For the Next Patient…

Heng Shee Kim

[1]Cardiology Department, Sultanah Aminah Hospital, Malaysia

A 65-year-old woman with hypertension, diabetes, and dyslipidemia presented with atypical chest pain. ECG and cardiac enzymes were unremarkable. CT coronary angiogram showed 50–70% proximal LAD stenosis. Diagnostic angiogram confirmed distal LM 50%, proximal LAD 70–80%, proximal LCx 50%, and mild RCA disease. PCI was deferred to allow family discussion.

She returned a month later for elective PCI. She was pre-loaded with DAPT. Right femoral access was used due to poor radial pulses. FFR showed LCx 0.92, LAD 0.76. IVUS of LM–LAD revealed 50% soft plaque at distal LM and circumferential calcification with calcium nodule at ostial LAD, extending into pLAD causing 70–80% stenosis. Calcium score was 3; we planned for rotational atherectomy.

About 45 minutes into the procedure, during contrast injection for roadmap before Rotablation, we were shocked to find total LM–LAD–LCx occlusion. The patient became hypotensive and tachycardic, with severe chest pain and new ST elevation. While evaluating for dissection, perforation, or thrombosis, we identified the true cause: **no heparin had been administered**.

It was a team-wide oversight. The case began with physiology assessment and transitioned into PCI with the same FFR wire without a formal pause or anticoagulation check.

Urgent thrombus aspiration retrieved large red thrombus. The patient developed PEA—CPR was started and ROSC achieved after 10 minutes. We POBA with a 3.0 mm NC balloon, re-establishing LAD TIMI II flow, followed by a 3.0 × 48 mm DES from LM to pLAD. Unfortunately, she deteriorated into VF and asystole. Despite full resuscitation and TIMI III flow to all vessels, we could not revive her.

That night, shaken and devastated, I typed out a simple pre-PCI safety form: patient name, IC, allergy status, DAPT, and heparin dose/time. It is now a **mandatory cross-check in all our PCI cases**.

A tragic loss that changed our system. This case did not end with heroics—but it sparked a real and lasting change. In sharing it, I hope it helps others prevent the same.

Lessons Learned:

• Never begin PCI—diagnostic or interventional—without confirming anticoagulation.

• Familiar workflows can breed blind spots. Never assume.

• A 5-second pause could have saved a life.