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The 66-year old male patient was presented with effort chest pain for 2 months. He had a prior history of hypertension and type-2 diabetes mellitus, both of them were well treated at private clinic. His chest X-ray and electrocardiogram were non-remarkable and echocardiogram(ECG) on admission showed normal LV ejection fraction(61%) without regional wall motion abnormality. His laboratory test result showed no abnormal values. To evaluate the cause of chest pain, coronary angiogram(CAG) was performed. CAG showed 2-vessel disease with both 70% stenosis of d-LCx and m-RCA lesions. Angiogram-guided fractional flow reserve(uFR, Pulse Medical, Shanghai, China) was performed and the results were 0.62 and 0.72, each. Mid-RCA was treated with drug-eluting stent(Biofreedom Ultra 3.0x24mm) without residual stenosis, whereas d-LCx was treated with drug-coated balloon(Genoss DCB 2.25x20mm) due to small vessel caliber and the residual stenosis was less than 30% with good distal flow. So, the procedure was finished without acute complication. Then, 90 minutes later the patient complained of chest pain and the ECG showed ST elevation on II,III,aVF leads. Follow-up CAG was taken and revealed occlusion of DCB-treated d-LCx. After struggling to advance guidewire to the true lumen by IVUS-guidance successfully, progressive balloon dilation(Zinrai 1.5x15mm, Minitrek 2.0x20mm) was performed and finally placed DES(Synergy 2.5x24mm) followed by post-dilation with NC balloon(NC Emerge 2.5 x8mm). Dual antiplatelet therapy with aspirin and clopidogrel, as well as other anti-ischemic medications were given and the patient was stabilized afterwards. 5 days later, the patient was symptom free and ready to be discharged. However, all of a sudden, the patient complained of severe chest pain with the same ST elevation on II,III,aVF on ECG as before. Again, emergent CAG was taken which revealed subacute stent thrombosis of d-LCx stent. After succesful guidewire passage, balloon dilation with Minikrek 1.5x15mm along with thrombosuction(Extractor) and intracoronary bolus injection and intravenous infusion of glycoprotein IIb-IIIa inhibitor(Clotinab) stated. After flow restoration and thrombus removal, another DES(Synergy 3.0x16mm) at proximal part of prior stent was placed to enhance upstream coronary flow. Final angiogram looked suitable and the procedure has finished. Because the nature of this event is acute coronary syndrome, clopidogrel was escalated to ticagrelor(90mg bid). After stabilization, FU CAG was taken 4 days later, which revealed excellent distal flow without hint of thrombosis. Then, the patient was discharged and doing well until latest out-patient clinic visit (2 months later). The CYP2C19 genetic test during hospital stay turned out to be positive (*2/*2, poor metablizer).