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52-year-old female, known hypertensive (for 7 years), Autoimmune Hemolytic Anemia (AIHA) since 2025 who was later diagnosed as a case of Evans syndrome (early 2026), came in complaining of cough, and shortness of breath. Symptoms initially began a week prior, which worsened and progressed, hence admission. On the 2nd hospital day, she noted worsening clinical condition, and dyspnea with desaturation (70% at room air) with minimal improvement with oxygen support (87% at 15LPM non-rebreather). Suspicion for pulmonary embolism (PE) was entertained after an elevated D-Dimer on screening (3040ng/mL, ref normal: <500ng/mL), hence CTPA done confirming acute PE in the bilateral pulmonary arteries and saddle embolus at the main pulmonary artery, with additional findings of right heart strain (increased RV>LV ratio and elevated HStropI/NTProBNP biomarkers). Promptly referred to the pulmonary embolism response team (PERT) and advised subsequent intervention.

Pulmonary angiogram findings showed multiple filling defect and contrast staining in the bilateral pulmonary arteries, specifically in the main pulmonary artery (MPA), upper and middle right pulmonary artery (RPA), as well as upper and lower left pulmonary artery (LPA). Decision to proceed with mechanical aspiration thrombectomy done, and multiple runs using the penumbra aspiration catheter showed improved flow to the bilateral pulmonary circulation initially. Shortly after the aspiration thrombectomy, there was note of worsening clinical status (persistent shock, desaturation and worsening dyspnea). Repeated angiographic shots showed further clot propagation in the left pulmonary circulation (angry clot phenomenon). Catheter directed thrombolysis in the LPA was done giving a total of 10mg Alteplase, as well as repeated runs of mechanical aspiration thrombectomy, which improved flow to the LPA. Due to some difficulty in optimal catheter positioning for aspiration, operators decided to do manual aspiration using a JR4 guide catheter properly positioned at the upper and mid LPA, which attached to a negative pressure aspiration system, to further aspirate the residual thrombus in the left PA. Final cineangiographic shots showed improved flow into the bilateral pulmonary arterial system, and drainage as well. During the interim post procedure, there was improved clinical status with stable vitals leading to subsequent removal of inotropic support and eventual mechanical ventilatory support.