



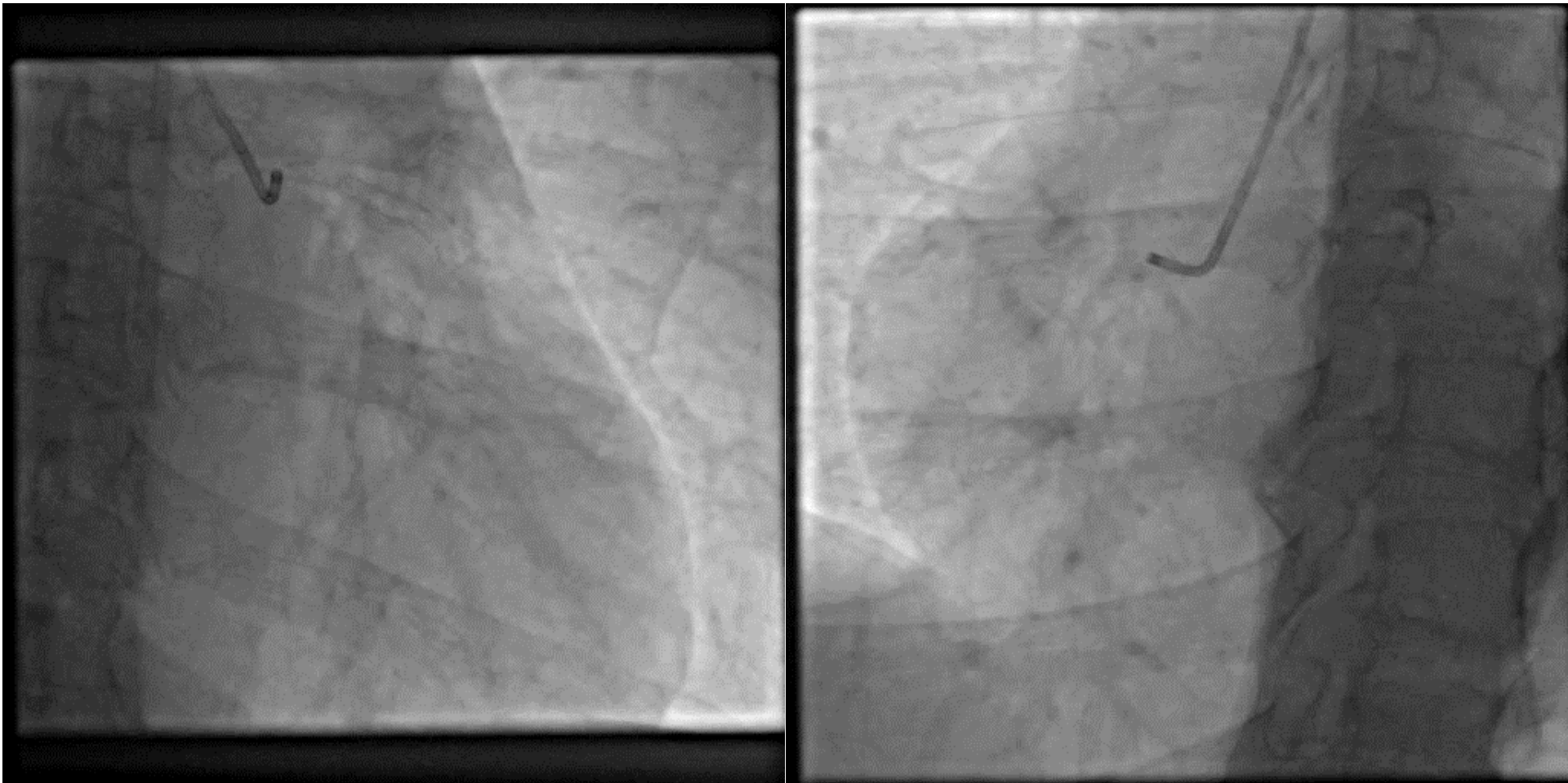
# A life-threatening complication of radial access

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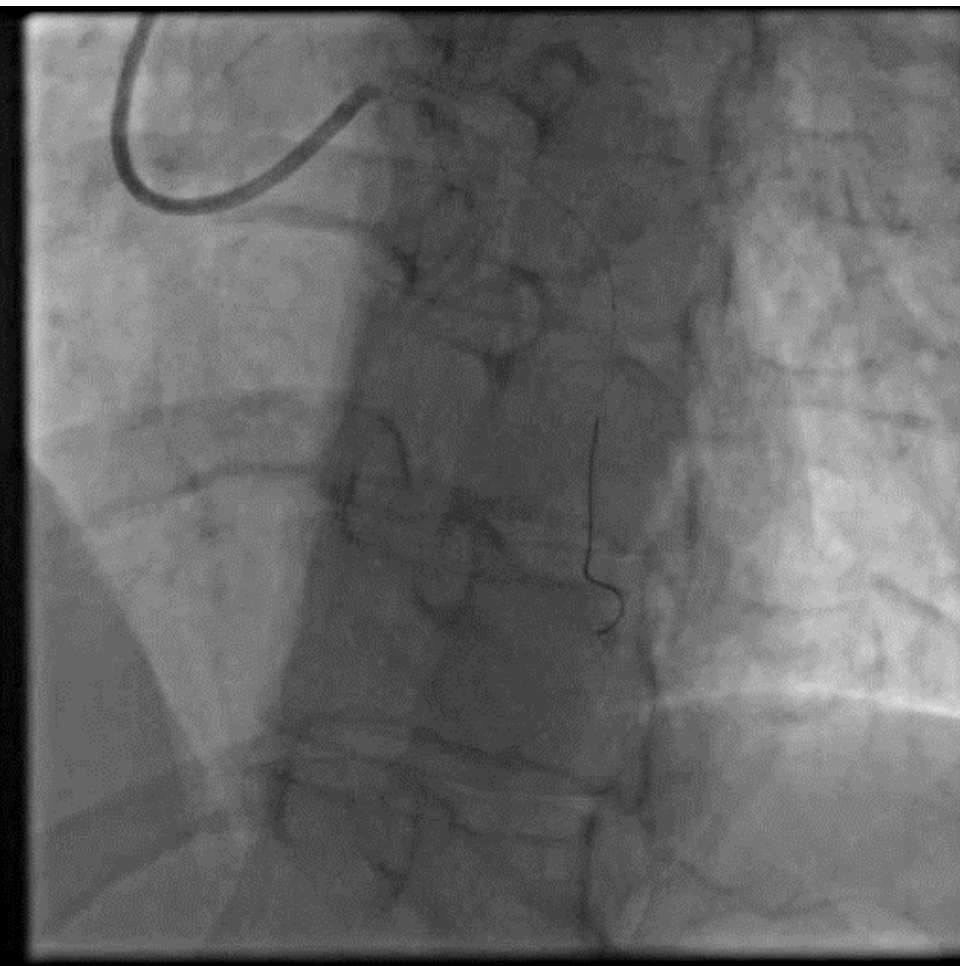
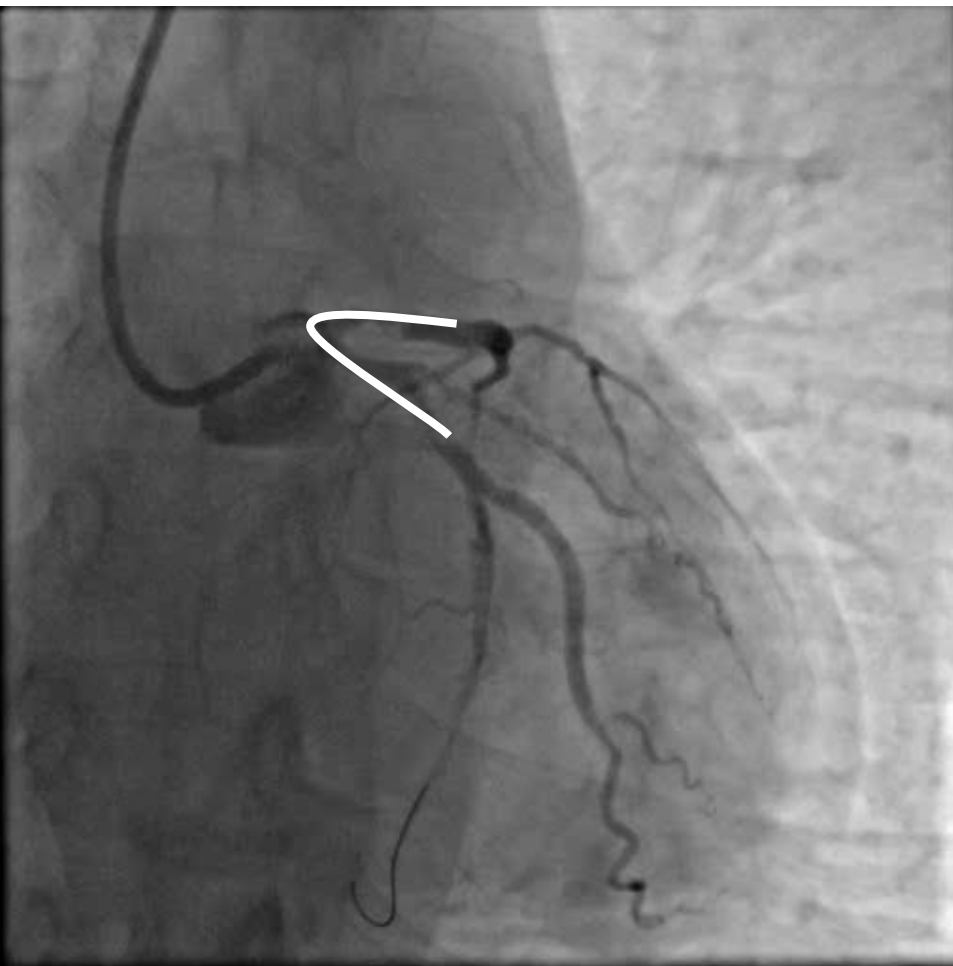
Emergency Institute for Cardiovascular Diseases  
and Transplantation, Tirgu Mures, Romania

- **A 54-year-old female** with insulin treated **diabetes mellitus** type 2;
- Uneventful elective PCI of the left anterior descending artery (2 DES) and an obtuse marginal branch (1 DES) 3 months ago;
- Readmission for symptoms of **effort angina pectoris**;
- Normal laboratory analyses, except a mild hyperglycaemia (134 mg/dl) ;
- Left ventricular ejection fraction: 65%.

# Diagnostic angiography, right radial approach

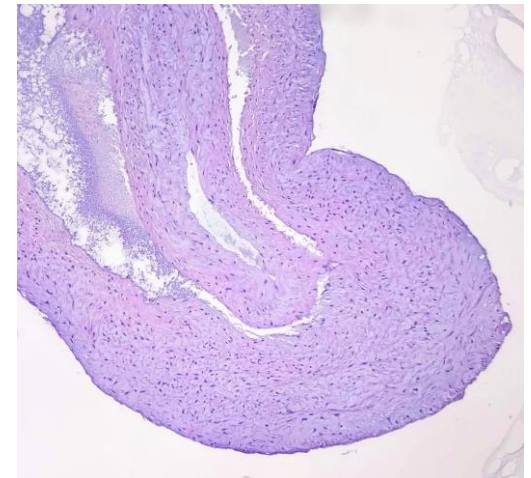
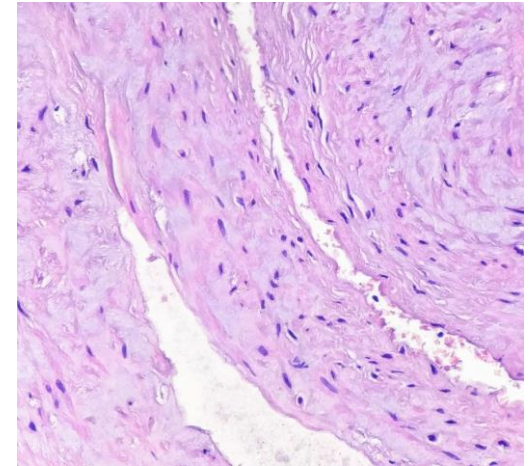
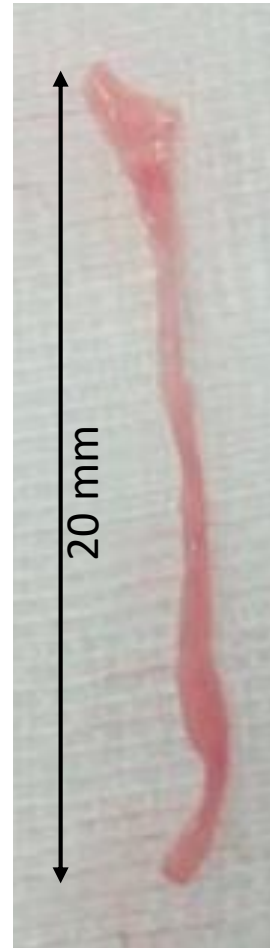


# First contrast medium administration after diagnostic angiography





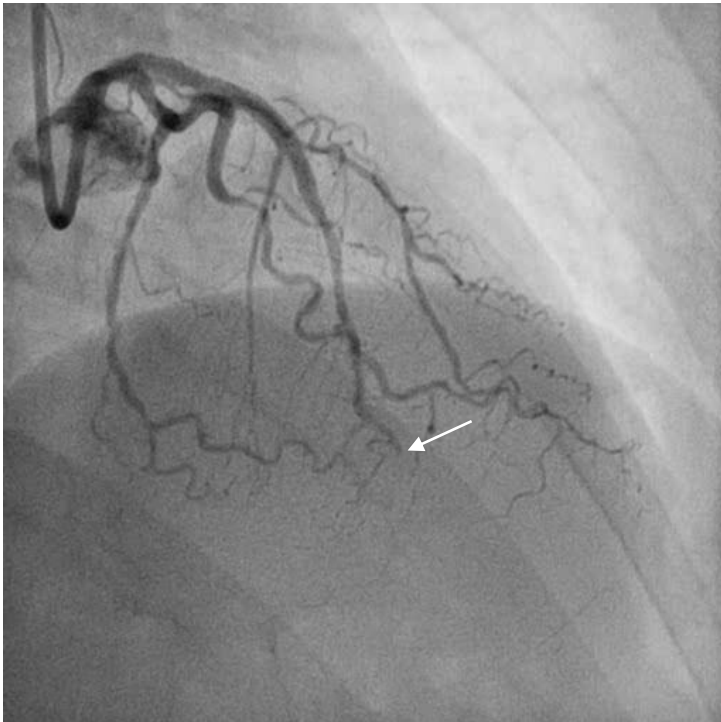
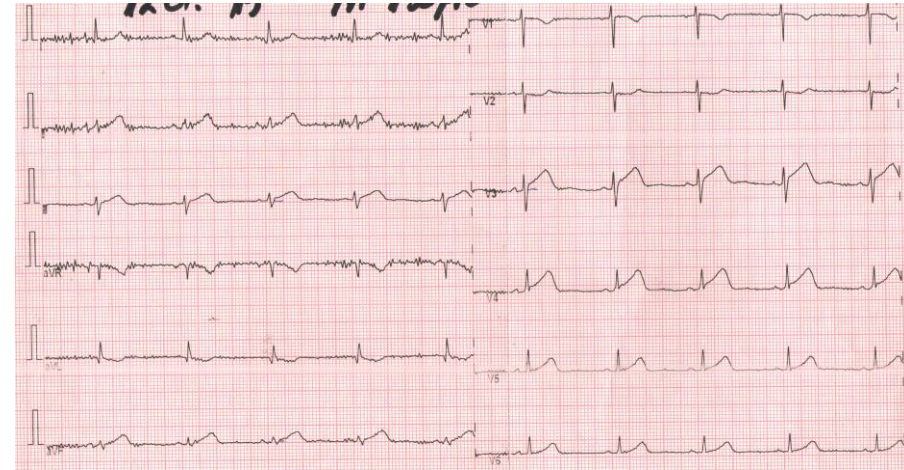
# Result of the intervention



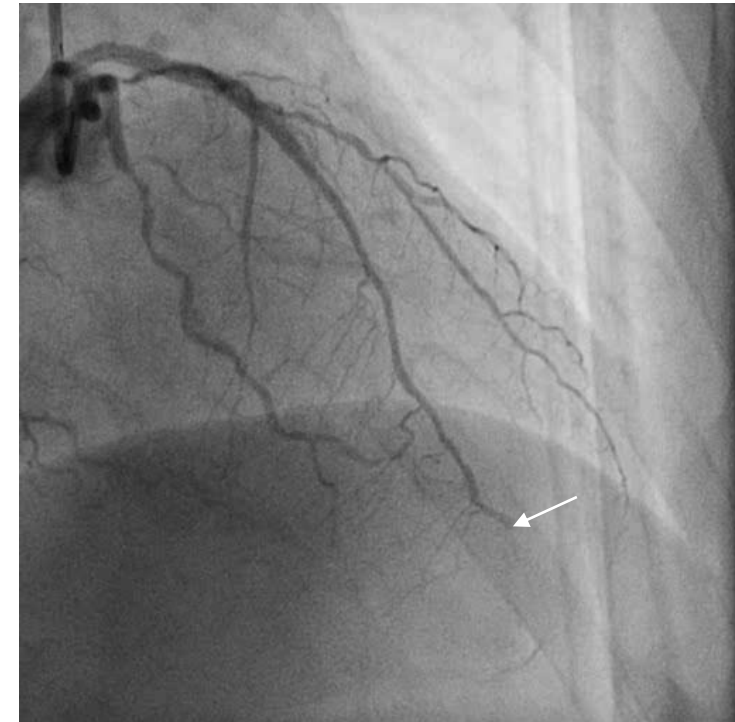
# Reintervention?

At 90 minutes after the intervention:

- chest pain is still present
- persistent ST-segment elevation
- right forearm hematoma



- Right femoral approach
- 6 French extra backup 3.5 guiding catheter
- repeat thrombus aspiration
- balloon angioplasty (1.5/20 mm, 10 atmospheres)

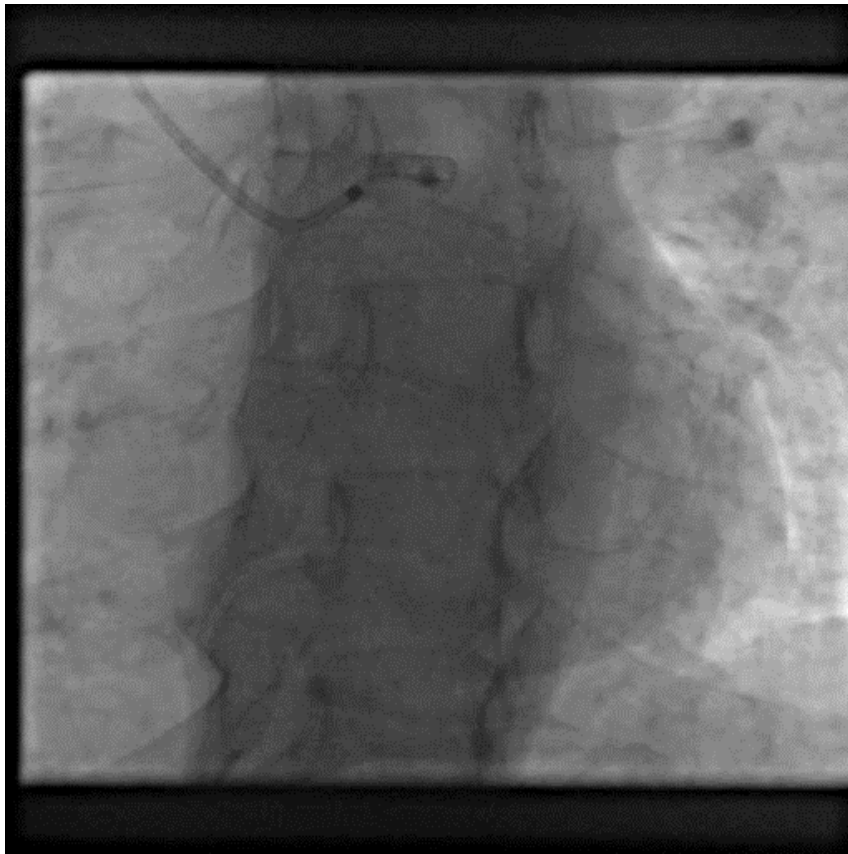




**In hospital evolution – discharge at 2 weeks after PCI**

- Peak creatin phosphokinase level: 677 U/l (normal range: 0-195 U/l); LVEF: 47%
- Dressler's pericarditis needing colchicine therapy

**Long term evolution – at 1.5 years LVEF 55%, coronary angiography from right radial approach:**



- Preventive strategies:
  - intraarterial verapamil in addition to glycerin trinitrate;
  - inflated balloon in front of the guiding catheter during advancement;
  - meticulous flushing;
  - femoral approach for PCI if important radial spasm is still present
- Treatment: manual aspiration could be effective
- Late arterial recanalization?