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## Guideline myocardial revascularization

Introduction and commentary on the methodology of the Spanish Society of Cardiology supports the Clinical Practice Guidelines (CPG) published by the European Society of Cardiology (ESC). As part of this policy, the ECONOMIC and Social Commission guidelines for economic materials are translated into Spanish and published in the electronic version of Revista Española de Cardiología, with the aim of increasing accessibility and facilitating their implementation.<sup>1</sup> The translated articles are accompanied by an editorial by a panel of Spanish experts highlighting the most important content of each CPG document and the details of changes and innovations introduced since the previous edition. . discusses the most controversial aspects and possible limitations. The editorial also seeks to evaluate and adapt the recommendations to the context of healthcare regulation and clinical practice in Spain. The latest ESC guidelines for cardiomyopathy revascularization<sup>1</sup> previous CPG update published in 2014.<sup>2</sup> It should be noted that a great effort has been made to maintain consistency with the previous guidelines. Diagnostic tools to guide MYOCARDIAL Revasalnoninvasive diagnostic tools for patients with gastrointestinal angina symptoms, and the guidelines recommend noninvasive imaging testing as a preliminary diagnostic procedure. In patients undergoing coronary angiography (CT) imaging, regional ischemia can be detected by pumping the heart muscle or selecting a partial flow reserve (FFR-CT). Patients with advanced heart disease (HD) and maintaining the viability of the heart muscle must be revascularized before considering support for mechanical circulation or heart transplantation. The most prominent invasive diagnostic tools in this section relate to the introduction of instant wave-free ratio (iFR), a new measure that does not require adenosine-induced hyperemia. In the new guidelines, iFR is included in the first instance a recommendation to assess the functional impact of intermediate lesions. The FFR and iFR guidelines are equivalent, and the cutting to identify a lesion of the heudimica is  $iFR \leq 0.89$  and  $FFR \leq 0.8$ . For the use of FFR to guide dermatomal therapy from polycystic disease, and the new CPG document maintains the previously established recommendation (IIa B)<sup>2</sup> New guidelines place significant value on the functional indicators derived from pressure (FFR and iFR), which

have increased in clinical practice sharply. A clear example of this is provided by the experience in Spain, where 2017 data reveal a 23% increase compared to the previous year.<sup>3</sup> A separate section is devoted to assessing the severity of the narrowing of the main left coronary artery (LMCA), which often involves bone lesions. Job evaluation by FFR or iFR can be technically complex, and the evidence that supports their use in this context is rare. Thus, intravascular ultrasound (IVUS) is a grade IIa B recommendation, and re-anastomosis should be excluded when the lighting area is minimal <math>\leq 6\text{ mm}^2</math>. For everyone. Outside of LMCA, job evaluation is better than photography within the korari. The process of making decisions and patient information in line with the 2014,<sup>2</sup> guidelines emphasizes the importance of giving patients up-to-date evidence-based information about treatment options. The guidelines emphasize the need to identify treatments by the multidisciplinary heart team. This decision-making process is designed not only to ensure routine adherence to guidance recommendations, but also to create specific algorithms for decision-making, measurement, short- and long-term communication of results, and consideration of patient preferences. The recommended timing of revascularization (allocated versus deferred) depends on the clinical presentation. For patients with acute coronary artery syndrome (ACS) or trauma, it is acceptable to perform a custom re-scholastic procedure in accordance with a protocol created by the multidisciplinary heart team. In contrast, delayed revascularization is recommended for most patients with sedentary abdominal angina, with a delay of 2 to 6 weeks depending on clinical and anatomical characteristics and ventricular function. In general, temporary re-incarceration (in the same procedure as vascular diagnosis) is not recommended for patients with stable coronary angina and complex coronary anatomy. For a number of reasons, fewer coronary artery grafts (CABG) are performed in Spain than in similar countries, which is reflected in a lower rate of CABG relative to percutaneous coronary intervention (PCI), according to data from the Organisation for Economic Co-operation and Development.<sup>4</sup> REVASCULAR for coronary artery stability has been introduced in this section, which now includes a discussion on the assessment of surgical risks and anatomical complexity. The new format (Figure 3 in cpg) summarizes the clinical and anatomical factors affecting the decision between CABG and PCI, and the guidelines assess the benefits of a full reassessment. The CPG document assesses alternative definitions of full annexation muzzie, and the preferred strategy is full reunification based on functional definition rather than anatomical definition. Furthermore, priority is given to the possibility of full reconfiguration in the decision-making process between the capand PCI (IIa B). Despite the benefits of this recommendation, it may conflict with the reference to re-creation in specific anatomical cases requiring CABG or PCI independently of the possibility of full reconfiguration. Recommendations according to the extent and anatomical complexity of coronary artery disease (CAD) remain unchanged except for diabetics with 3-vessel CAD and SYNTAX score  $\leq 22$ , whose recommendation for PCI was reduced from IIa B in 2014 to IIb B in the current CPG. This change is somewhat surprising because 3 CAD ships and The result  $\leq 22$  indicates a decrease dissection and lower future rate of revascularization and coagulation. Capgi remains the ideal treatment for LMCA and 3-vessels. PCI and CABG are both first-rate LMCA recommendations with SYNTAX score  $\leq 22$  and 3-vessel CAD without diabetes and SYNTAX score  $\leq 22$ . For most other patients with LMCA or 3-vessels, PCI is contraindicated if CABG is possible; The exception is LMCA patients with an intermediate SYNTAX score, who maintain PCI apc. Compared with previous guidelines,<sup>2</sup> new guidelines give less weight to EuroSCORE II in surgical mortality prediction (IIa B in 2014 versus IIb B in 2018), while STS and SYNTAX grades maintain a Grade I B recommendation. EuroSCORE logistics points and other grades are no longer considered, and syntax-II points are not recommended. ESC members acknowledge the major limitations on SYNTAX points, but still consider them to be an essential tool in selecting a reassessment method, a finding supported by data from an individual lycée analysis of patient aggregation.<sup>5</sup> To date, only one study has compared CABG and PCI Specifically with regard to SYNTAX points.<sup>6</sup> The new guidelines reduce left ventricular fracture (LVEF) to indicate reassessment in patients with polyphazine and siasia documented; it was previously cut  $\leq 40\%$  and now  $\leq 35\%$  (I am a). This section of the CPG document addresses the controversial issue of the potential placebo effect of PCI, which orbita.<sup>7</sup> concludes that despite its elegant design, the ORBITA study has major limitations that make it unsuitable for directing changes in clinical practice, however, the ORBITA study emphasizes the importance of optimal medical treatment for patients with CAD. THE ESC NEW GUIDELINES INCLUDE DATA FROM A NETWORK META-ANALYSIS OF 100 STUDIES CONFIRMING THAT THE NEW GENERATION OF PHARMACOLOGICAL STENT (DES) IMPROVES SURVIVAL COMPARED TO MEDICAL TREATMENT, ALTHOUGH THIS WAS NOT SHOWN IN ANY INDIVIDUAL STUDY.<sup>8</sup> REVASCULARIZATION IN ACUTE NON-ST-HEIGHT INVASIVE STRATEGY SYNDROME REMAINS THE STANDARD TREATMENT FOR MOST PATIENTS WITH ACUTE CORONARY SYNDROME (NSTEMACS) NON-ST PART-PART. An early penetration strategy (intervention in the first 24hours) is recommended for most NSTEMACS patients, including those with high troponin, repolarity change, or grace grade <math>\geq 140</math>. The debate on the basis of intervention within 24 hours is old, and this strategy has known logistical and procedural implications that could contribute significantly to its incomplete implementation in Spain. Therefore, in Spain, the decision should be communicated on whether the invasive strategy should be used early Consider the regional healthcare organization and the type of hospital in which the patient is admitted. Radiological access and the use of des new generation are recommended for all patients. The guidelines highlight the usefulness of FFR to identify functionally important lesions in NSTEMACS patients, although the predictive value of this approach is unknown. Complete revascularization is recommended for patients with polyfasase disease and should be carried out in one procedure except in patients with heart trauma. CABG is required in only 5% to 10% of NSTEMACS patients, and the ideal timing should be determined for careful intervention for each individual. The guidelines do not give a specific recommendation for antiplatelet treatment before surgery; However, they remind readers that while the incidence of preoperative events is <math>\leq 0.1\%</math>, the incidence of bleeding around the surgery is above 10%. Even so, dual antiplatelet therapy does not justify delayed surgery in patients with active ischemia and blood instability. There is no evidence in favor of choosing between PCI or CABG for patients with stable NSTEMACS, and doctors should therefore apply the same criteria used for patients with stable CAD. REVASCULARIZATION IN ST-PART LIFT MYOCARDIAL INFARCTIONTHTH SECTION OFFERS SEVERAL CHANGES COMPARED TO THE PREVIOUS CPG DOCUMENT. The most important changes include recommendations promoted for radiographic access and the use of DES (both now Class I A); recommendation against the systematic use of thrombosis ambition (which has been reduced from IIa to III A), allowing for use in selected patients; and the use of unbranched heparin as an anticoagulant of choice (Class I C), with enoxaparine and bivalirudin as alternatives in a decreasing order of preference (IIa and IB, respectively). Another major change compared to the 2014 guidelines relates to the treatment of severe stenosis in non-goospined vessels in Stasis patients. For stable patients, the recommendation is to reconstruct non-artificial vessels before discharge (Class IIa A). The basis for recommending re-treatment during hospital treatment is that this is the procedure used in trials; however, there is no reason to expect that the results will be different if angioidisation is performed after discharge. For patients with trauma, new guidelines are recommended against the systematic practice of PCI MULTIVessel in this setting (Class III B). MYOCARDIAL REVASCULARIZATION IN PATIENTS WITH HEART-TO-HEART HEART FAILUREPROCEDURE FOR PREFERRED ENCRYPTION FOR HIGH-RESOLUTION PATIENTS WITH LOW LVEF OR POLYFASONE DISEASE AND ACCEPTABLE SURGICAL RISK (CLASS I B). PCI is recommended as an alternative to CABG (IIa C) for patients with 1-oot or 2-vessel disease when full re-insasal can be achieved. PCI is also recommended for patients with 3-vessel disease based on the heart team's assessment of Risk (comorbidities), coronary artery anatomy, expected completeness of revascularization, and above all diabetes. PCI should also be considered for elderly patients with diabetes when complete revascularization can be achieved, while the capage is recommended for younger patients with extensive CANADIAN and diabetic son. There has been no comparison of CABG and PCI in heart failure patients with low LVEF, and the evidence gap in this area should somewhat affect the application of these recommendations. Acute heart failure and cardiac traumasmot than this section is to maintain a low recommendation for short-term mechanical periodic support (Class C) and to restrict it to a set of specific patient characteristics. The document does not contain any recommendations on the use of intraoornized balloon pumps in patients with some period of farm trauma and mechanical complications. The CPG document states that oxygen support for the membrane outside corporeal seems to provide a superior clinical benefit versus balloon infusion into the aorta in monitoring studies; In contrast, no such feature has been reported for left ventricular percutaneous percutaneous assistance devices (Impella and TandemHeart). Revascularization in patients' groups with specific diabetes only in this retained section of the previous guidelines is to check kidney function if patients have taken metformin immediately before angiography and suspension of metformin if kidney function deteriorates. Other recommendations for diabetes are contained in the general sections of the document. The discussion of evidence supporting re-saisalysis in diabetics has been simplified, and concludes that the recommendations for this group of patients are similar to those of the general population in the light of a meta-analysis showing no significant interaction between diabetes and the benefits of revascularization. The authors of the guidelines note that this meta-analysis only included patients with ACS and that the largest study designed to compare re-anastasila and medical treatment in diabetics showed no benefit. CABG is still the recommended re-ms method for polysacheus in diabetics. As mentioned earlier, PCI guidelines recommend for diabetics with a SYNTAX score  $\leq 22$  (Class A), based on several studies in a variety of clinical contexts. New studies are needed to explore whether functional revascularization and new generation DES also provide benefit in patients with low anatomical complexity. Patients with chronic kidney diseaseprevious editions, new guidelines highlight the underrepresentation of this group of patients in clinical trials. The need to prevent variability-induced nephropathy in all patients is addressed by raising the preoperative risk assessment recommendation category (Class IIa C in 2014 to Category I C in the new CPG document) and Sufficient water (Class I C). For patients with moderate or severe chronic kidney disease, the guidelines recommend pre-ethal and post-ethal saline salinity if the expected contrast size is <math>\geq 100\text{ ml}</math> (IIa C). Patients who need valve interventionthere are no major changes in this section. The severity of coronary artery stenosis with FFR or iFR can be assessed in patients with severe aortic stenosis; However, current evidence is insufficient to support the use of these approaches in this context. For patients with moderate aortic narrowing/coercion that undergoes the amount of capage, the heart team should evaluate the possibility of implanting the aortic valve across the course on a case-by-case basis. The guidelines introduce a new signal for mitral valve repair at the time of the caper in patients associated with severe primary coronary coercion. However, the general recommendation for mitral valve repair applies only if the effective cargate nozzle area (EROA) is <math>\geq 0.4\text{cm}^2</math>, and the decision should be to combine mitral valve repair with individual CABG for patients with EROA between 0.2 and 0.4cm<sup>2</sup>. A Class IIa C recommendation for mitral valve repair has been added in patients with severe mitral and LVEF <math>\leq 30\%</math> with evidence of myocardial incompetence. Patients with peripheral artery diseaseapprovd myocardial vascular revascular guidelines 2017 ESC guidelines for peripheral artery disease.<sup>9</sup> Current CPG authors note a high rate of stroke in patients undergoing CABG and discuss the causes and preventive strategies available. The new guidelines do not address the recurrent problem of myocardial sleeve in patients who also need surgical intervention or blood vessels through the skin, and the evidence of this is well established. RevascularizationClinic's apparent recurrence of early graft failure after CABG is a rare event ( $\approx 3\%$ ). For patients suspected of severe myocardial infarction immediately after CABG, an angiography is recommended in the period around the surgery to detect the cause and report the joint decision between the surgeon and the catheter specialist. In this case, it is best to target treatment for the original vessels or internal mammary artery (IMA) and avoid stacked snare veins. The frequency of the capg increases the risk of death between 2 and 4 times for primary surgery, and therefore patients with early graft failure should always consider THE PCI. However, PCI in bypass despthes is associated with a higher risk of complications. Although procedures to prevent coronary embolism are effective, the current recommendation for regular use of PCI in this case is Class IIa B, which was reduced from I B in the previous guidelines. In venous bypass grafts, DES produces superior preliminary results for metal stents and is therefore recommended; however, the relative benefit of DES has not been confirmed in the very long term (5 years). When the recurrence of re-insacolar surgery is IMA should be used whenever possible. Patients treated by PCI can develop angina during follow-up due to re-rest, incomplete revascular reconstruction, or the development of the disease, with the development of the disease is the most common cause in the long run. In patients with repositioning, repeat PCI remains a selection strategy. Both DES and drug-coated plastics are recommended for patients with re-politicization of the metal naked stent or DES (Class I A)<sup>10</sup> intra-canopy imaging provides useful information about the mechanism of stent failure caused by reoscopy or blood clotting and helps make decisions about optimal treatment (IIa C). ARRYTHMIASCoronary revascularization cad patients should always be considered with LVEF <math>\leq 35\%</math> before they are fitted with implantable fibrillation remover for primary prevention. Capge reduces mortality for 10 years in patients with low LVEF. Regardless of the ECG pattern, survivors of cardiac arrest should undergo cardiac arrest outside the hospital without a clear non-verbal cause of arrhythmia in early coronary angiography (IIa C). Patients who develop atrial fibrillation (AF) as complications of PCI or CABG should be evaluated for coagulation. Beta-blocker should be considered as a measure to prevent the appearance of AF after the cap (I B). The procedural aspects of coronary artery bypass vaccination guidelines remove recommendations on medications about surgery and the handling of blood products around blood in the blood in the blood in favor of focusing on surgical techniques. With regard to the selection of coronary graft II, the CPG document recommends bilateral grafts for IMA in patients under 70 years of age, noting that the second arterial graft should be considered depending on the patient's characteristics and other factors. The recommendation for ima structural harvesting technique is limited to patients with a risk of infection. Hybrid reorganization (CABG and PCI) performed respectively as part of the same procedure or sequentially in separate operating environments) retains a low recommendation (IIb) for selected patients treated in experienced centres; however, the evidence level was changed from C in 2014 to B in the current document. Recommendations for full vascular resection (with no infarcting vein grafts) are based exclusively on the results of 5 years of arterial revascular recirculation experience.<sup>11</sup> Spain has a low per capita rate of CABG, and therefore it is difficult for Spanish centers to follow the recommendation to assemble teams specializing in minimally invasive blood vessel resection, surgery without extracorporeal circulation, or laparoscopic dissection. The procedural aspects of percutaneous coronary intervention are now downloaded using balloon angioplasty to vessels that are unfit for stent transplantation due to technical difficulties or because they are too narrow. As mentioned above, radioaccess has been upgraded to a Class A recommendation, which is already used in 88% of the procedures in Spain.<sup>3</sup> Maximum (Category I A) is the maintenance of DES use in all clinical contexts and for all types of lesions. However, the implementation of this recommendation could be limited by spending constraints in the health-care sector. Despite this concern, DES is very widely used in Spain.<sup>3</sup> The polymer guidelines used or absent are discussed in the various types of DES available; studies published so far have shown no significant clinical differences between new generation DES devices. This applies even to the higher risk of bleeding and the subsequent reduction in the duration of dual antiplatelet therapy, although evidence in this area is limited to specific types of DES.<sup>12</sup> biodegradable scaffolding (Class III C) is recommended only in clinical trials. Visual cohesion tomography (OCT) is recommended to improve stent transplantation (Class IIa B). The 2014 guidelines have already included this recommendation for IVUS, and now OCT has been upgraded to the same recommendation category (from IIb C in the previous guidelines). Reclassification to a firmer recommendation (category I) hampered by the predominance of observational studies.<sup>13</sup> Regarding specific pest subgroups, and guidelines increasing the recommendation for main branch supports only with temporary support for the side branch (Class IIa A in 2014; upgrade to I A in the new guidelines). In the specific case of lmca lesions of lmca branching correctly, double kissing crushing technique (Class B) is recommended in preference to a temporary T-prop strategy. Although the only grade IIb, the specific recommendation for the actual LMCA complexity lesions is controversial due to the complexity and subordination of the operator to the double kissing crushing technique; The IIa B-grade maintenance guidelines recommend the treatment of chronic kidney obstruction in patients with refractive chest pain or a large ischemic area near the clogged vessel. There is no distinction between access to decomposition and retrosection. Since evidence of the benefit associated with PCI derives mostly from registration data, the recommendation less than category I.ANTIROBOTIC TREATMENTSRecommendations for antiplatelet treatment has experienced no significant changes with regard to previous guidelines. P2Y<sub>12</sub> receptor inhibitors of choice for ACS are ticagrelor and prasugrel, except in patients with a higher risk of bleeding or other contraindications. For patients with stable CAD treated by PCI, clopidogrel remains the drug of choice; However, for patients with high ischemic risk, the most effective P2Y<sub>12</sub> receptor inhibitors (IIb C) should be considered. A weak recommendation (IIb A) for cangrelor is made as an alternative drug for patients undergoing PCI and who have no history of P2Y<sub>12</sub> receptor inhibitor therapy, independently of Clinical presentation. This option is not available in Spain until this drug is marketed. Recommendations for the duration of dual antiplatelet therapy after PCI retain starting points from 6 months to stable CAD and 12 months for CSCS; However, the guidelines emphasize the need for individual treatment duration in accordance with ischemia and the risk of bleeding. With regard to coagulation therapy during PCI, the only major change is the decline of bivalirudin to the first-class IIb A recommendation for patients with STEACS and NSTEMACS. The new CPG document updates recommendations regarding the use of platelet function testing to guide antiplatelet therapy. These changes include a Grade B recommendation to consider reducing P2Y<sub>12</sub> receptor inhibitor therapy in ACS patients to less powerful drugs. Furthermore, the use of platelet function testing to guide the interruption of antiplatelet therapy in patients undergoing heart surgery has been reduced from ia-class recommendation to Grade IIb. Thus, the recommendation is weak in both cases. Non-phytolithic AF patients who need antiplatetherapy simultaneously, non-vitamin K oral anticoagulants (NOAC) are preferred on vitamin K antibodies and should be used in the minimum dose shown to prevent stroke. Furthermore, NOACs are recommended in triple therapy (aspirin, clopidogrel, and oral coagulation), although none of the published trials of triangulation have not used any of the drugs not intended for the treatment of coagulation at an appropriate dose for the prevention of stroke. This recommendation has significant cost implications in Spain, where the current level of prescriptions for which they cannot be breathed is low and varies among different autonomous societies. The magnitude of the relationship with the resulting new REVASCULARIZATION Guidelines procedures maintains the previous recommendation that surgical remake is performed in the centers with an annual volume of  $\geq 200$  patients (IIa C). A new recommendation has been made for periodic monitoring of performance measures to promote continuous improvement (Category I C). There is no standard European training programme at CABG; however, the guidelines recommend trainee surgeons perform at least 200 supervised operations before working independently. Due to the fragmented organization of cardiac surgery centers in Spain, it is difficult for our cardiac surgeons to achieve these figures. The guidelines also maintain recommendations for training in PCI, both for ACS ( $\geq 75$  procedures per operator in centres with at least 400 PCI procedures per year and 24-hour on-demand service) and sedentary SCAD ( $\geq 75$  procedures per operator in centres with at least 200 PCI procedures per year). For the first time, the guidelines recommend that LMCA be treated by experienced operators (IIa C), which is defined in the article mentioned in the guidelines as those treating at least 15 patients per year.<sup>14</sup> A particularly significant adjustment has been made to the recommendation for the treatment of optional PCI patients considered.<sup>14</sup> The guidelines maintain the PCI requirement in these patients to be performed by experienced operators, with access to circulatory support and treatment in intensive care. However, the requirement was removed in previous guidelines for an on-site surgical team. For training in interventional cardiology, the guidelines propose a unified programme based on that put forward by the European Association for Perforatal Cardiovascular Interventions (EAPCI). This programme provides for at least 200 procedures as a major operator in a centre that performs more than 800 angiography operations annually and a 24-hour angiography service. This proposal supports the accreditation plan administered by the Securities and Exchange Commission's Working Group on Cardiac Catheterization and Interventional Heart Disease and should strengthen moves to grant it legal status. Medical treatment, secondary prevention, and follow-up strategiesparadise strengthened for cardiac rehabilitation in the new guidelines for all patients treated for ACS with CABG or PCI, rising from category Ia in 2014 to category I A currently. This is a difficult recommendation in Spain because some centres lack a cardiac rehabilitation unit, and the effective implementation of these programmes is hampered by limited funds, lack of infrastructure, patient care time and multidisciplinary teams. However, compliance with this recommendation can be improved with the emergence of telecardia c.t.a. supervised programmes available to patients at home. Although the rest rate has decreased with the use of DES, it is important to check for recurrence of ischemic symptoms, along with other secondary prevention measures. These concerns require clearly defined follow-up strategies, but there are many gaps in this area. Finally, the guidelines do not recommend invasive or non-invasive screening for ischemia in patients without symptoms. See related article: SS Cardinal. 2019;72(1):16-20B. Ibanez, et al./Pastor Esp Cardinal. 2019;72(1):16-201718B. Ibanez, et al./Pastor Esp Cardinal. 2019;72 (1): 16-201885-5857/\$- See Front Issue © 2018 Sociedad Española de Cardiología. Published by Ambassador of Spain, S.L. All rights reserved. Conflicts of my parking announced. See Working Group of the 2018 Economic Committee for Assessment/Economic Regulation (2018) on cardiomyopathy: Borja Ibanez (Coordinator), Víctor Bautista-Hernandez (Coordinator), Fernando Alfonso, Gemma Berga Congost, Hector Bueno, Manuel Carneiro, Beilin A. Syd-Alvarez, José María maria de la Torre Hernández, Juan Antonio Franco-Pelez, and Soleil Ouáge. Reviewers for 2018 ESC/EACTS guidelines for cardiovascularization Revascularization: Vivencio Barrios, Armando Pérez de Prado, Eduardo Armada, Carlos Escobar, Juan Cosin Sils, Raúl Moreno, José García Aconia, Rosa María Lydon, Esteban López de San, Oriol Rodríguez Leor, Alessandro Ciones. Securities and Exchange Commission Guidelines Committee: Fernando Alfonso, Ipañez, Fernando Aribas, Gemma Berga Kongost, Hector Bueno, Arturo Evangelista, Ignacio Ferreira-González, Manuel Jimenez Navarro, Francisco Marin, Leopoldo Pérez de Isla, Antonia Sambula, Rafael Vázquez and Ana Viana-Tejesdur. The names of all the authors of this article mentioned in the appendix. I was neglecting .

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