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We present the case of a 66-year-old gentleman with a history of hypertension and dyslipidaemia, electively admitted for multivessel PCI after a positive MSCT revealed three-vessel coronary artery disease.

Diagnostic coronary angiography demonstrated:

- Severe stenosis in the mid LAD
- Severe stenosis in the LCx (OM2)
- Severe stenosis in the proximal RCA

Initial access via right radial artery (TERUMO 6Fr) was complicated by significant arterial spasm, necessitating conversion to right femoral access (TERUMO 6Fr). PCI of the left coronary system was performed successfully.

When addressing the right coronary artery, engagement with a standard Judkins Right (JR) catheter proved challenging due to frequent catheter rebound and inadequate support. To overcome this, we switched to an Amplatz Left (AL) guiding catheter, which provided enhanced backup support and allowed successful stenting of the proximal RCA.

During withdrawal of the AL catheter, however, repeated torquing maneuvers caused the catheter to spring back from the RCA into the descending aorta. Further attempts to rotate the catheter were unsuccessful, and fluoroscopy revealed kinking and entrapment of the catheter shaft within the descending aorta, preventing standard retrieval.

An emergency bailout was performed using a peripheral Amplatz Goose Neck Snare Kit (20 mm) via the previous radial site. The snare successfully captured and retrieved the kinked AL catheter, allowing safe completion of the procedure without vascular injury.

This case illustrates the trade-off between achieving strong guide support and the mechanical risks of aggressive catheter curves, emphasizing the need for early recognition and prepared bailout strategies for rare but potentially serious device complications during complex PCI.