

Successful Management of Dislodged Stent in Distal Left Main; A Case Report

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A 69-year-old male patient was admitted to our hospital with the symptoms of effort angina for last 3 months. He was ex-smoker and non diabetic, and reported previous treatment for high blood pressure and dyslipidemia, he had underwent coronary angioplasty and stenting to left main to LAD and to RCA in another center abroad 11 months back.

An electrocardiogram at admittance showed the sinus rhythm with no specific ST segment and

T-wave changes. Physical examination showed arterial blood pressure 124/65 mmHg and a pulse rate of 63bpm. Transthoracic echocardiography revealed no regional wall motion abnormality with left ventricular ejection fraction 60% and grade I LV diastolic dysfunction. In view of his exertional anginal symptoms despite optimal medical anti-anginal treatment, he was planned for check coronary angiogram. His coronary angiogram revealed patent stent (left main to left anterior descending coronary artery, patent RCA stent), whereas a severely ostial disease of non dominant but large size circumflex coronary artery (CX), and the right coronary artery (RCA) were without significant disease.

Left coronary system was engaged with JL 4-7 Fr guiding catheter and coronary wire Fielder FC was advanced through the ostial LCX lesion to distal segment. Several sequential balloon predilatations (low profile balloon 1.1 x 10mm at 18atmosphere and Sprinter Legend 2.0 x 10 mm at 14 atmosphere) in the Left main to ostial LCX done with TIMI-III flow, while trying to cross the stent 2.5 x 12mm DES through the previously deployed left main to LAD stent with a sharp angle between left main and LCX and tortuous proximal segment of LCX, stent dislodged in the bifurcation of LM to LCX.

The patient complained on intense chest pain and suddenly developed severe bradycardia (30 beats per minute) with a drop in blood pressure to 60/40 mmHg. The flow in LCX was disturbed but there was TIMI-III flow in LAD, As we could not pull back the stent which was stuck with the previously left main stent and in sharp angle of ostial LCX, and on the other hand we lose the guide wire in the target vessel, we re-wired the lesion and decided to crush the unexpanded dislodged stent against the wall in the distal left main and ostio-proximal LCX with 2 x 10mm balloon inflating it up to 16atm, This resulted in a rapid blood flow restoration in LCX (TIMI-III), thought there was some plaque shifting in the ostial LAD then crushed with a stent 2.5 x 12mm (DES) at 14atm, with a good TIMI-III flow, another coronary wire BMW was advanced in left main to LAD and final kissing balloon done with 3.5 x 13mm non complaint balloon in left main to LAD and 2x 10mm balloon in LCX at 12atm.

Meanwhile application of atropine and normal saline infusion resulted in hemodynamic stabilization of the patient. The final angiographic result was optimal with uneventful later in hospital course. The patient was discharged on day 3rd.

A follow-up during the next three months showed good patient health with the absence of ischemic symptoms. Coronary angiography was performed after three months which showed patent all stents.