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A case of iatrogenic LMT dissection, a life-threatning complication of PCI

71 year old male with diabetes mellitus and hypertension was admitted to our hospital because of chest discomfort on effort. CAG revealed the distal LCx and mid LAD artery lesions. We performed PCI for the LCx and LAD lesions via left radial approach with a Neo's soft wire using sheathless JL3.5ST, 6.5Fr guiding catheter. A 2.5 x 18 mm Nobori stent was deployed at the distal LCx and a 2.5 x 14 mm Nobori stent at the mid LAD. The IVUS revealed good stent apposition. Unfortunately, a final injection revealed a contrast stain of the LMT showing spiral dissection of the LMT involving the aortic root and the LCx. Because the guiding catheter was not in co-axial position with the artery before contrast injection, the guiding catheter caused dissection in LMT. A vigorous injection of contrast into the subintimal space played a role in extending the dissection. Immediately, we performed bail-out stenting. Firstly, a 3.0 x 18 mm Nobori stent and a 3.5 x 24 mm Nobori stent were deployed at the LCx. Then, a 3.5 x 24mm Nobori stent was placed from the ostial LMT toward the LAD. Final angiogram showed no residual stenosis in the stented segment, with good distal flow. Follow-up CAG at 3 months revealed good results. Iatrogenic LMT dissection is a catastrophic complication of PCI. We should always keep in mind that the engagement of the guiding catheters in co-axial alignment with the artery reduces the risk of causing catheter-induced LMT dissection.