19 [10001]

Coronary perforation, caused by post-dilatation of a CTO vessel

86 y/o F with a history of HTN, T2D presenting with SOB, she had h/o CKD, and +ve TnI, Q waves with minimal ST depression, pulmonary edema, NSTEMI, Echo. showed borderline LVP, CAG: triple vessel CAD with heavily calcification (m-LAD: CTO, collateral vessel from LCx; p-LAD, p-LCX: diffuse diseased; RCA: diffuse diseased) (Syntax score : 39.5),. 7F EBU4 GC with sheathless for LAD/LCx PCI. A Fielder FC GW was loaded on FC MGC and was used to re-canalize CTO from m-LAD. After failure in using Fielder FC GW x2, we switched to a Fielder XT-A GW opened the calcified d-LAD. A Rota-Wire was substituted for Fielder FC to very-d-LAD and rotablation was done with step-wise 1.25 mm, 1.5 mm burr at 180K-220K rpm. We dilated the whole LAD sequentially. Three DES (2.25x28 mm, 2.75x38 mm, and 3.0x38 mm) were deployed from very distal to p-LAD, and followed by post-dilation. A new Fielder FC GW was loaded on 2nd new FC MGC and was advanced to d-LCx. An Ellis type III LAD perforation was discovered at the m-d-LAD. Subcostal pericardocentesis restoring BP to more than 100 mmHg. Protamine 50 mg given. We completed deployment of a 2.75x33 mm DES at p-m-LAD under guide-linear catheter support and anchoring at m-LAD. A 2.8x19 mm covered stent was placed at m-d-LAD followed by 3.0x15 mm HPB. For persistent extravasation another 2.8x16 mm covered stent was placed at d-LAD overlapped the last one.