Case Scenario

- Mr. M.A.Z. 56-year-old complained of typical angina for one week and dyspnea for one month. His history was positive for coronary artery disease, +ve Dyslipidemia and hypertension.
- At June 2017, he was admitted to our CCU by NSTEMI.
- On admission, he was treated with Aspirin, Clopidogrel, Perindopril, Bisoprolol and Atorvastatin, NG infusion, Enoxaparin. His vital signs was stable and his physical examination was normal.
- However, persistent chest pain with minimal exertion (Crescendo Angina).
- So, urgent CA was decided.
Caudal injection shows normal LM mid LAD subtotal occlusion with marked haziness (Unstable Plaque with thrombotic burden. Markedly diseased Lcx
The decision was made to proceed for LAD Intervention.
While I was discussing with the Pt relatives that he was in need for urgent PCI, the Pt developed agonizing chest pain and raising ST seg. Emergency PCI was started using XB 3.5 smoothly selected LM (without any difficulty) contrast injection I saw that the LAD is totally occluded marked raising of ST segm. VF Cardiac massage was initiated while DC immediately prepared.

However, an injection revealed a contrast stain of the ascending aorta and also showing spiral dissection of the LM artery involving the LAD and circumflex arteries. The patient SR was returned but complained of intractable chest pain, agitation and marked hypotension.

O2 therapy, Morphia, Inotropes, and other emergency TTT.

Call for cardiac surgery.

An intra-aortic balloon pump may help to stabilize the patient and should be used as a bridge to surgery but here was contraindicated in the presence of concomitant aortic dissection.

Injection after resuscitation
Revealing catastrophic iatrogenic complication.
This movement is an Artificial respiration and There is cardiac arrest.
BMW universal passed quickly then a balloon 2X

Balloon inflation at the site of LAD occlusion

The patient was Bardycardic>>Cardiac Arrest. This movement is artificial respiration
After resuscitation>>>
Restoring SR

1st Stent positioning of LAD to fix the 1ry Lesion and dissec...
Angiogram after long DES to LAD.
NC Balloon to LM then flaring at the LM ostium at high Pressure.
After LM stenting, the patient’s chest pain and ST segment elevation were resolved. His ejection fraction moderately depressed (EF 45%) and the patient was discharged 4 days later in stable condition.

He visited us 2 ws ago in good QOL.
Conclusion

- Ascending aorta and Left main artery (LM) dissection is a catastrophic complication of angiography and angioplasty that should be managed promptly once encountered, using stents which start distal to proximal up to 1-2mm outside LM with ostial fanning by NC Balloon (to seal entry hole of dissection).

Be careful of Cardiac Massage while Deep engagement of the Guiding catheter in LM>>> to my recommendation it is better to withdraw the Catheter before massage then re-engage again.

- ‘Watchful waiting’ is a reasonable option in the hemodynamically stable patient with a low-grade self limiting aortic and LM dissection. The presence of hemodynamic instability is the main indication for quicky PCI while calling Cardiac surgery.

Thanks for your Attention