TCTAP C-110

Left Anterior Descending Artery Stenting with Stent Dislodgement in Left Main-Retrieved

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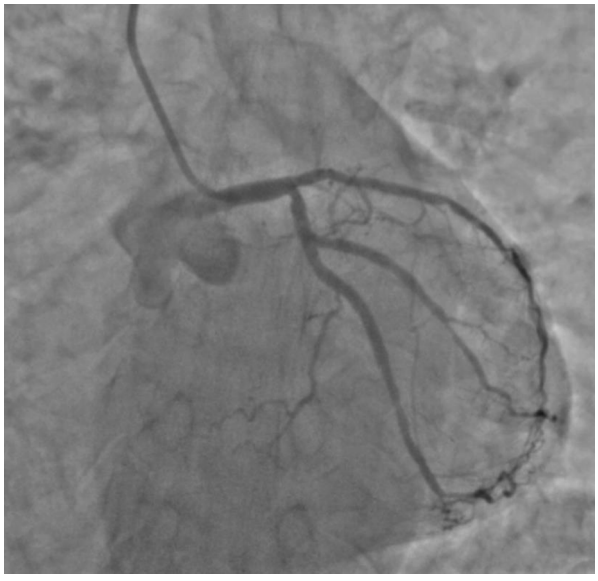
[CLINICAL INFORMATION]

Patient initials or identifier number. KK

Relevant clinical history and physical exam. Recent AWMI, Not thrombolysed
AOE NYHA Class III

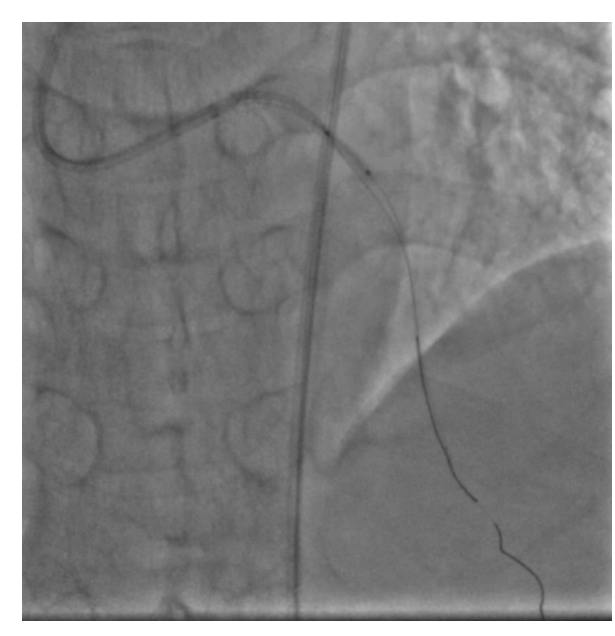
Relevant test results prior to catheterization. Echo:LVEF 55%

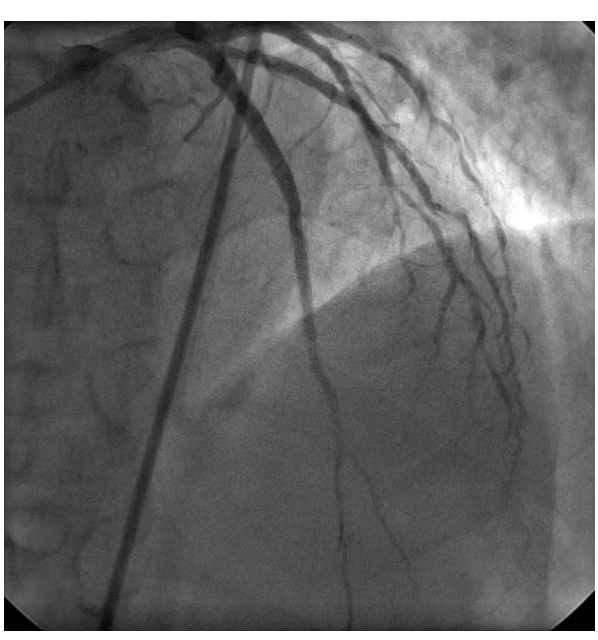
Relevant catheterization findings. OM1 and OM2 shows plaque
LAD cut off after diagonal, retrogradely filling from left injection
RCA normal LV Angio shows LVEF 55%



[INTERVENTIONAL MANAGEMENT]

Procedural step. EBU guiding and micro catheter support, floppy guide wire taken
Lesion predilated with 2 * 15 mm balloon
As lesion is thrombotic, thrombus aspiration done
A 3 x 43 mm stent tried to negotiated into LAD however couldn't cross the lesion and while pulling dislodged into the LM
A small 1 x 6 mm balloon tried to pass through the dislodged stent, however could not pass
Another floppy wire taken and tried to intertwine distally, however not successful
A balloon inflated over the second wire and whole assembly tried to pull into the guiding, still not successful
During all these manoeuvre, guide wire came out
A coronary snare taken and tried to engage the dislodged stent
After multiple attempts, coronary snare grasped the proximal end of dislodged stent and the stent retrieved
In second sitting the patient taken up again and lesion recrossed with floppy guide wire
Distal entry into the true lumen confirmed by giving contrast by a micro catheter into the LAD
Stent 3 x 28 mm deployed from ostial LAD
Another stent 2.75 x 23 mm deployed distally
Both stents post dilated
Final cine shows a good result





Case Summary. • Stent loss during PCI occurs infrequently in the current era (incidence 0.32%) and is more likely to occur in tortuous and calcified coronary arteries.

• Lost stents can be successfully retrieved in the majority of cases using a variety of retrieval techniques like low pressure balloon inflation technique, small balloon technique, double wire technique and loop snare technique.

• Stent loss is associated with an increased risk of complications, such as significant bleeding and need for emergency coronary artery bypass graft surgery.

• Stents lost in small branches can be left.

• If stent is not retrieved it may be deployed or crushed.

TCTAP C-111

Stent Edge Dissection Caused by Hinge Motion in Tortuous Vessels

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[CLINICAL INFORMATION]

Patient initials or identifier number. M.O.

Relevant clinical history and physical exam. A 67-year-old female with hypertension and diabetes was admitted to our hospital to be evaluated for chest discomfort on effort. She hadn't received any catheterization yet. On her physical examination, blood pressure was 140/70 mmHg and heart rate was 70 bpm.

Relevant test results prior to catheterization. There were no specific findings on electrocardiography and echocardiography.

Relevant catheterization findings. Coronary angiography revealed focal 75% stenosis at the proximal right coronary artery (RCA) in tortuous vessels. There was no significant stenosis in left anterior descending artery and left circumflex artery.

[INTERVENTIONAL MANAGEMENT]

Procedural step. Percutaneous coronary intervention (PCI) was performed from right radial artery. The proximal RCA lesion was dilated with a 3.0×15 mm balloon (HiryuPlus, TERUMO) and treated with a 3.0×18 mm biolimus-eluting stent (NOBORI, TERUMO). Intravascular ultrasound (IVUS) didn't show any dissection and intramural hematoma. The final angiography was acceptable. In a general ward after the PCI thirty minutes later, she suddenly got chest pain and nausea with ST segment elevation in leads II, III and aVF. Emergent coronary angiography revealed an occlusion of the proximal RCA in the stent. PCI was performed from femoral artery with a 7 Fr Judkins right guiding catheter (Launchar, Medtronic) and a guide wire (Sionblue, ASAHI Intecc). IVUS showed the stent edge dissection and intramural hematoma expanded to the far distal RCA. The true lumen was compressed by the enlarged, tense, false lumen. We put 2.5×38 mm and 3.0×28 mm everolimus-eluting stents (XienceAlpine, Abott) after making the re-entry point by a 3.0×10 mm cutting balloon (Flextome, BostonScientific). Then, RCA flow got TIMI3 and her symptoms were getting better. The final angiography was acceptable. She was discharged after 2 days with no elevation of cardiac enzyme.