



# ‘Hangover’ after side-branch stenting

The discomfort comes afterwards

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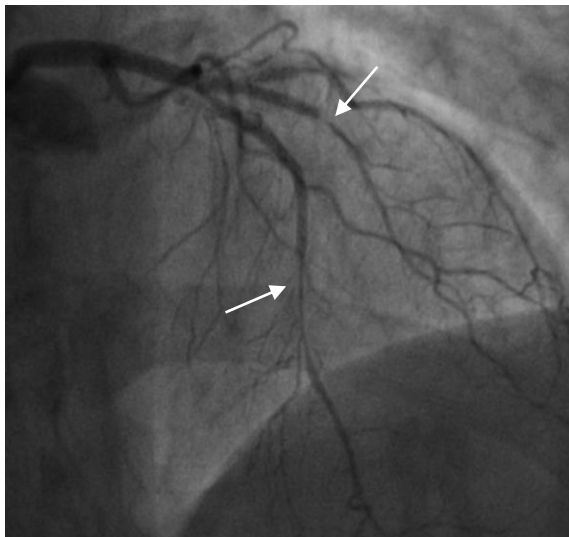
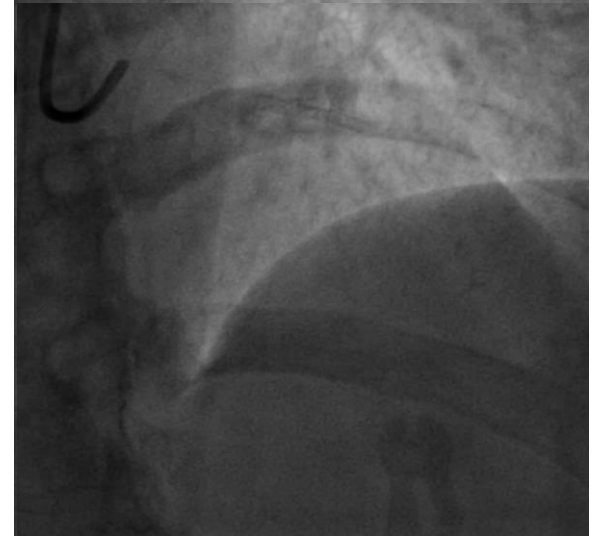
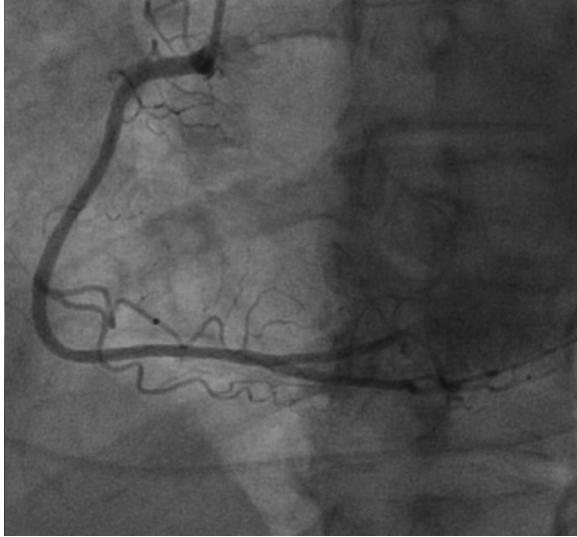
- There are no conflicts of interest to be declared.

- Speaker: R.H.J.A. Volleberg

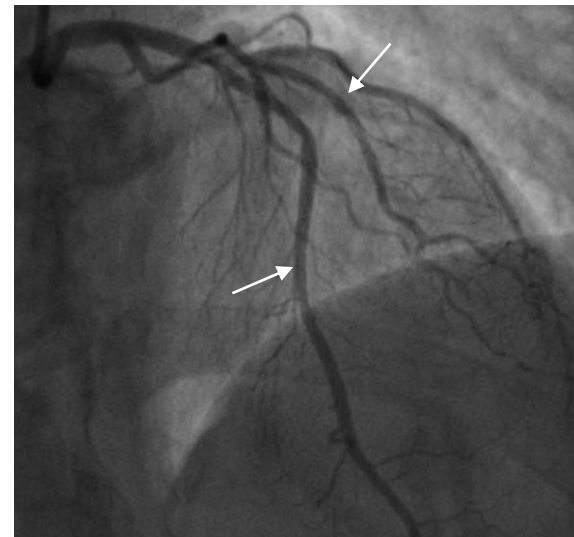
47 year old female

- Cardiovascular history: 2018 instable angina requiring 2x DES D1; left anterior descending mid 50%, FFR negative.
- Recurrent angina at rest and on exertion
- Fatigue
- No risk factors for cardiovascular disease
- Diltiazem 80mg once daily, isosorbidmononitrate 50mg once daily
- Referred for second opinion; recurrent angina caused by microvascular dysfunction or coronary artery spasm?

# Coronary angiography

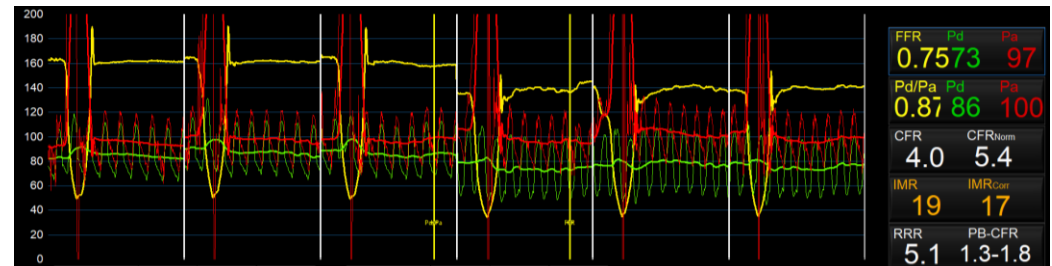
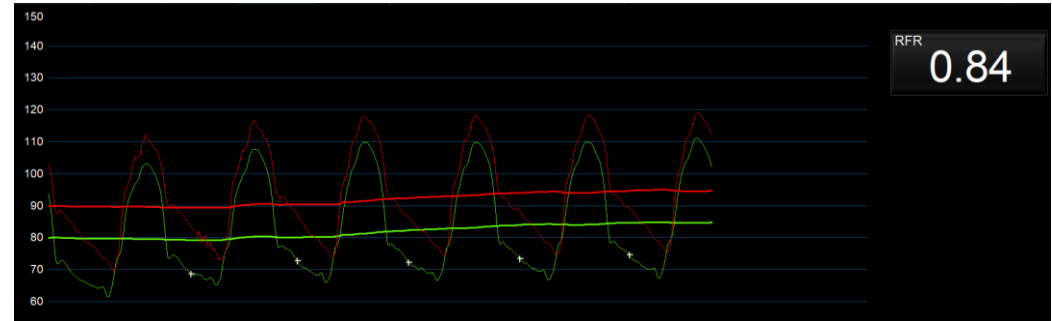
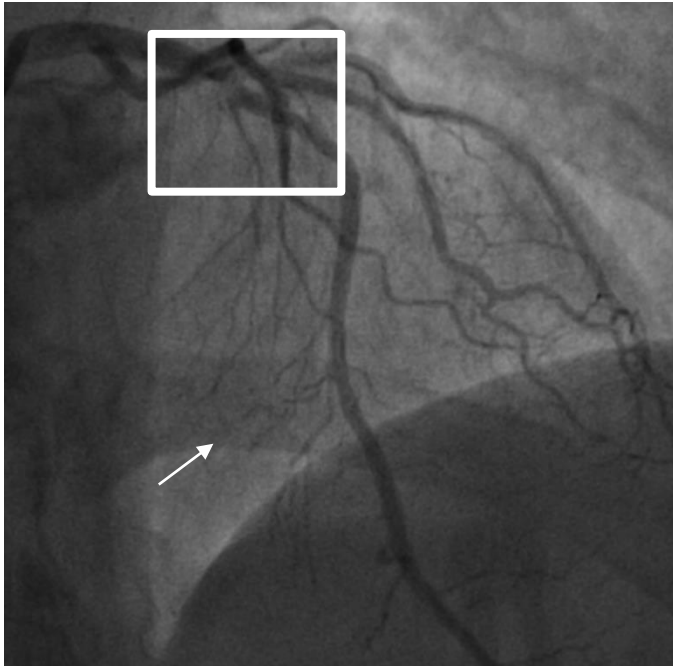


Acetylcholine



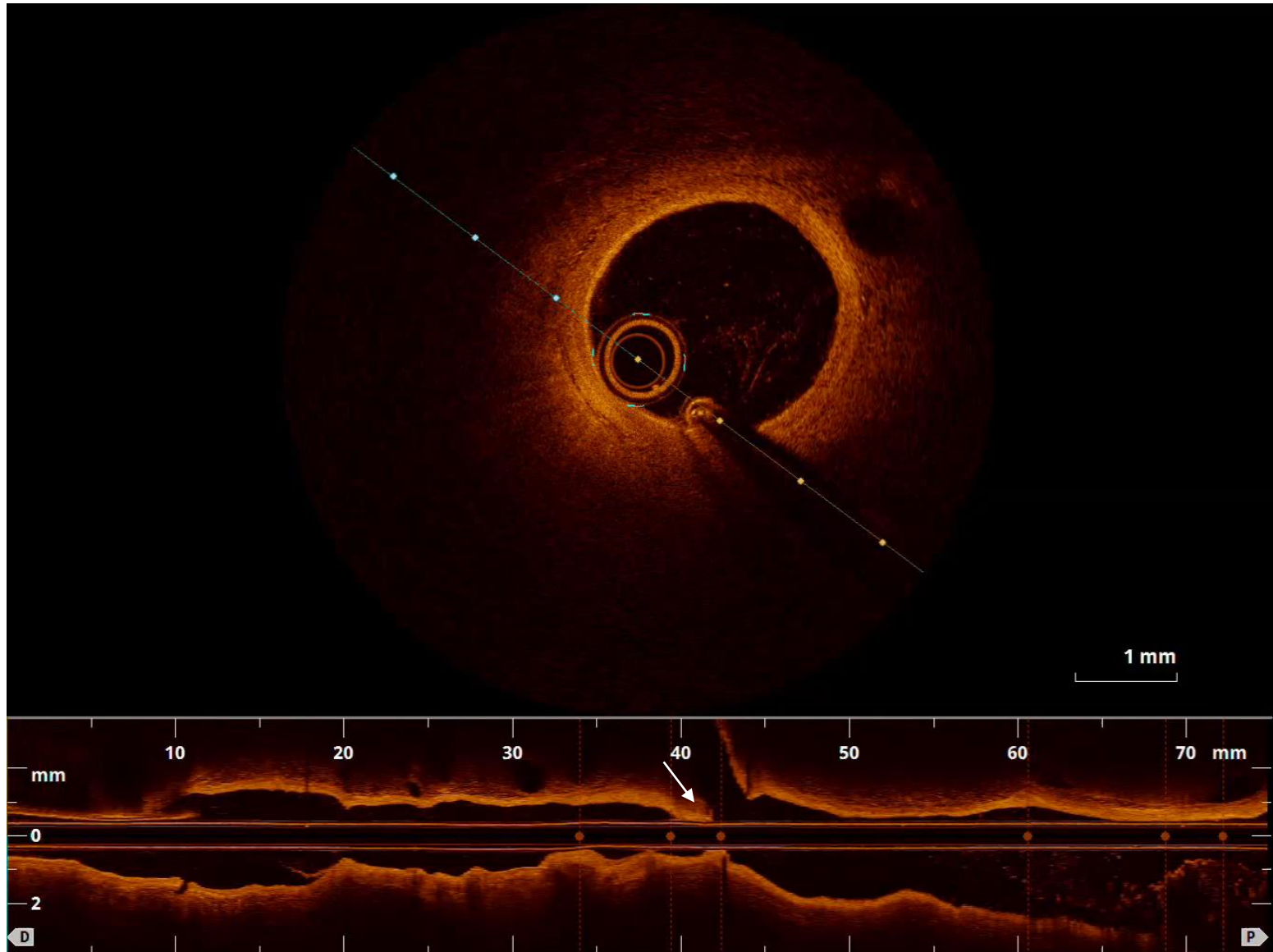
Nitrogen

# Left anterior descending lesion

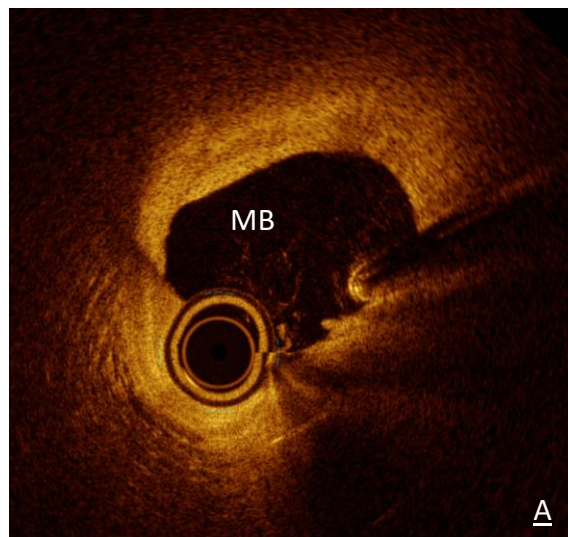


## Adenosine

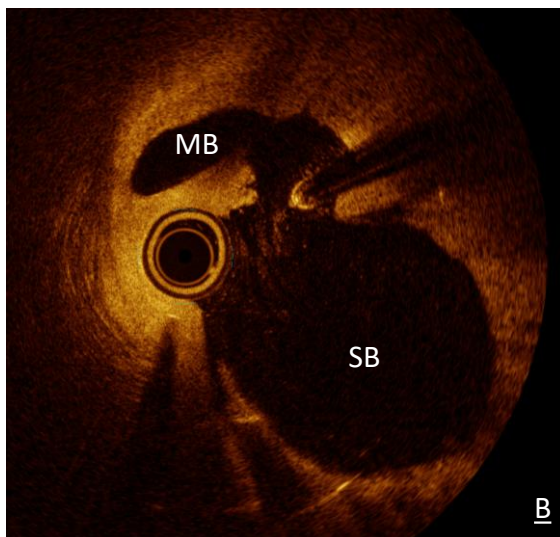
- Diffuse epicardial spasms cause angina at rest
- Exertional angina is caused by functional lesion in left anterior descending artery
- Plan: OCT-guided PCI to assess underlying mechanism of obstruction



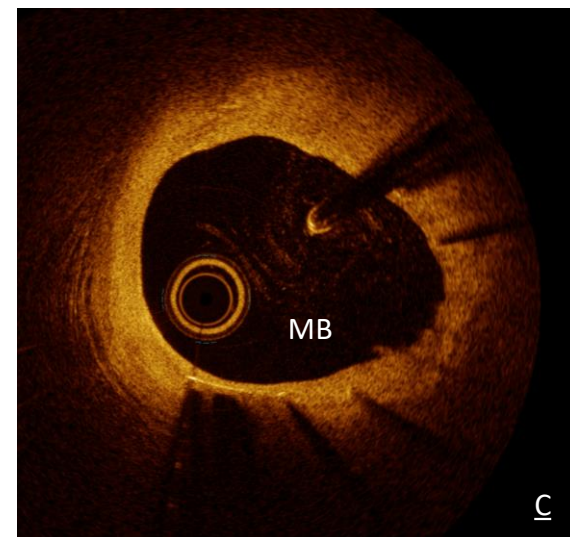




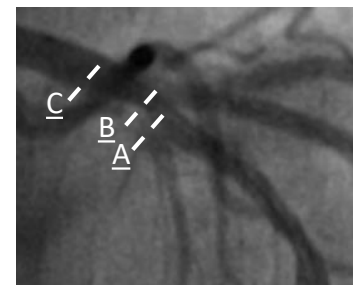
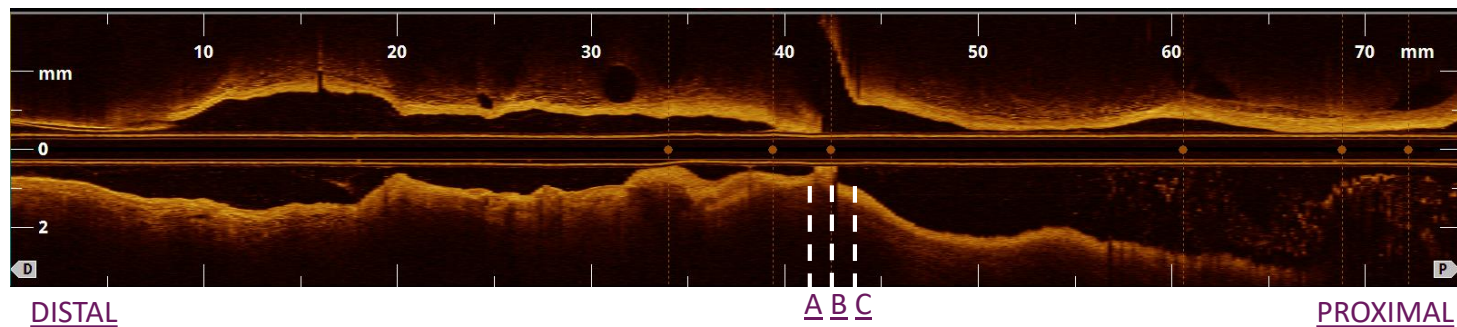
Stenosis of main branch distal to side branch



Carina shift towards main branch



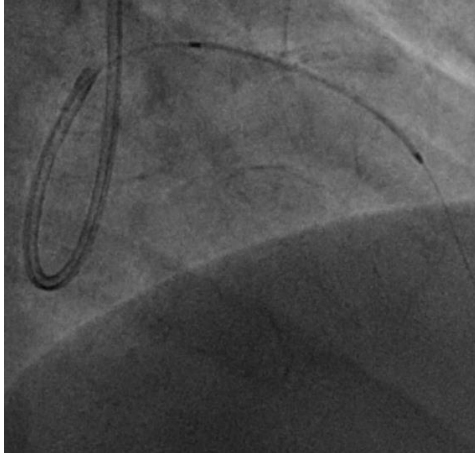
Stent protrusion into the main branch



MB main branch  
SB side branch

# PCI of the left anterior descending artery

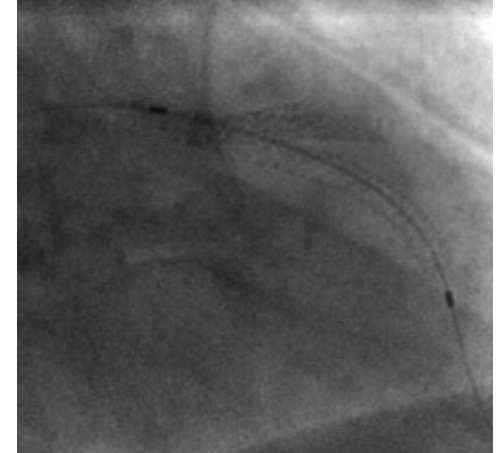
Radial access, .035" guidewire



Positioning over target lesion



DES (3.0x38) implantation, 16 atm



In the meantime



Intermediate result

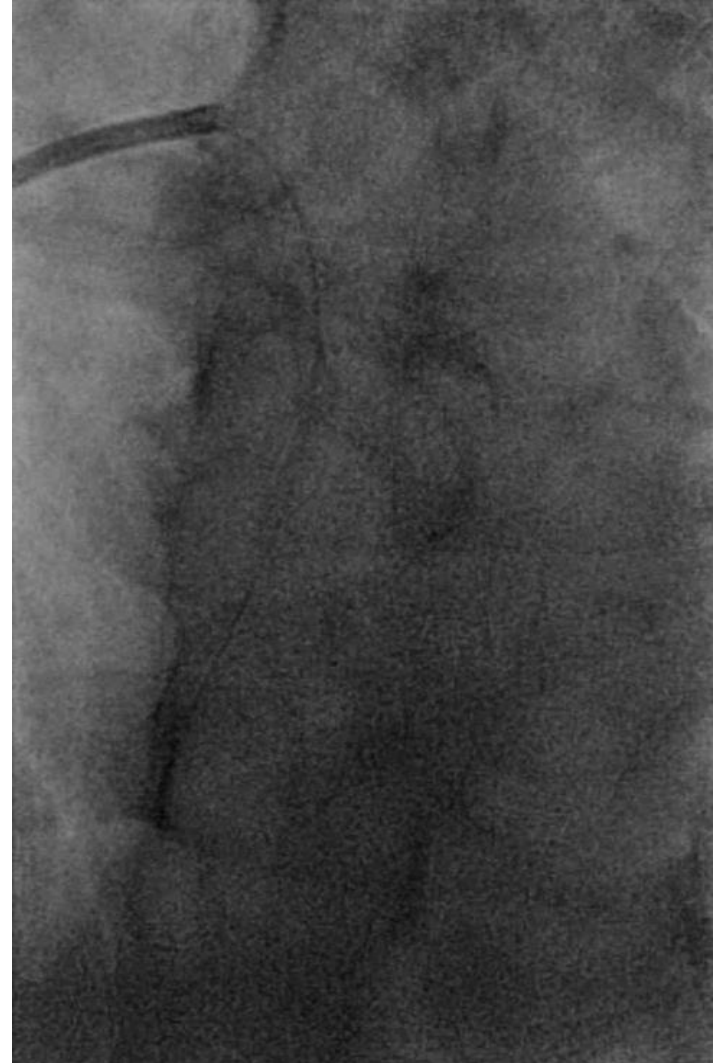


Postdilatation 20 atm



Postdilatation 20 atm





- Full functional testing (FFR, acetylcholine, coronary microvascular resistance) identified two mechanism for angina in this patient
- OCT is valuable for detecting stent protrusion as the underlying mechanism for obstructive coronary artery disease
- Carina shift and neo-intima bridging may compromise the main branch in case of stent protrusion
- After side branch stenting, stent protrusion into the main branch is not to be neglected