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76, Male
DM, HTN
Angina and dyspnea since 1 month
ECG unremarkable
Echo no RWMA, normal LVEF

Coronary angiography showed critical Mid LAD, critical LCX and distal RCA disease with non obstructive lesion in distal LM disease. After heart team discussion and taking into consideration patients preferences, decision to do PTCA to distal LCX, LM-LAD provisional with sos DEB to distal RCA was decided.

PTCA with stenting to distal LCX, mid LAD and LM-LAD was done, POT to LM was done, post dilation to LAD stent was done; but then started having complications

1st was pinching of almost all the side branches from LAD – septals, large diagonal and LCX with severe hypotension requiring high dose vasopressor support. Diagonal was crossed and KBI was done to restore TIMI III flow in diagonal but with dissection at the ostium of Diagonal. LCX was crossed and KBI was done.

2nd complication happened while attempting to cross a stent into LCX through LM-LAD stent struts, this stent got stuck in LM part of the stent and deformed the LM-LAD stent. After some forcefull pulling that stent came back into the guide and was removed out of the body. Inspection of the retrieved stent showed that it was grossly deformed and hence was discarded. Repeat KBI and POT to LM was done. Another stent was taken and attempt to cross it through LM-LAD stent struts was made, but that also got stuck into the struts. Again forceful pulling of that stent lead to another 2 complications

3rd complication that LCX stent got dislodged from the balloon but came back into the guiding catheter.

4th complication, LM-LAD stent got unraveled and longitudinally deformed and came upto arch of aorta while pulling the guide in attempt to remove the previous dislodged stent.

The dislodged stent was retrieved from iliac artery using balloon trapping.

5th complication happened when poorly thought attempt to snare the dangling part of LM-LAD stent was made using home made snare put through contralateral femoral access, because that snare also got badly entangled with that stent.

At this point of time, cardiac surgeon was involved and opinion was sought to bail out the situation. But patient was hemodynamically unstable, hence again after heart team discussion, it was decided to complete LM-LAD-LCX bifurcation PCI to restore coronary blood flow at earliest and then remove only the entangled snare and protruding part of LM-LAD stent surgically with intension to minimize on pump time.

According to plan LM was anagin engaged using 7F EBU, predilation to plaster LM-LAD unraveled stent part aside was done aggressively and an attempt to twist and un-entangle the snare was made and eventually snare got free from protruding stent part. After this LM-LAD-LCX bifurcation PCI was completed using MINI-CRUSH technique with good final result and stable hemodynamics on moderate vasopressors support.

In the end, PCI result was satisfactory but what was left behind was a protruding unraveled stent part from LM ostium and dangling across arch of aorta. It was decided to leave this part and follow up and retrieve if required later after stabilization.

To summarise, case that was deemed simple provisional bifurcation PCI, ended up having series of complications, hemodynamic instability, peri-procedural MI and heart failure, but survived against all odds.