

A 71 years old gentleman has past history of hypertension, hyperlipidemia, obesity and gout. He is a chronic smoker.

He had history of ischemic heart disease with PCI done to distal RCA-pPDA and dLAD 2017, and PCI to mLCx-pOM2, dLAD occlusive ISR 2021. He complained of recurrent angina in 2025.

Restudy coronary angiogram showed LM moderate disease, pLAD severe disease, mLAD diffuse mild to moderate disease, dLAD stent tight recurrent ISR.

PCI was performed to dLAD ISR. Patient developed excruciating chest pain, sweating and cardiogenic shock after stenting. Repeat coronary angiogram showed extensive coronary spasm noted at LM and proximal LAD. Stenting was performed at LM-pLAD and inotropes were given. Chest pain persisted and noted spasm over LCx and RCA as well.

Patient was intubated, IABP was inserted. He was noted to have generalized skin rash over the body.

Intravenous nitroglycerine, IV hydrocortisone were given. Patient was stabilized and later serum tryptase was found elevated 30.8 µg/L (reference range: <14 µg/L).

These findings support the diagnosis of coronary allergic reaction, Type I Kounis syndrome.