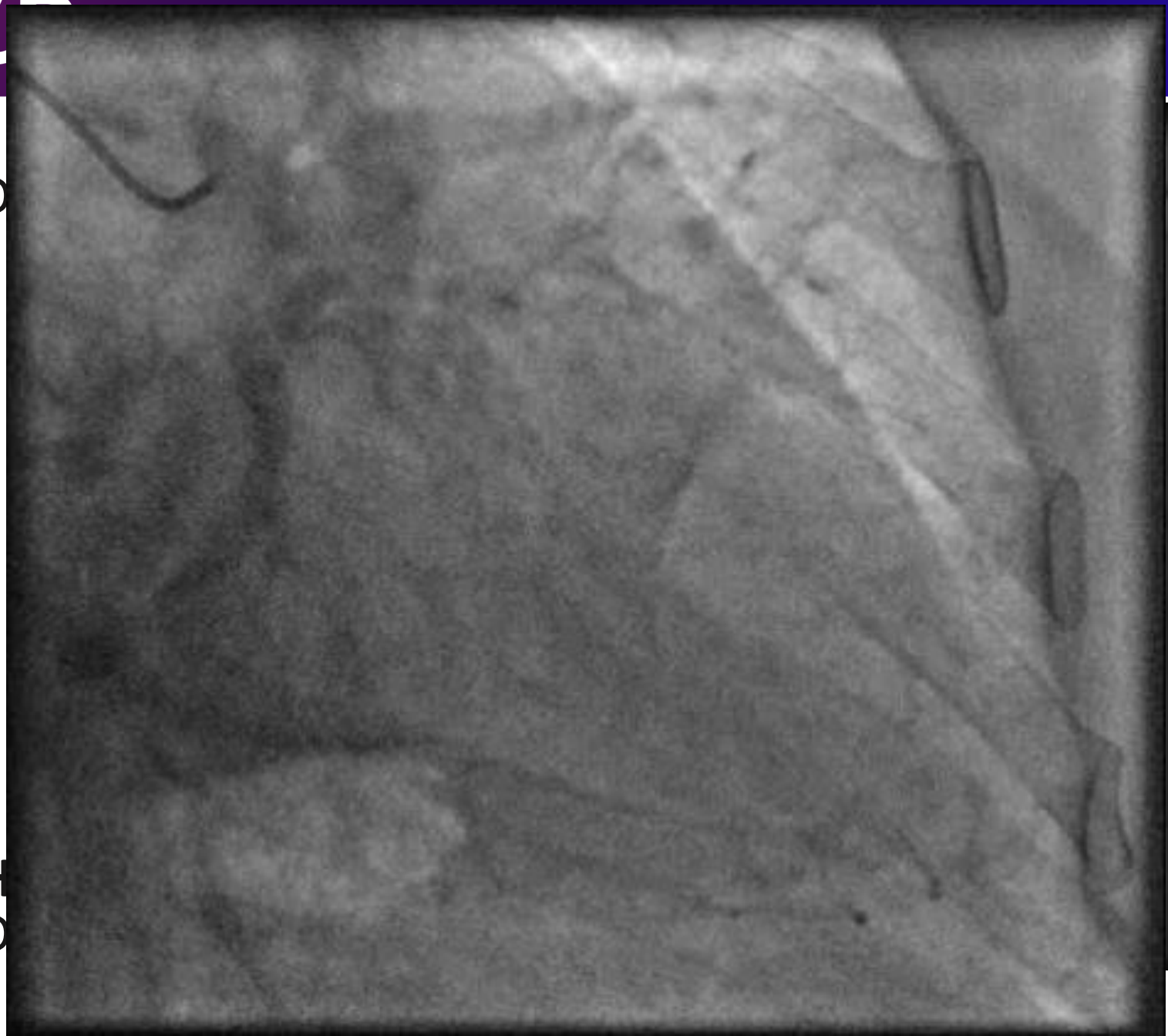
Deep engagement of guide extension catheter, a cautionary tale

Case History

- 76 year old male presented with worsening exertional angina, hs-troponin negative
- Fit and well with good functional baseline
- **PMH:** Hypertension, dyslipidemia
- **FH:** Father MI 64
- Non smoker

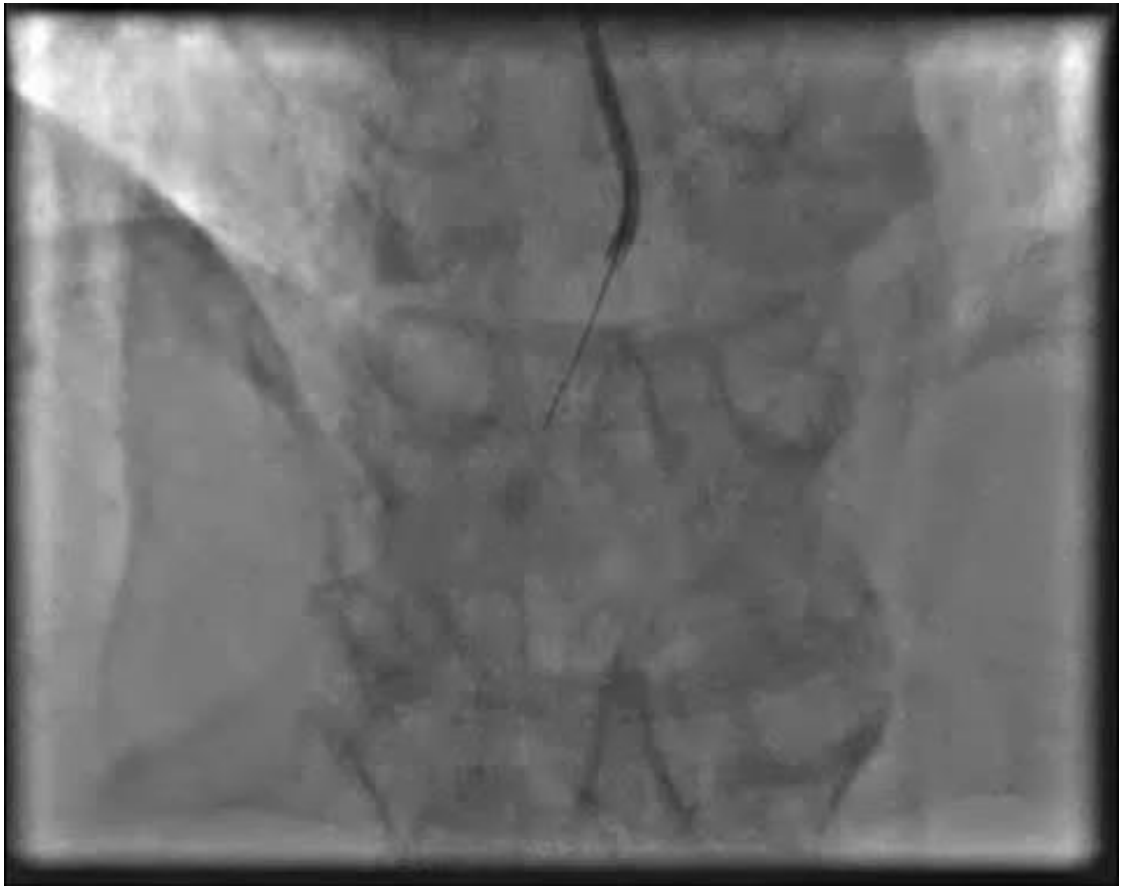
- Coronary angiogram performed based on high pre-test probability of CAD and convincing anginal symptoms on OMT: **ASA 75mg, bisoprolol 5mg, ISMN 60mg, ranolazine 500mg bd, atorvastatin 80mg.**

- D

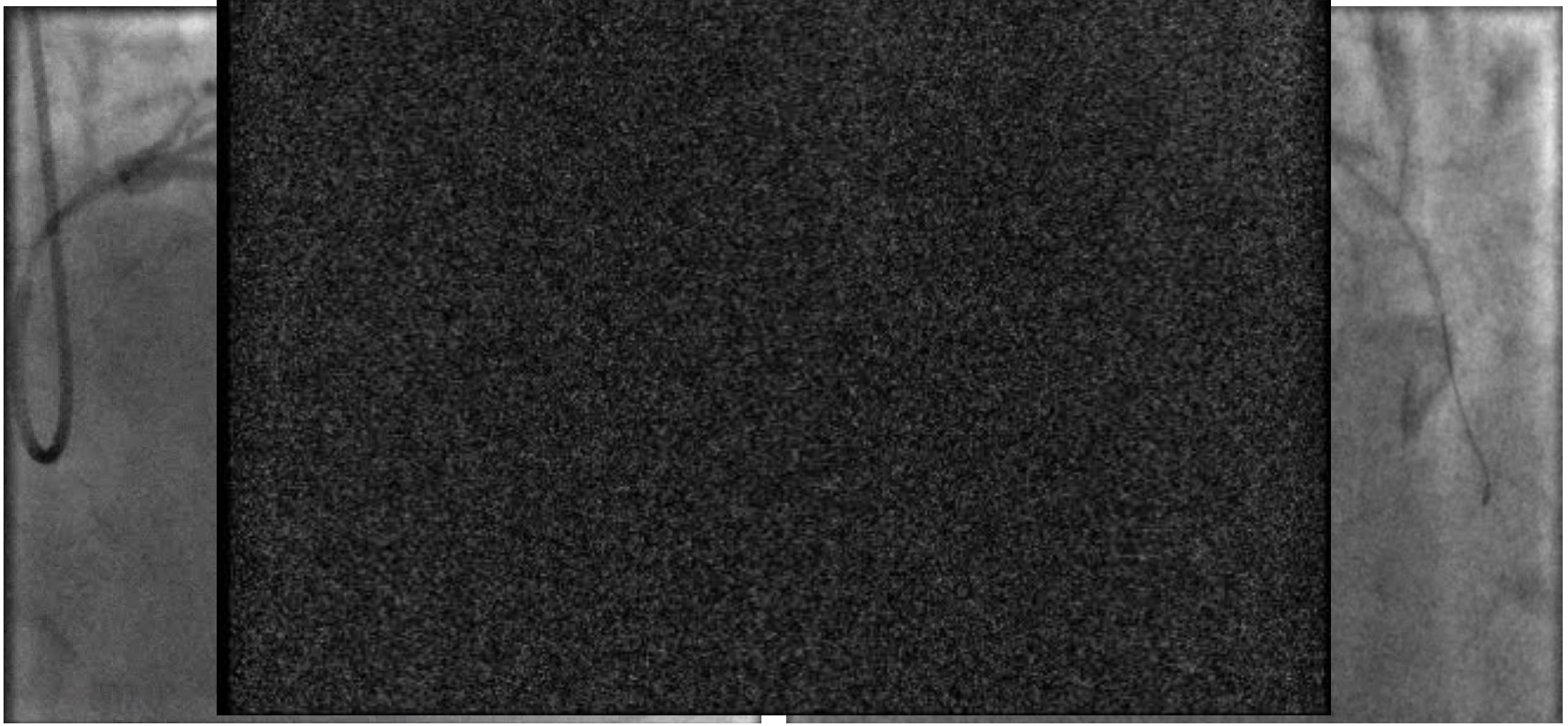


- H
  D

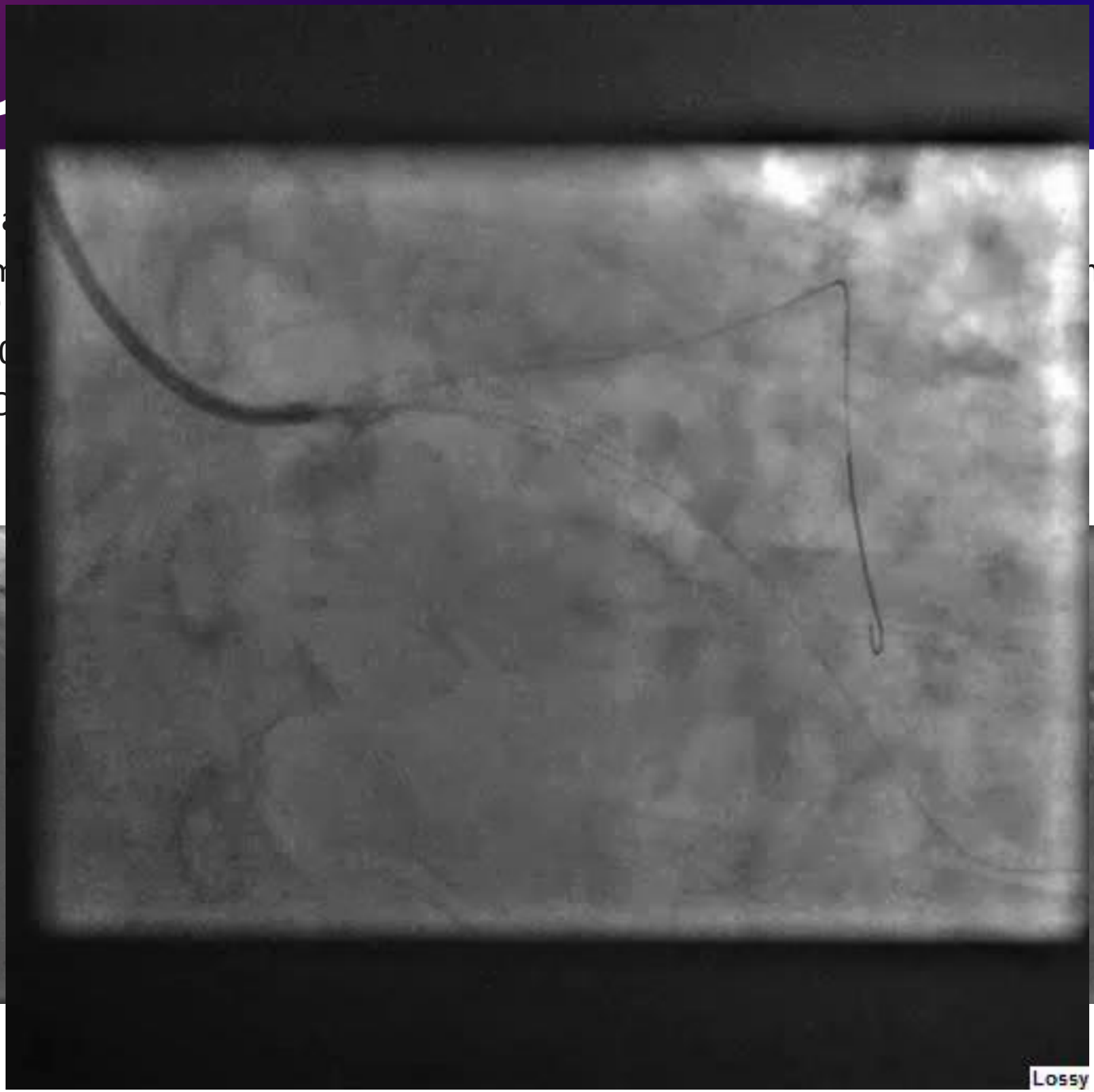
- RCA PCI performed without incident with 4.0x38mm Synergy stent post dilated to 5.0 with NC balloon. Good angiographic result.

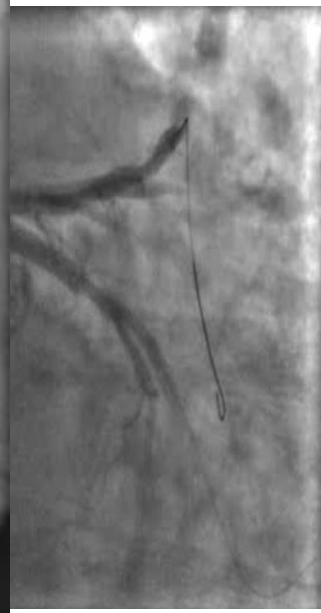


- Proceed
- Guide ex
- Subsequ S involving LAD/Cx/

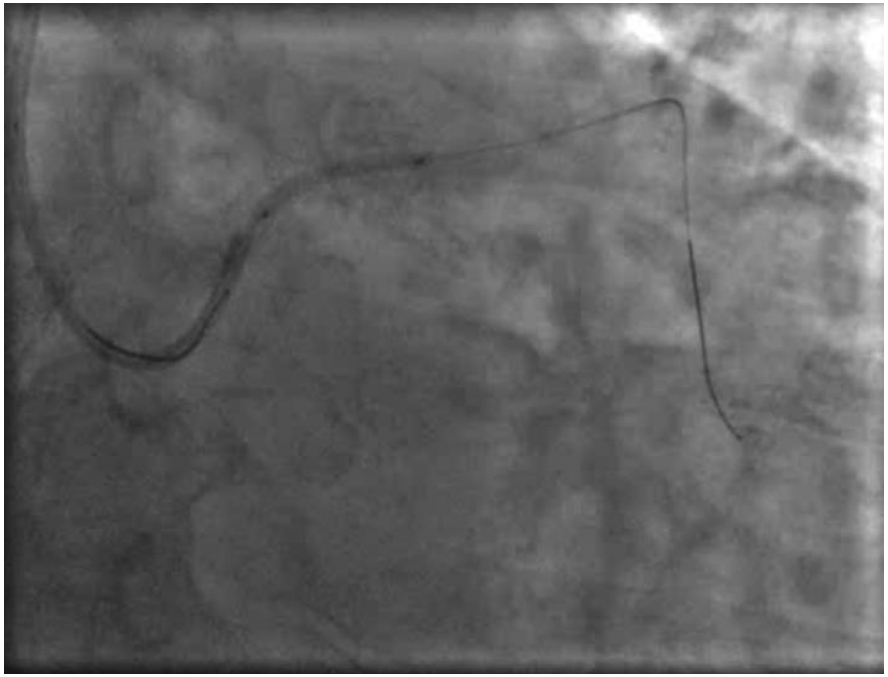


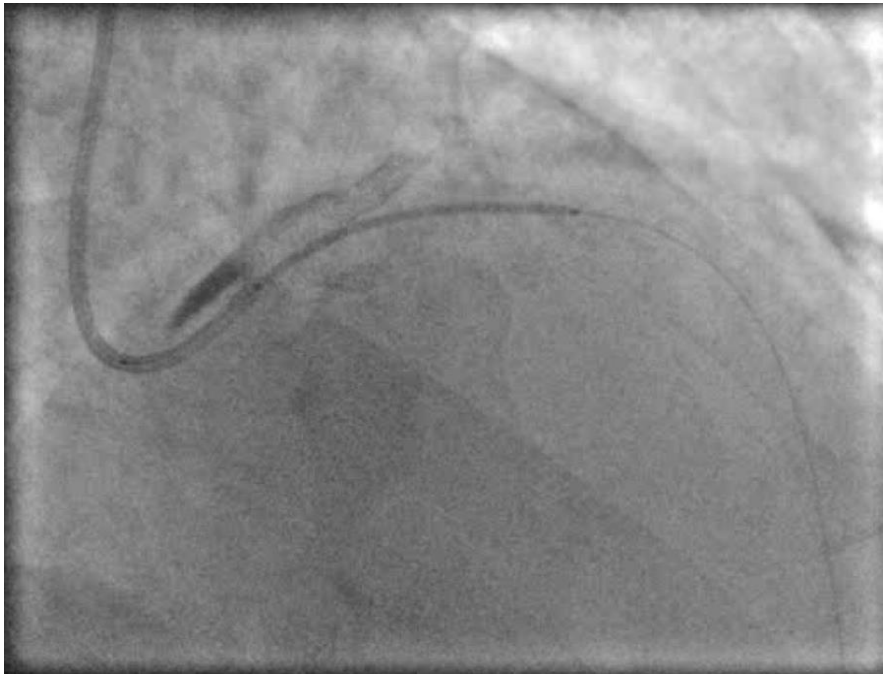
- Di
- Em n re-directed to
- 4.0
- PC



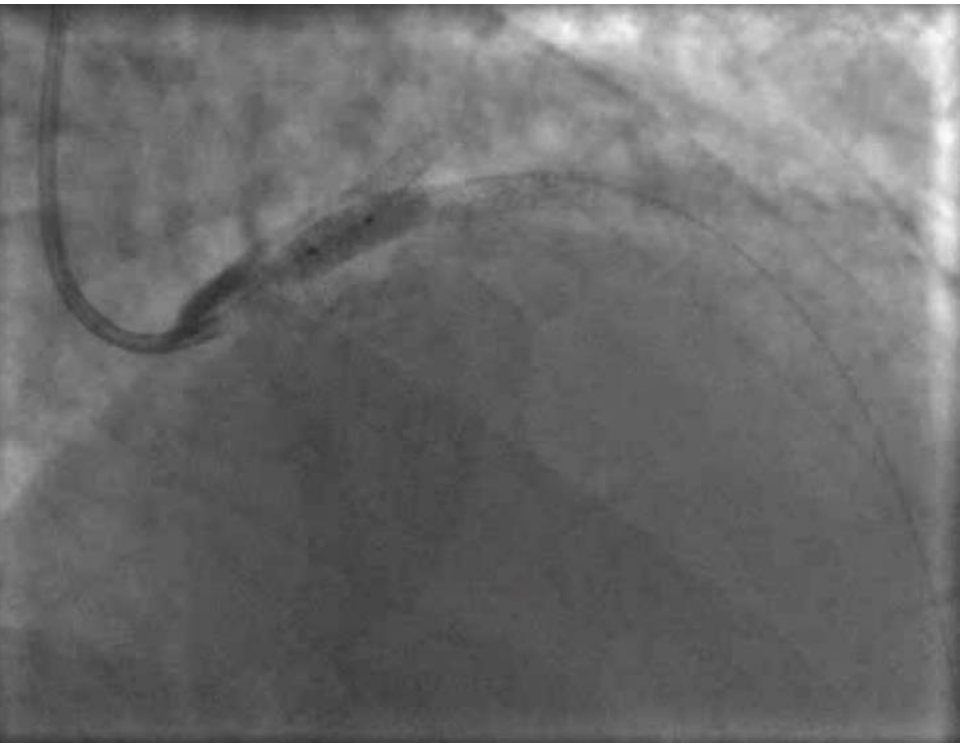


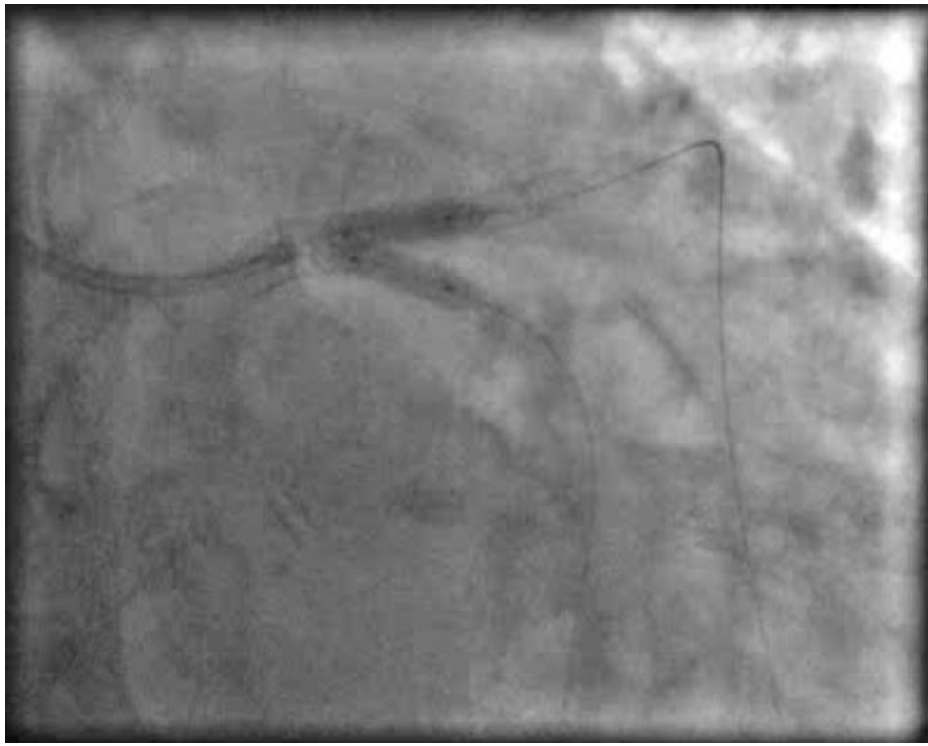
- Struts of LCx stent recrossed with sion wire and opened with 2.0x20mm emerge balloon
- 4.0x32mm Synergy deployed from LM to proximal LAD





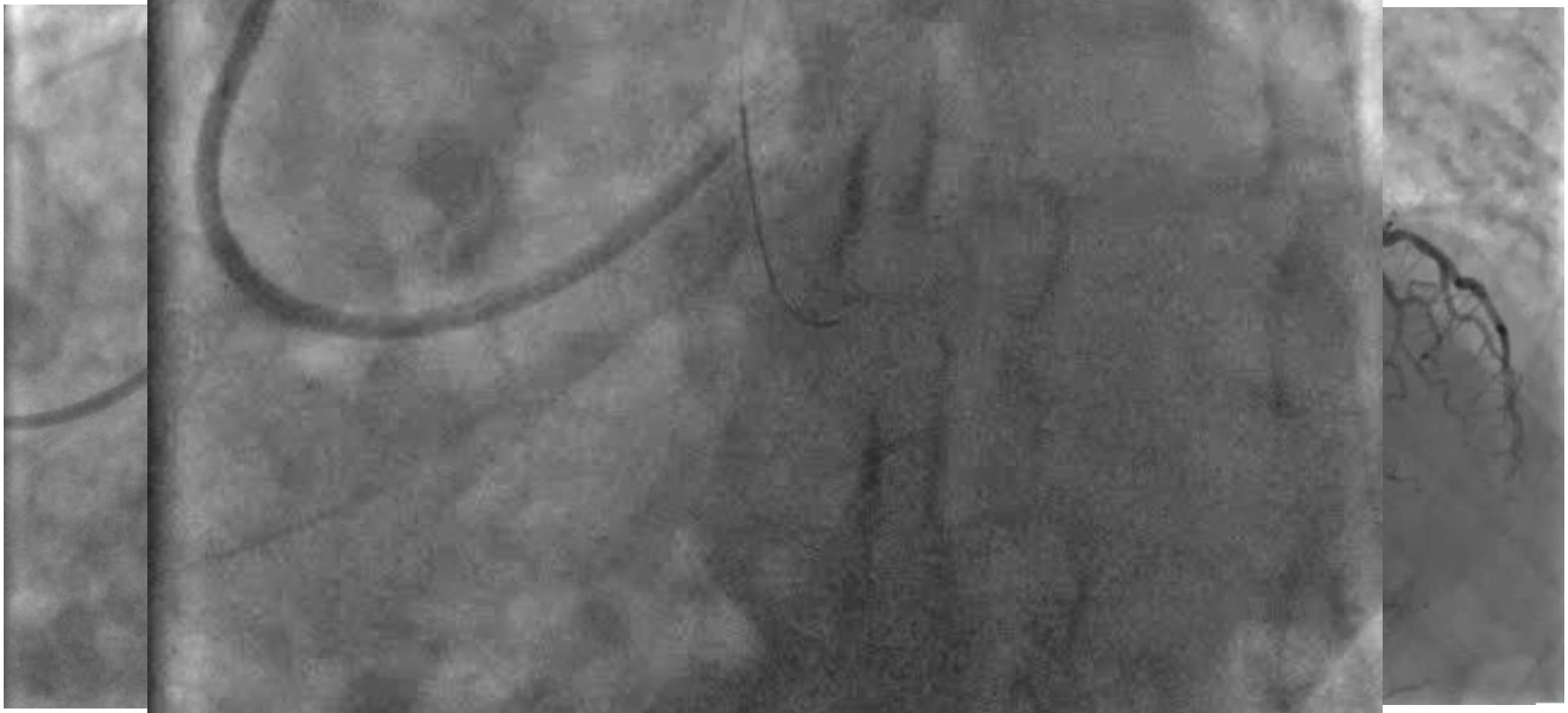
- POT 6.0mm NC balloon, LCx struts recrossed.
- KBI to finish





Result

- Good a
- Echoca



Discussion points

- Whilst extremely versatile useful tools caution must be taken with deep intubation of guide extension catheter
- Pre-planning of approach, and awareness of, potential complications should be considered before any case
- Decisive appropriate action in a controlled fashion to contain adverse situation- Caution with contrast use during bail out or risk propagating dissection plane more
- Patient returned to OPD very well 6 weeks post procedure