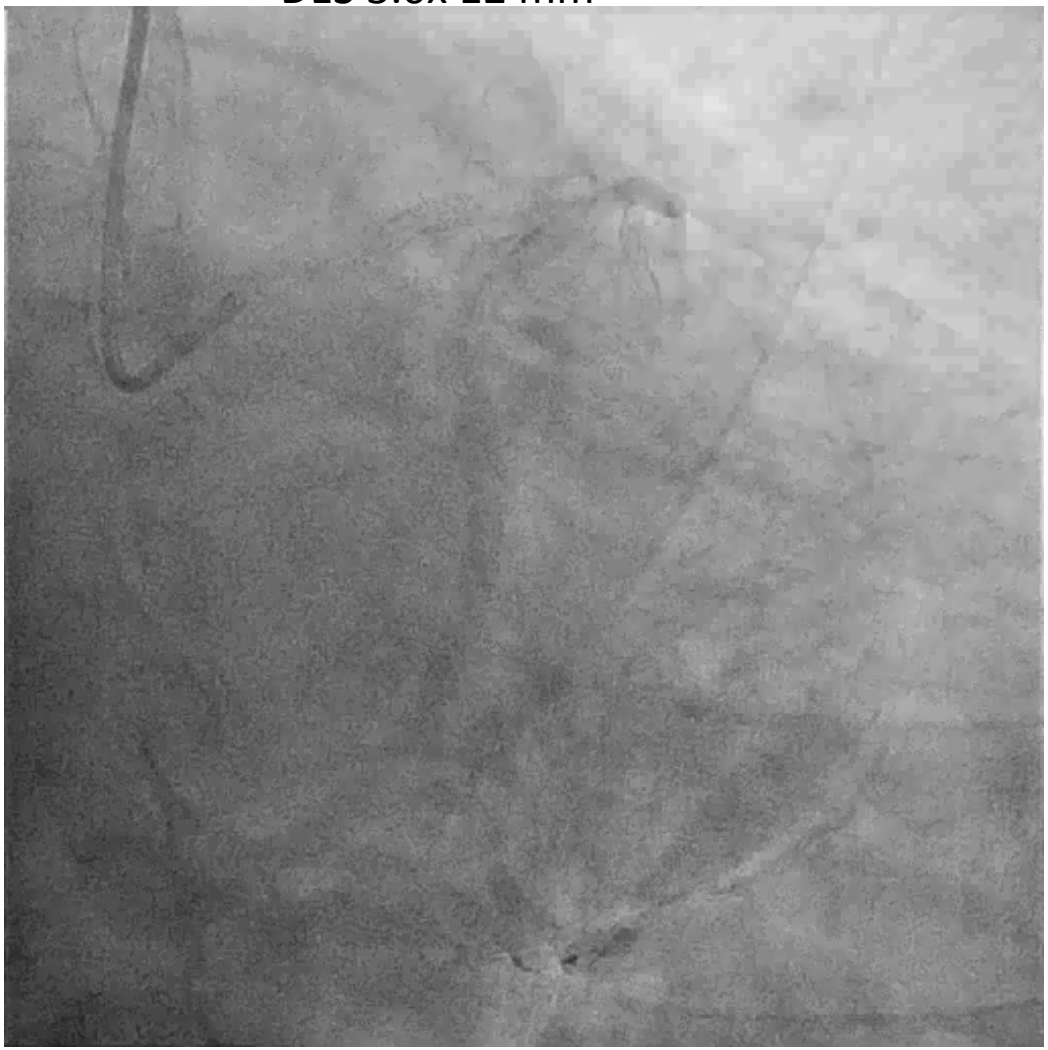






Angioplastie IVA 1

DES 3.0x 12 mm



Tripe thérapie

Coro @ 3 mois

Conclusion

Stent couvert: nécessaire en salle KT

Indication : rupture coronaire “proximale”

Utilisation plus rare si CI chir : anévrysme coronaire

Limites stent couvert+++
délivrabilité➔ PK papyrus
endothelialisation/risque TDS: DAPT prolongée