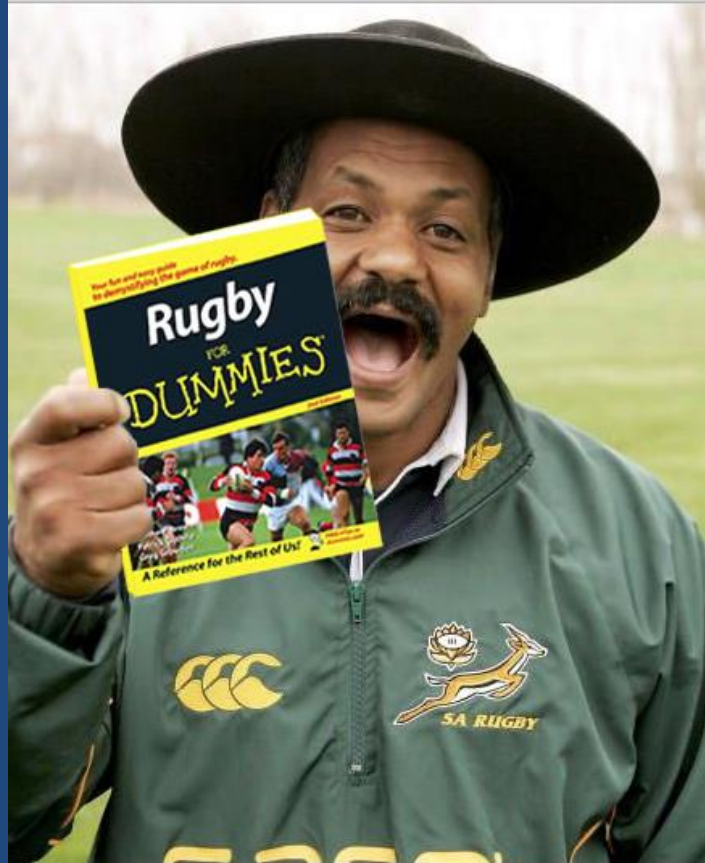


WHAT TO DO IF YOUR FIRST STRATEGY (PLAN A  
) FAILS

WHAT TO DO IF YOUR FIRST STRATEGY  
(PLAN A ) FAILS

USE PLAN B



PLAN A IS NOT WORKING GUYS, LET'S SWITCH TO  
PLAN B



OK COACH. JUST TELL US WHAT PLAN A WAS

# IF NO PROPER PLAN A AND YOUR STRATEGY FAILS, THE OPTIONS ARE:

- Stop the procedure, take a few minutes to re-asses the situation and plan a proper strategy. If you need additional information (clinical, anatomical or functional) - Reschedule!

# PLANNING TO FAIL: Trial and Error Approach

- Try something else; another: Guide wire/Balloon/Stent/Guiding catheter ? Operator
- This is a trail and error approach (try and fail again)
- The errors with complications are going to occur!

# A PROPER PLAN A STARTS WITH RISK STRATIFICATION

- QUALITATIVE RISK ASSESMENT
- QUANTITATIVE RISK ASESSMENT

# QUALITATIVE RISK ASSESSMENT

- End of the bed test:  
Subjective assessment of the risk of the individual patient, also taking the operator's experience and skills into consideration.
- As your skills and **own** experience with similar patients or clinical situations increase the reliability of this test improves



# QUANTITATIVE RISK ASSESSMENT USING DIFFERENT RISK MODELS

Models include both clinical and angiographic scores, as well as combined scores and should be used for the patient population they were designed to evaluate.

No perfect single risk score exists

**Table 1A**

EDUCATIONAL CONTENT ENDORSED BY EAPCI,  
A REGISTERED BRANCH OF THE EUROPEAN SOCIETY OF CARDIOLOGY

Score	Development cohort (patients, design)	Patient inclusion	Coronary procedures	Number of variables		Outcome	Recommendation		Validation studies	Calculation	Ref <sup>a</sup>
				Clinical	Anatomical		CABG	PCI			
STS Score	n = 774 881 Multicentre	01/2006 – 12/2006	100% (i) CABG	40	2	In-hospital or 30-day <sup>b</sup> mortality, and in-hospital morbidity <sup>c</sup>	<b>I B</b>		5–10	<a href="http://riskcalc.sts.org">http://riskcalc.sts.org</a>	51, 54
EuroSCORE II	n = 16 828 Multicentre	05/2010 – 07/2010	47% (i) CABG	18	0	In-hospital mortality	<b>IIa B</b>	<b>IIb C</b>	>10	<a href="http://www.euroscore.org/calc.html">www.euroscore.org/calc.html</a>	22
ACEF	n = 4557 Single-centre	2001 – 2003	-	3	0	In-hospital or 30-day <sup>b</sup> mortality	<b>IIb C</b>	<b>IIb C</b>	5–10	[Age/ejection fraction (%)] + 1 <sup>d</sup>	68
NCDR CathPCI	181 775 Multicentre	01/2004 – 03/2006	100% PCI	8	0	In-hospital mortality		<b>IIb B</b>	<5	-	11
EuroSCORE	n = 19 030 Multicentre	09/1995 – 11/1995	64% (i) CABG	17	0	Operative mortality	<b>III B</b>	<b>III C</b>	>50	<a href="http://www.euroscore.org/calcold.html">www.euroscore.org/calcold.html</a>	9, 10

The PCR-EAPCI Textbook – Percutaneous interventional cardiovascular medicine  
**Risk stratification and risk models in revascularisation**

Scot Garg, David R. Holmes

**Table 1B**

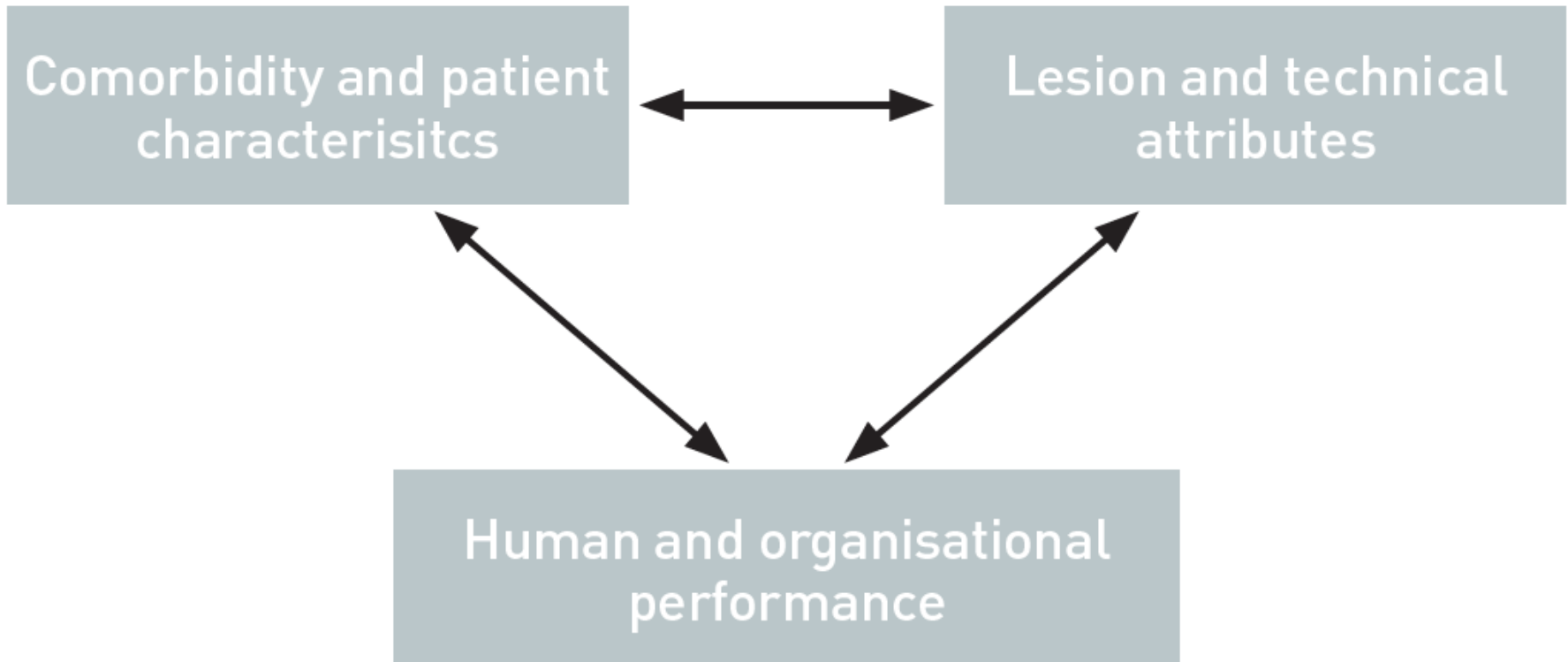
Score	Development cohort	Patient inclusion	Coronary procedures	Number of variables		Outcome	Recommendation		Validation studies	Calculation	Ref <sup>a</sup>
				Clinical	Anatomical		CABG	PCI			
SYNTAX	None, expert opinion	none	-	0	11 (3 general, 8 per lesion)	MACCE	<b>I B</b>	<b>I B</b>	>50	www.syntaxscore.com	45
SYNTAX II	1800 Multicentre	03/2005 – 04/2007	50% CABG, 50% PCI	6	12	4-year mortality	<b>IIa B</b>	<b>IIa B</b>	<5	-	26
ASCERT CABG	174 506 Multicentre	01/2002 – 12/2007	100% (i) CABG	23	2	Mortality >2 years	<b>IIa B</b>		<5	-	55
ASCERT PCI	206 081 Multicentre	2004 – 2007	100% PCI	17	2	Mortality >1 year		<b>IIa B</b>	<5	-	56
Logistic Clinical SYNTAX	6 508 Multicentre	03/2005 – 04-2007	100% PCI	3	11	1-year MACE and mortality		<b>IIa B</b>	<5	-	57

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# RISK SCORES: (David Holmes)

- The specific risk score must be **relevant** to the patient at hand.
- The risk score needs to have been **validated** in external data sets and be found to be robust.
- The risk score must include the **data which either is available or can be obtained** in the specific patient.
- The risk score should be able to be used at the point of care so that the physician, health care team, and patient receive full benefit.
- The risk score can only be used as a **guideline**, because each patient is unique and offer unique challenges as well as unintended consequences.
- The ideal risk score will never be available, as the medical information used in decision making and the opportunities available continue to evolve. Accordingly risk scores need to continually evolve
- Finally, the specific score used should be as closely as possible **matched to the specific patient** being evaluated.

**Figure 2**

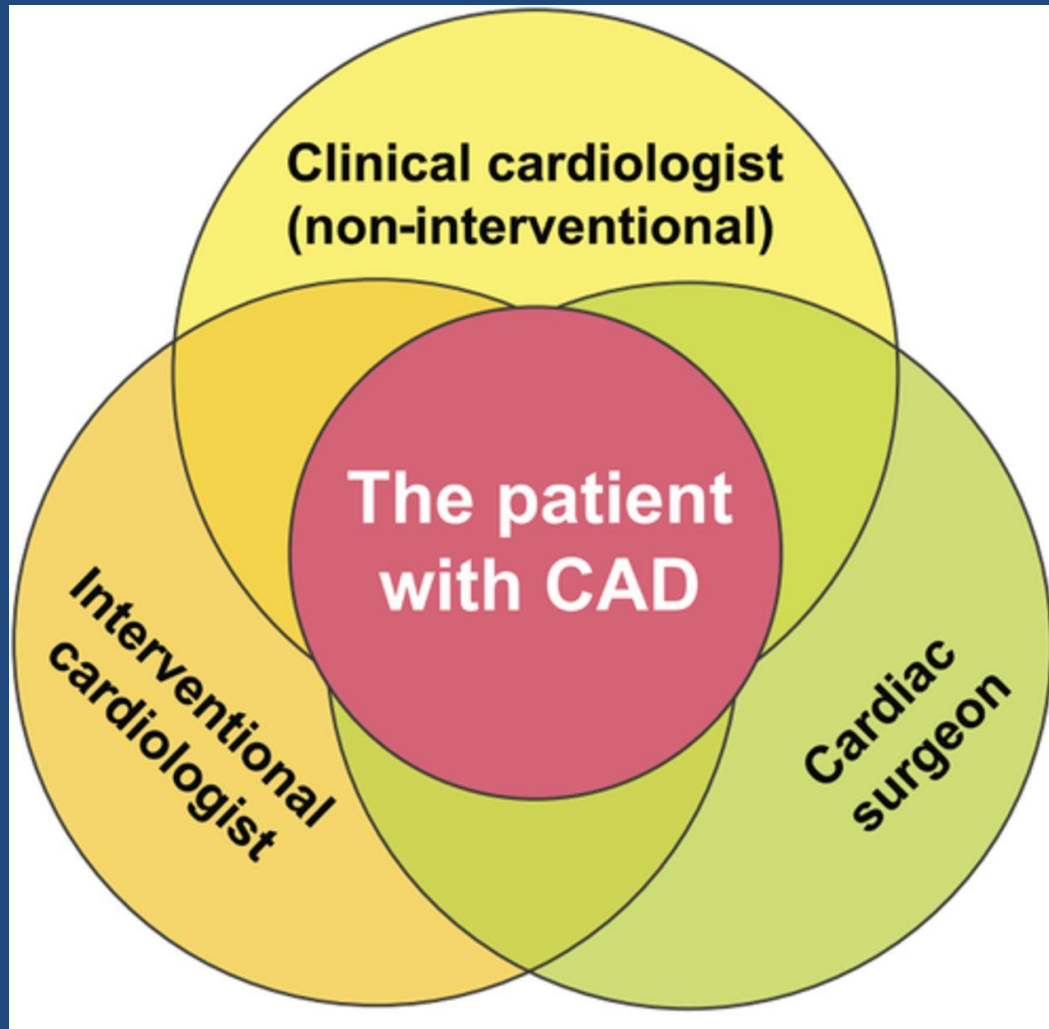
The PCR-EAPCI Textbook – Percutaneous interventional cardiovascular medicine

## **The prevention and management of complications during percutaneous coronary intervention**

Rodney De Palma, Christian Roguelov, Adel Aminian, Olivier Muller, Tito Kabir, Eric Eeckhout

# THE HEART TEAM

The basis for a Heart Team is involvement of necessary specialties and the patient to facilitate shared decision-making.



Stuart J. Head et al. Eur Heart J 2013;eurheartj.eht059





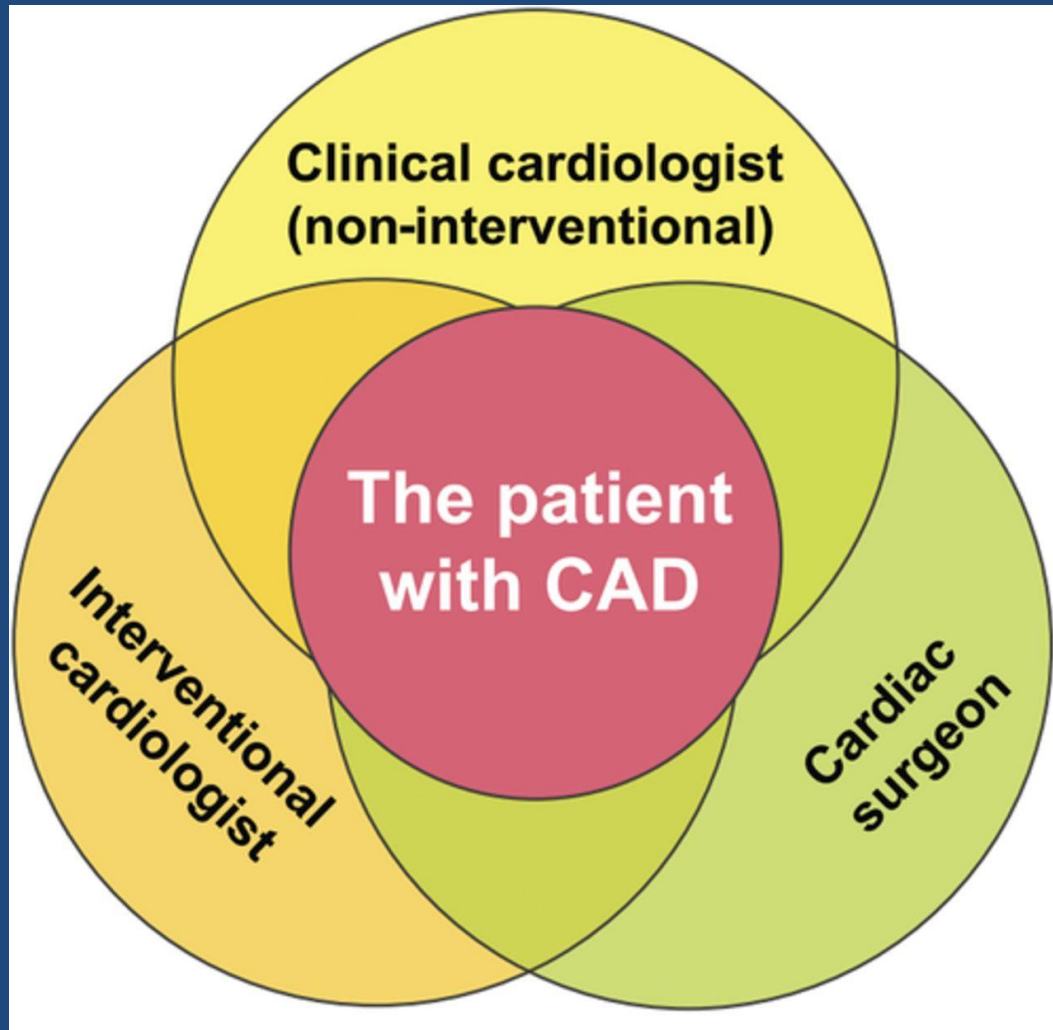




“You’ve got six months, but with aggressive treatment we can help make that seem much longer.”



The basis for a Heart Team is involvement of necessary specialties and the patient to facilitate shared decision-making.



Stuart J. Head et al. Eur Heart J 2013;eurheartj.eht059

# FLOW CHART FOR AD HOC PCI Consensus statement SCAI Catheterization and Cardiovascular Intervention 19 Nov 2012

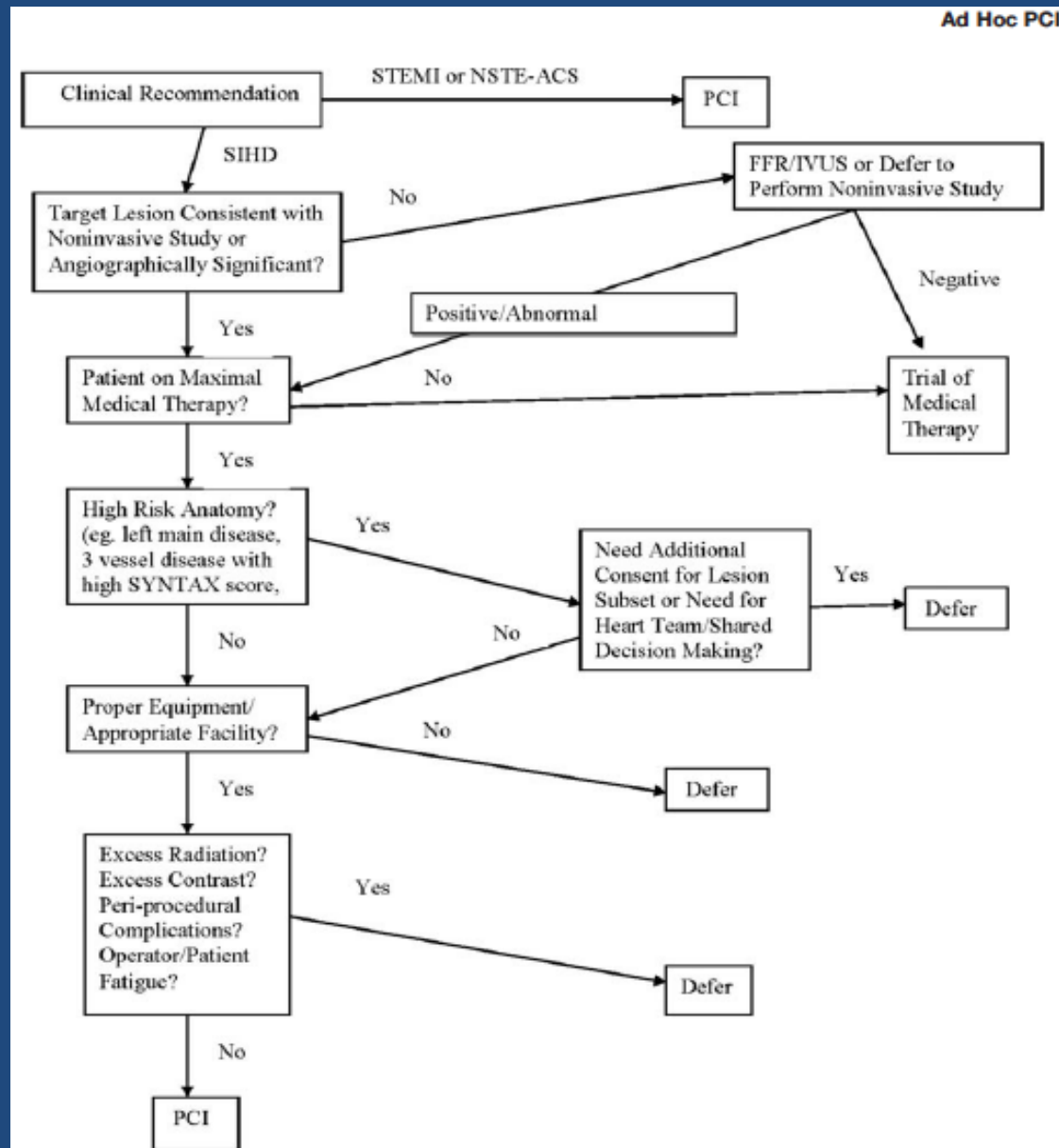
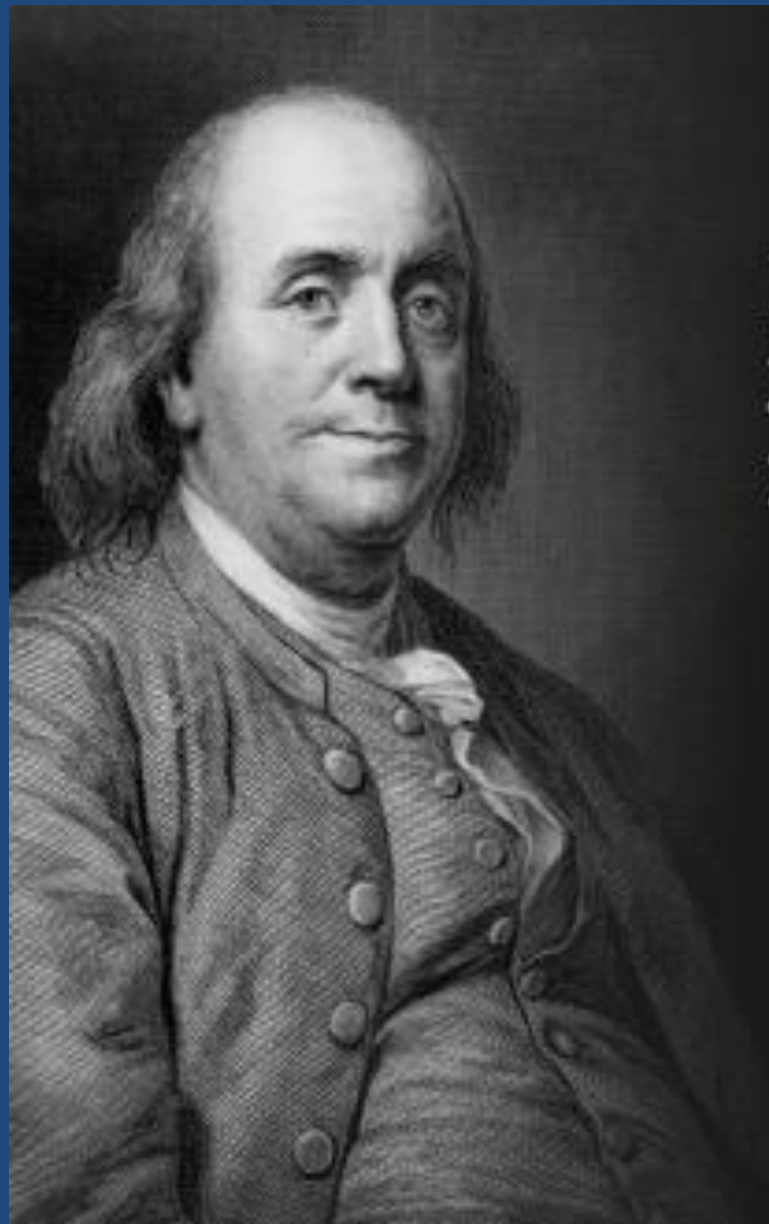


Fig. 1. Decision flow chart for ad hoc PCI. STEMI, ST elevation myocardial infarction; NSTEMI-ACS, non-ST elevation acute coronary syndrome; PCI, percutaneous coronary intervention.

# PART OF PROPER PLANNING IS BEING PREPARED TO ADDRESS COMPLICATIONS

- LEFT MAIN DISSECTION
- VESSEL PERFORATION
- CARDIAC TAMPONADE
- NO RELOW



**By failing to prepare,  
you are  
preparing to fail.**

**Benjamin Franklin**