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Coil embolisation of a perforated distal LAD without reversal of heparin in a 63 year-old female with 3-vessel disease

PCI was planned to the LAD, LCX and RCA in a 67 year-old female with non-ST elevation acute coronary syndrome. Using a 6F radial access, a 6F XB3 Cordis guide catheter engaged the left main coronary artery after 1,000 iu of heparin, clopidogrel loading (300mg) more than 24 hours previously and aspirin (80mg). An Asahi Sion angioplasty guide wire was used to cross the lesion in the LCX which was a 95% irregular disease in the mid segment. A 2.5 x 23mm Xience Xpedition was then successfully deployed at a pressure of 18 atm in the LCX lesion. The same Asahi Sion wire was used to cross the lesion in the LAD and was distalized, however coronary perforation was seen in the distal segment. Balloon tamponade was carried out with the 2.5 x 15 mm NC Trek to 6 atm for approximately 30-40 minutes which resulted in sealing off of the perforation. Given the deployment of the stent in the LCX, reversal of heparin anticoagulation was not performed. The distal LAD perforation was occluded with two 2.0 x 6.0mm and 3.0 x 10mm Target microcoils (HELICAL ULTRA) delivered using an Excelsior? 2TIP STRAIGHT 150 X 6 CM initially advanced over the Boston Scientific Transend? EX SOFT TIP wire and positioned in the distal LAD. Extravasation ceased after the second coil and was confirmed on angiography. A 2.5 x 3mm Xience Xpedition was then deployed over the proximal LAD using an initial pressure of 6 atm. The RCA was then cannulated with a 6 Fr JR4 guiding catheter without difficulty. The same Asahi Sion angioplasty guidewire was then used to cross the 90% lesion in the mid portion. A 2.0 x 12mm Mini Trek was used to predilate the lesion to 8 atm afterwhich, a 2.25 x 12 mm Xience Xpedition was then deployed at a pressure of 6 atm. Its proximal and mid stented portions were post dilated to 10-14 atm. Full angiographic pictures of all stented segments reveal good stent expansion as well as clear stent margins. The coiled area in the distal LAD showed no further signs of contrast extravasation and the distal LAD had TIMI1 collateral flow from the RCA. Patient experienced chest pain post procedure which lasted for less than 48 hours. Repeat ECG showed new T wave inversions in the anterior wall. A repeat transthoracic echocardiogram the following day did not demonstrate any pericardial effusion. Patient remained stable throught the course of hospital stay.