Left circumflex artery rupture in subacute STEMI

When it ends where it all began
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☑ I do not have any potential conflict of interest to declare
• male, 69 years old
• chest pain for the past 24 hours
• past history: arterial hypertension
• smoker
• vital signs: BP 160/100 mmHg, HR 100/min
• laboratory findings: troponin T 2909 ng/L (< 15 ng/L)
• radial approach

• EBU 3,75 (6 F), workhorse guidewire

• predilatation with NC balloon catheter (2,0 x 15 mm/10 atm)
Primary PCI

- second guidewire
- second predilatation with NC balloon catheter (2.75 x 15 mm/10 atm)
- DES (4.0 x 25 mm/14 atm) implantation
• coronary artery rupture after postdilatation with NC balloon catheter (4.0 x 15 mm/20 atm)

• inflation of the same NC balloon catheter (6 atm) with coronary artery occlusion
• hemodynamically unstable with clinical signs and echocardiographic evidence of cardiac tamponade and shock
• emergency pericardiocentesis performed
• orotrachealy intubated with rapid sequence induction, mechanically ventilated
• cardiac surgeon on stand by
• stent graft (3.5 x 26 mm/10 atm) implanted

• dissection extended to distal segment of the artery with contrast extravasation
- another inflation of NC balloon catheter (6 atm) with coronary artery occlusion

- 0.018” microcatheter over 300 cm workhorse coronary guidewire
  - pushable embolization coils – 6 pieces
• 1000 ml of blood evacuated in total
• after 5 days in ICU transferred to the ward
• TTE: LVEF 40-45%, akinesia of lateral and hypokinesia of inferior wall, no pericardial effusion
• discharged 9 days after the procedure

• after 3 months – sustained VT with syncope/ICD