Managing Stent Dislodgement during Primary PCI

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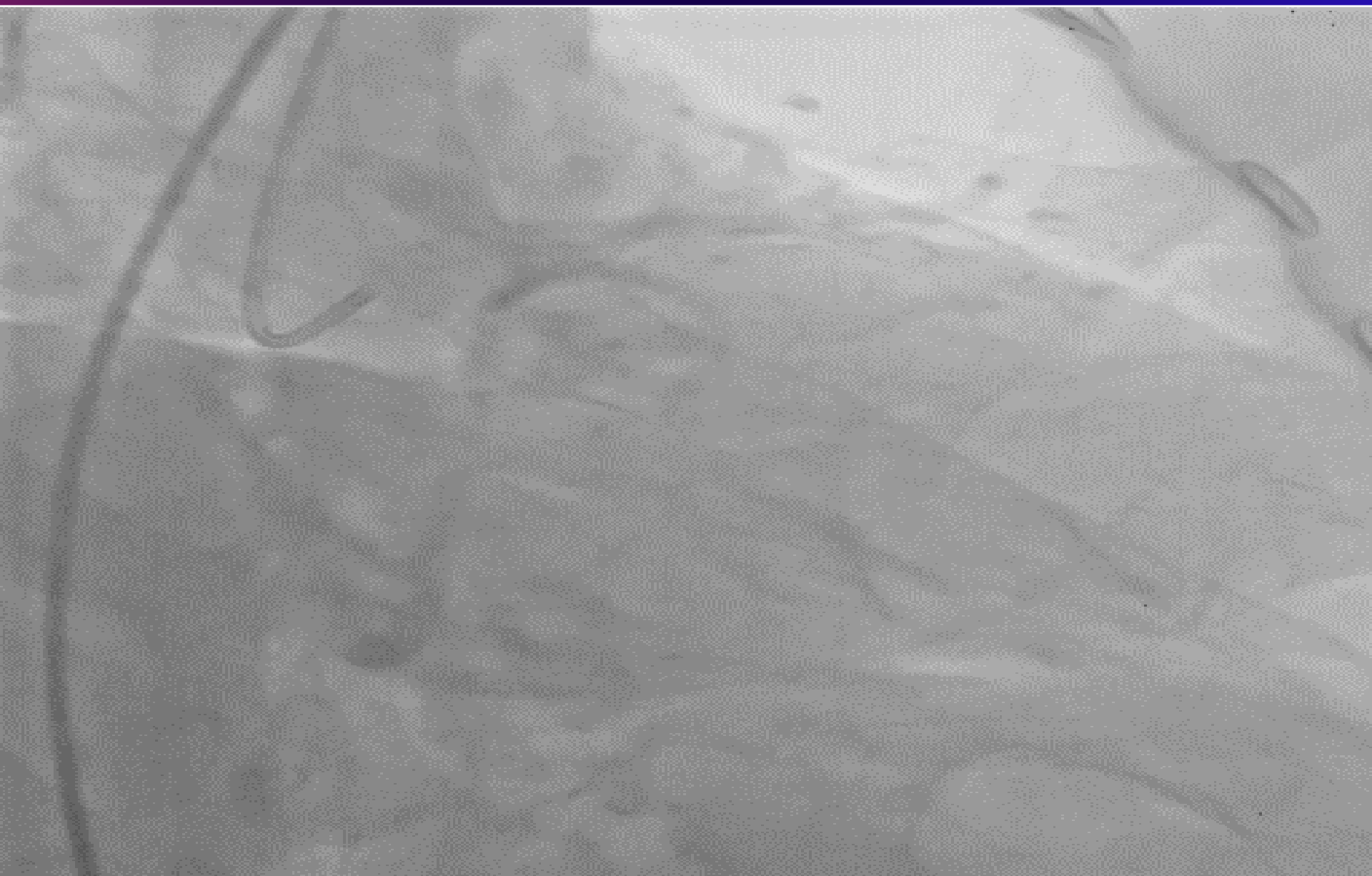
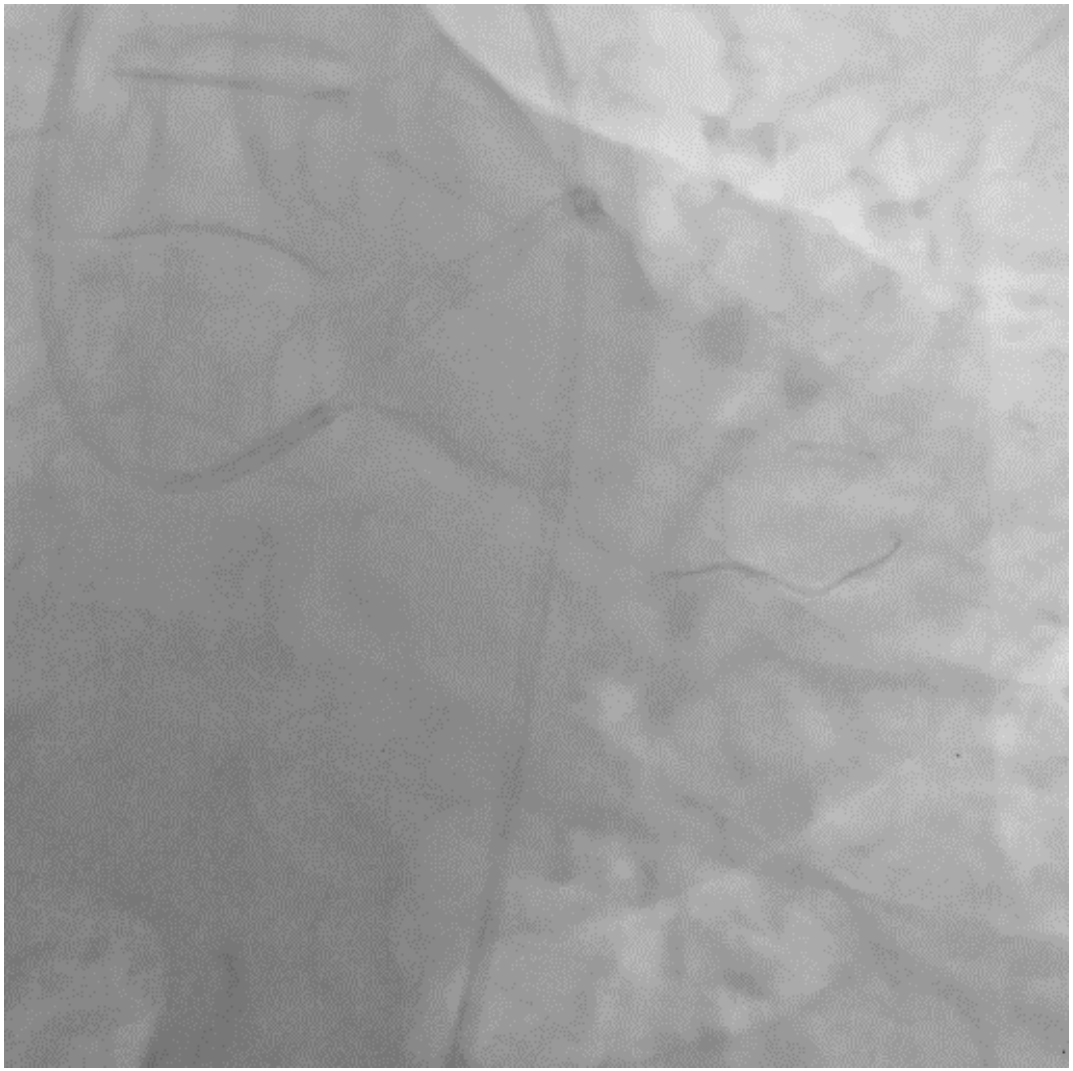
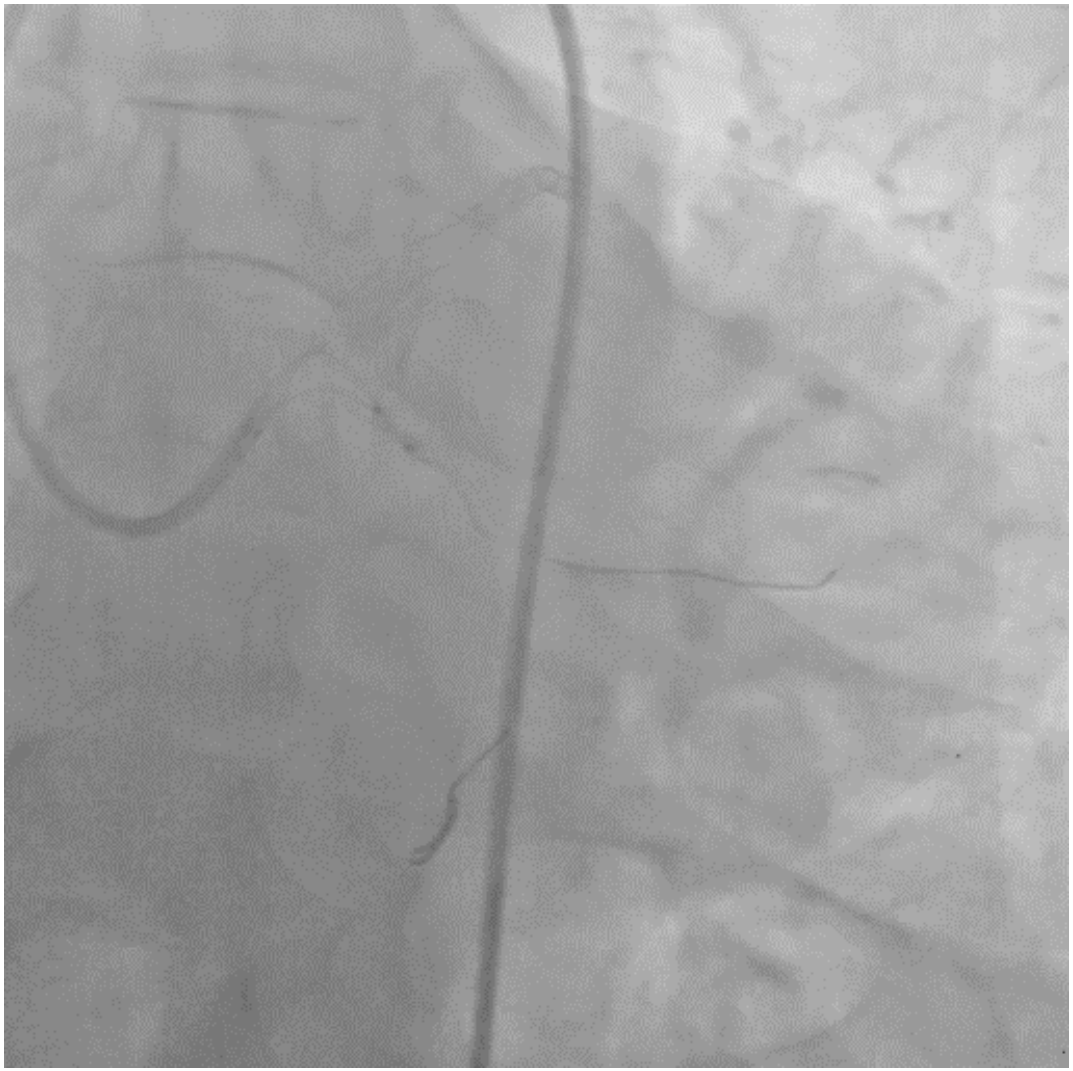
Clinical Presentation

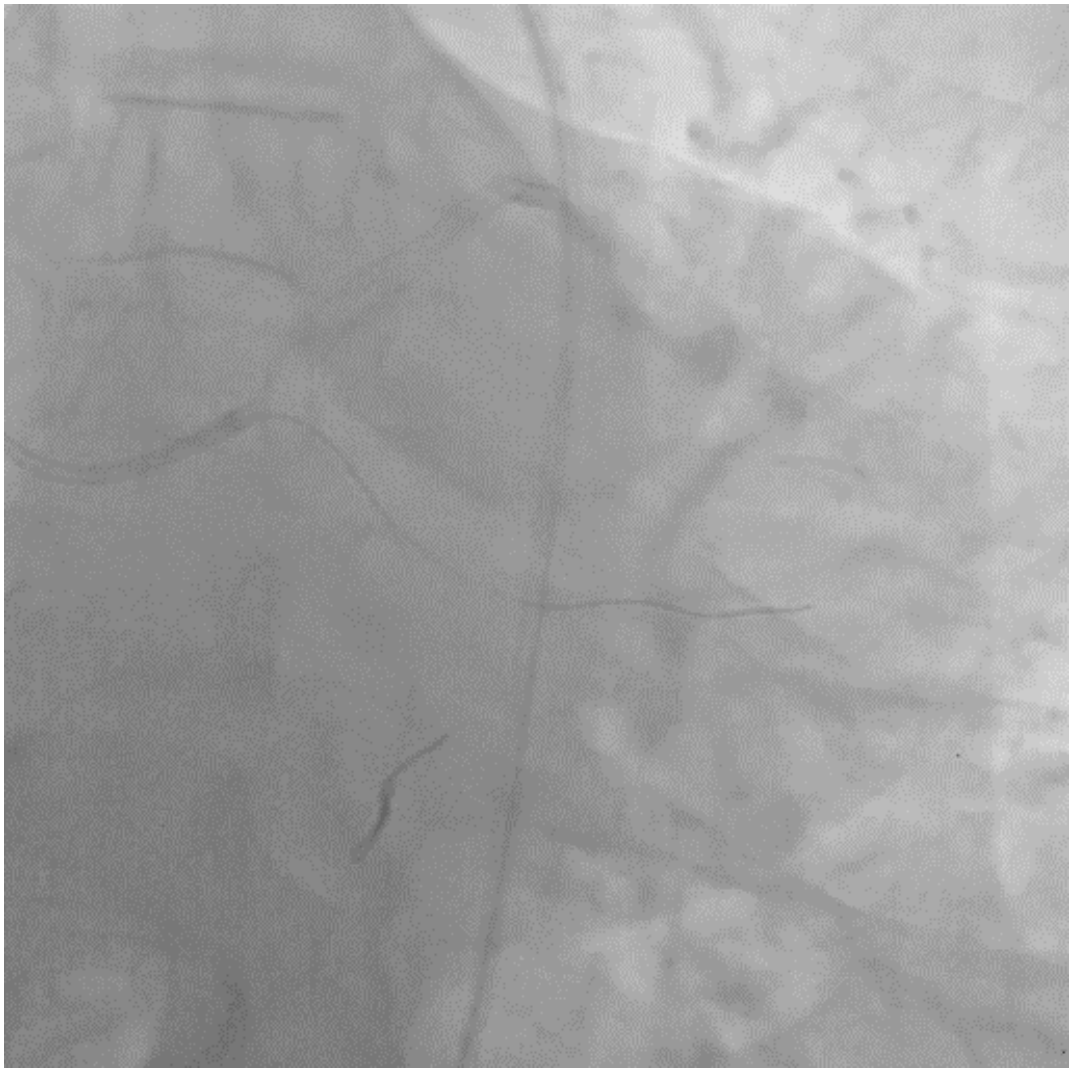
- 68 yr old male
- No comorbidities
- Smoker
- Known case of CAD: s/p PTCA with DES to OP LAD (2016)
- Presented with angina of 2 hour duration, reduced in intensity now when presented to the hospital
- ECG: ST elevation in inferior leads, sinus rhythm
- ECHO: Hypokinesia of Inferior wall, Inferoposterior wall, RLVSF-50% Grade I Mitral regurgitation, Normal PA pressure.
- Loading dose: Aspirin 325mg, Ticagrelor 180mg, Rosuvastatin 40mg, Inj UFH 4000 IU IV
- Planned for primay PCI

LAD stent Patent, Proximal LCX ulcerated 80% lesion, RCA: Normal

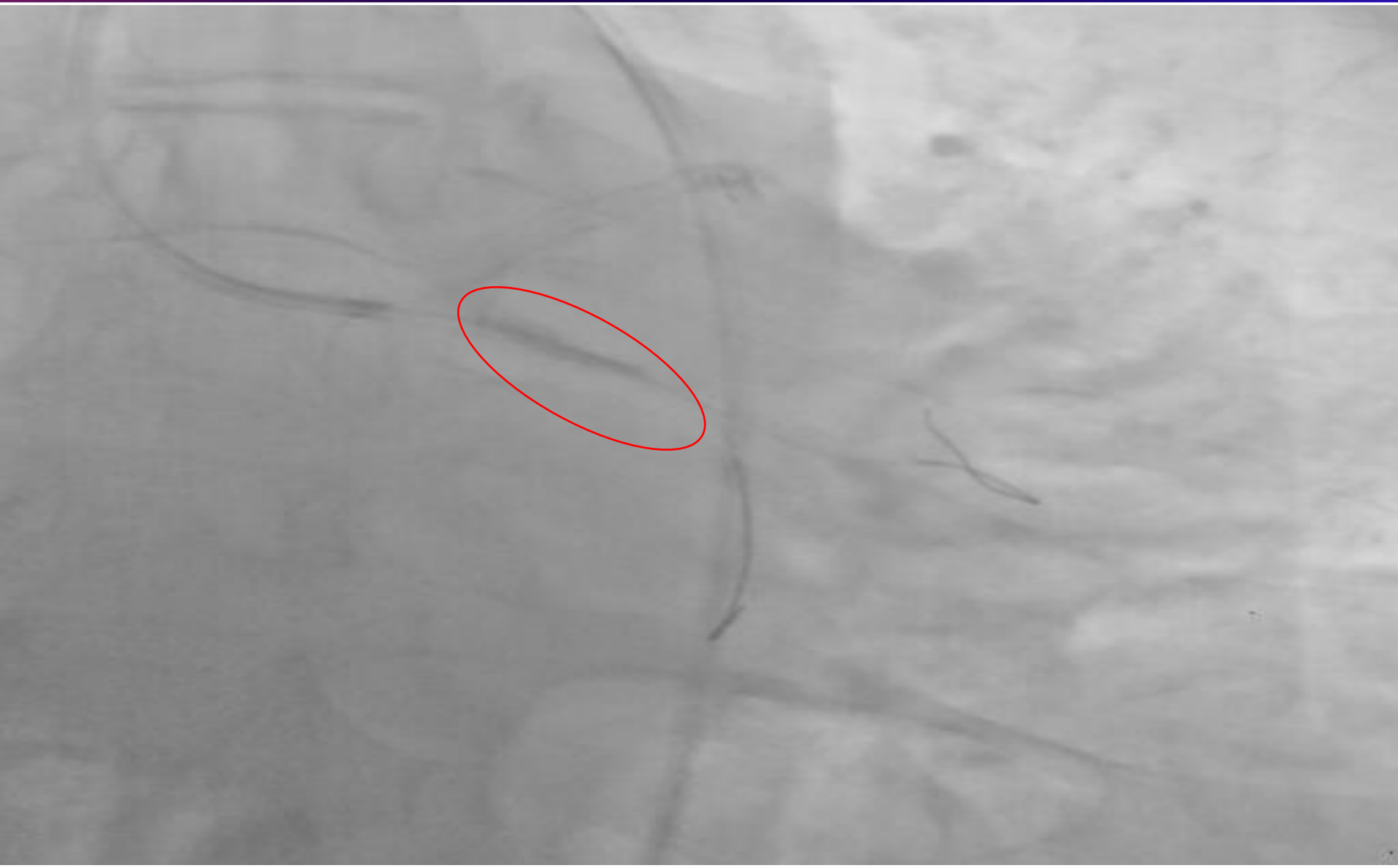








Dislodged Ultimaster 3.5 x 23 mm in proximal LCX



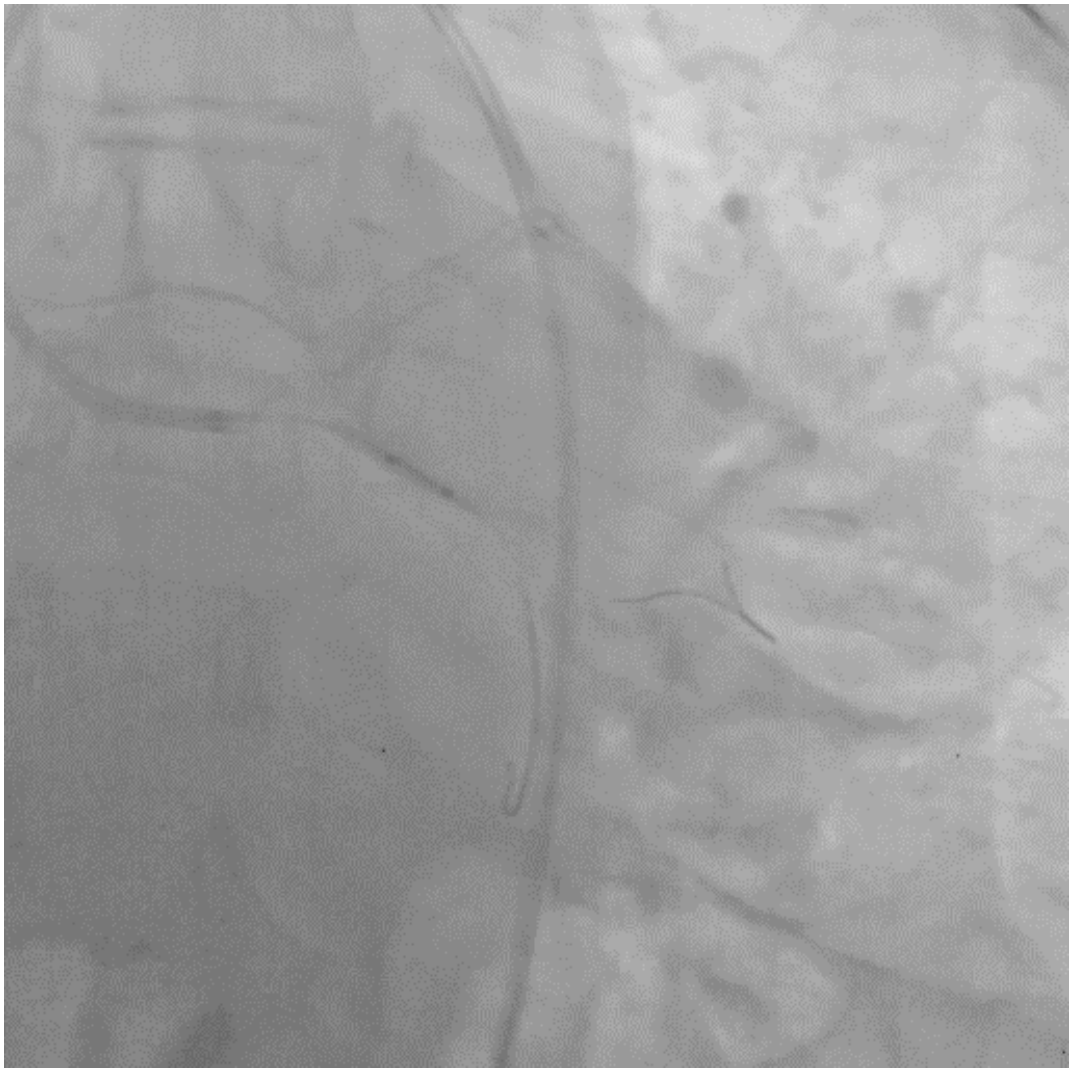
Now What to do?

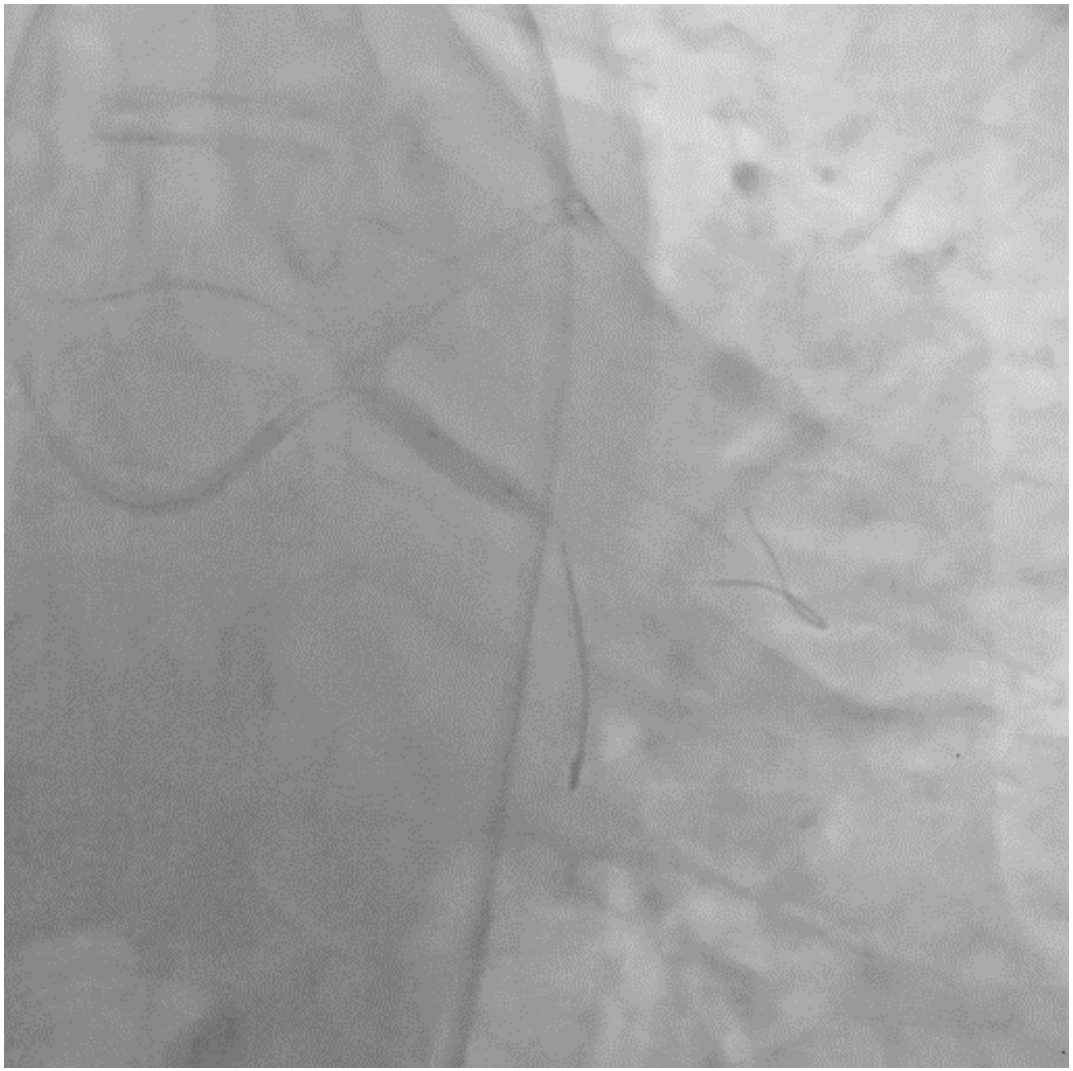
Things in our favour:

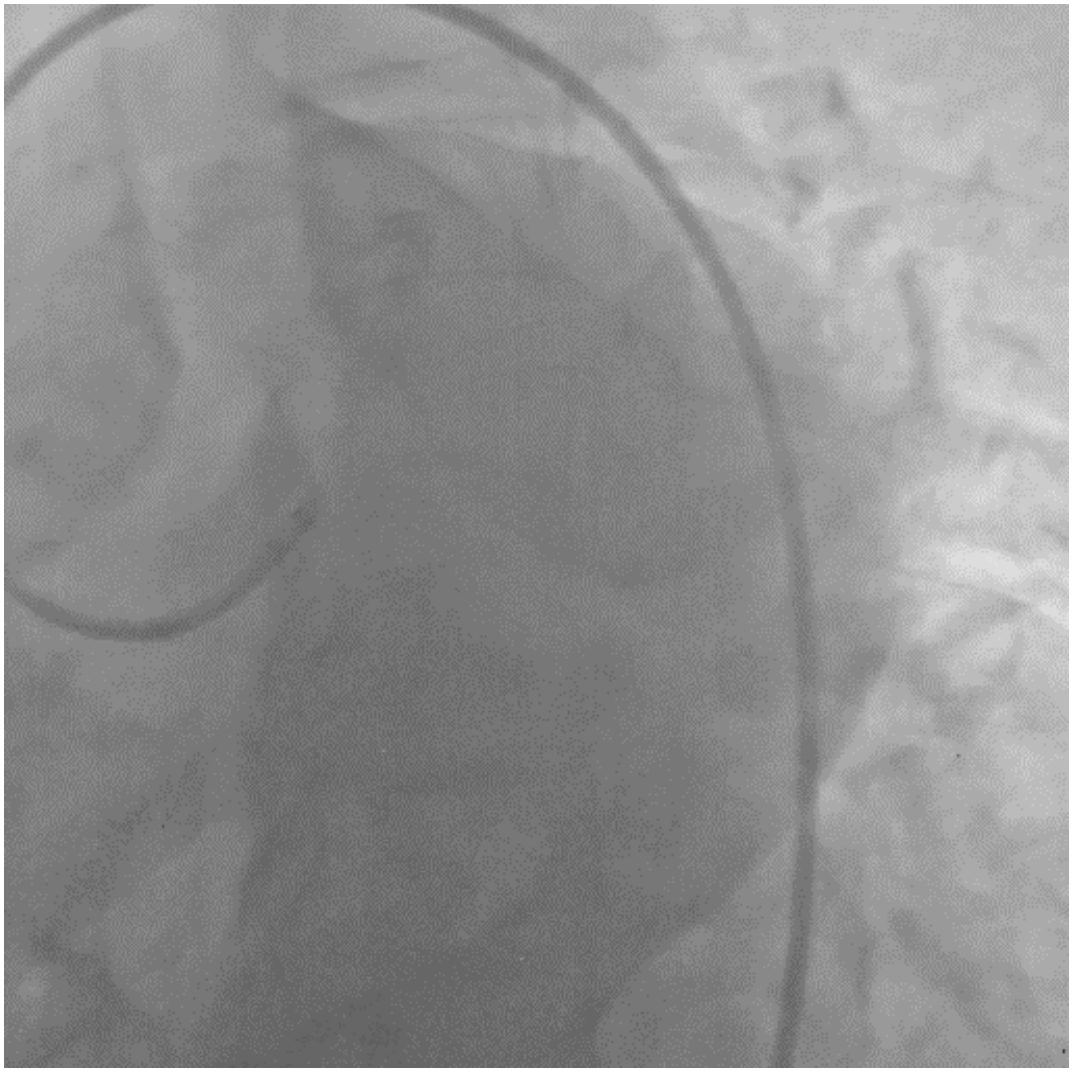
1. Stent on Wire
2. Stent already at the lesion site
3. Another wire already inplace

Possible treatment options:

1. Micro Snare the stent out
2. Pass another wire and externally rotate the wire and pull the whole assembly into the guide catheter
3. Crush the stent with another stent on the LCX wire
4. Try to inflate the same stent with sequential balloons







Conclusion

- Stent dislodgement is relatively uncommon in this era of great technological advancements in stent design and balloons.
- Poor lesion preparation, Aggressive guide manipulations, unfavourable anatomy, aggressive stent movements can play a role in dislodgement of the stent.
- Before adopting complex hardware based and technically challenging methods simple balloon inflation with semi compliant followed by NC balloon should be tried.

THANK YOU FOR KIND ATTENSION