**P1004 Saline flush during excimer laser pulse delivery in the rabbit femoral artery: an unexpected photodynamic therapy effect**

Ton G. van Leeuwen, Evelyn Velema, Gerard Pasterkamp, Mark J. Post, Cornelis Boszt. Heart Lung Institute, Utrecht University Hospital, Utrecht, The Netherlands

**Background:** To reduce the size of explosive water vapor bubbles formed during intra-luminal delivery of laser pulses, blood must be displaced by saline. In a previous study, we demonstrated that saline flush during excimer laser light delivery drastically reduced the number of medial dissections in the rabbit femoral artery. However, the transparent saline solution in front of the catheter tip provided direct irradiation of the arterial wall, which resulted in increased medial and adventitial necrosis. In this study, we evaluated the effect of flushing saline on interstitial hyperplasia (IH) and arterial shrinkage using two methods: 1) in the femoral artery of the rabbit, 600 excimer laser pulses (508 nm, 55 mJ/mm², 20 Hz) were delivered coaxially in 10 bursts of 3 seconds each. During laser pulse delivery, the 4.5 F multibladder catheter (0.67 mm/s) was pulled back over a length of 20 mm. In 12/24 procedures, saline was flushed (0.2 ml/s) via the guide wire channel. At 4 locations in the lesion, angiographic measurements were performed before and after the procedure and at follow-up. After termination, the arteries were pressure perfusion fixed. In 4 cross-sections of each lesion, the maximal IH thickness was morphometrically analyzed with a computer-based system. Arterial shrinkage was defined as the lumen loss diameter which was not explained by IH.

**Results:**

<table>
<thead>
<tr>
<th>Occlusions</th>
<th>Lumen loss</th>
<th>IH thickness</th>
<th>*2 Shrinkage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood 7/12</td>
<td>0.43 ± 0.30</td>
<td>0.15 ± 0.10</td>
<td>0.26 ± 0.28</td>
</tr>
<tr>
<td>Saline 4/12</td>
<td>0.27 ± 0.27</td>
<td>0.15 ± 0.13</td>
<td>0.22 ± 0.22</td>
</tr>
</tbody>
</table>

In the middle segments of the saline group no IH and no shrinkage was present. Furthermore, parts of the media were acellular, a histopathology that is also observed after photodynamic therapy of arteries. However, at both edges of the lesion, IH and arterial shrinkage reduced the lumen. In the blood group, the lesion was distinct with the maximal IH in the middle of the lesion.

**Conclusion:** Flushing saline during coaxial excimer laser pulse delivery facilitated direct irradiation of the arterial wall, which prevented, in the middle of the lesion, restoration of the media and formation of interstitial hyperplasia, resembling the effect of photodynamic therapy. In both groups, lumen reduction, either in the middle of the lesion or at the edges, is due to interstitial hyperplasia and arterial shrinkage.

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**P1005 Alternative energy source for intra-coronary laser interventions: the Er:YAG laser**

K.K. Haase, C. Rose, A. Athanasiadis, A. Baumbach, K.R. Karsch. Department of Cardiology, University of Tübingen, Germany

Coronary excimer laser ablation is limited by the induction of pressure waves and vapor bubbles which have been identified to be a major cause of vessel wall trauma during tissue ablation. Er:YAG lasers – as opposed to excimer lasers – offer significantly higher ablation rates with only minimal thermal injury. To identify the extent of pressure waves during Er:YAG laser ablation, normal and atherosclerotic vessel segments were irradiated in vitro using a pulsed Er:YAG laser system (λ = 2.94 μm). In a first series, the laser spikes (maccropulse duration: 250 μs) were focused in air on the tissue. In a second series, the pulses were delivered via a ZrF fibre and a quartz fibre onto the vessel wall samples being immersed in a saline solution. The pressure pulses were detected by needle type hydrophones at the back side of the samples in the first series and lateral to the ablating fibre tip in the second series.

Although Er:YAG laser ablation is associated with the induction of pressure waves, the maximum intensity of the stress waves is significantly reduced as compared to excimer laser ablation. In concordance with previous experiments, these results support the assumption that minimal thermal injury, low peak pressures and high ablation rates will lead to new clinical perspectives of treatment of coronary artery disease.

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**P1006 Coronary artery disease severity and left ventricular function**

**P1007 Does the change in quantitatively assessed coronary artery disease after lipid-lowering therapy relate to functional status of the patient? A substudy of the Regression Growth Evaluation Statin Study (REGRESS)**

W.R.M. Aengevaeren, G.J.H. Uijlen, A.V.G. Bruschke 1, J.W. Jukema 1, T. van der Werf. Department of Cardiology, University Hospital Nijmegen;
1 Interuniversitary Cardiology Institute the Netherlands (ICIN), Utrecht, The Netherlands

In conclusion: The impact of the severity of coronary artery stenosis and the collateral circulation on the functional outcome of myocardial infarction after revascularization in patients with chronic left ventricular dysfunction has not been evaluated.

**Methods:** We studied 40 patients with old myocardial infarction by low-dose dobutamine (up to 10 μg/kg/min) echocardiography (LDDE) before coronary artery bypass grafting. A 16 segments-5 grade score model was used to assess left ventricular function. Viability and functional recovery were respectively defined as a reduction of wall motion score ≥ 1 at LDDE 14 ± 8 days before surgery and at follow up rest echocardiography 3 months after surgery.

**Results:** There were 56 stenotic coronary arteries subtending severely dysynergic regions, of which 38 were occluded. Among 186 severely dysynergic segments postoperative functional recovery occurred in 42 (23%). There was no significant difference between regions with patent or occluded arteries with respect to prevalence or extent of viability and functional recovery. In patients with total occlusion, parameters of viability and functional recovery were not related to the collateral grade. Sensitivity, specificity and accuracy of LDDE for prediction of regional functional recovery were 71% (CI 65–78), 90% (CI 86–94) and 89% (CI 81–91) respectively.

Conclusion: In patients with chronic left ventricular dysfunction, the presence of total occlusion of coronary arteries supplying severely dysynergic regions does not imply a lower prevalence or extent of myocardial viability regardless of the grade of visualised collaterals. Independent on the severity of coronary stenosis, noninvasive evaluation of myocardial viability using techniques like LDDE is required to identify segments with high probability of improvement after revascularization.

**Results:** Complete follow-up after 2 years was available in 26 patients in the medical management (M), 10 in the PTCA (P) and 14 in the CABG (C) stratum, respectively. Effect analysis of prav. versus placebo was based on 36 patients (M and P strata, PTCA vessels excluded). The change in MOD was assessed by digital subtraction angiography after i.e. papaverine with video-densitometric calculation of the hyperemic mean transit time (HMTT). 3) Exercise time (EXT) and maximal ST-segment depression (MST), assessed during a standardised bicycle test.

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In conclusion: Change in MOD is moderately related to maximal ST-segment depression during the exercise test. Myocardial perfusion better correlates with the functional status of the patient, presumably because HMTT also reflects changes at the microcirculatory level.