dissection occurred during these procedures, Osiro 3.0 x 26 mm was deployed in RCA ostium. Left coronary artery was engaged with 7 Fr AL 1 with side hole and wired with Fielder XT. After predilatation with 2.5 mm from left main to proximal LAD, Osiro 3.5 x 26 mm was deployed in left main to proximal LAD. Immediate after left main stenting, LCx flow was decreased. Predilatation with 1.3 mm balloon in LCx ostium, and subsequent kissing balloon were done in both LAD with 3.5 mm balloon and LCx with 1.3 mm balloon. Finally Osiro 2.5 x 18mm was deployed in proximal LAD partially overlapped with previous left main to proximal LAD stent.

**Case Summary.** This is a successful PCI under PCPS support for tight left main stenosis with triple vessel disease combined with multiple comorbidities and severe aortic valvular stenosis, which is a poor surgical candidate. PCPS weaning and extubation were done at POD 7 and 8, respectively. However, he died from septic shock by multi-drug resistance Acinetobactor baumanii bacteremia at POD13, unfortunately.

**TCTAP C-120**
Several Attempts of a Stent Dislodgement During LCX PCI
Min Woong Kim
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**[CLINICAL INFORMATION]**
Patient initials or identifier number. LJS
Relevant clinical history and physical exam. A 70-year-old female was admitted with chest pain for 2 days. Since last month, he has suffered from crescendo chest pain.
The ECG showed ST elevation on inferior lead and biomarker was elevated.

Relevant test results prior to catheterization. The echo cardiography showed RCA territory RWMA with near normal LV systolic function (LVEF=53%).

Relevant catheterization findings. Baseline coronary angiogram showed nearly total occlusion of mid RCA and significant stenosis at LAD and LCA.(fig 1, 2)
**Procedural step.** 0.014 inch run through wires was inserted into the RCA. Initially, RCA was predilated with 2.5 X 20 mm Sprinter balloon. Then a 2.75 X 28 mm 3.0 X 28 mm Biomatrix stent was placed at proximal to mid RCA. (fig3) Final right angiogram showed that the procedure was successful. And then, 0.014 inch runthrough wires was inserted into the LCX. LCX was predilated with 2.0 X 15mm Sprinter balloon. (fig4) And we prepared a Biomatrix stent 3.5 x 14mm at the p-LCX. But the stent could not be advanced into more distal portion of LCX due to stent dislodgement at the edge of the 6.0F XB guiding catheter.(fig5) The stent was mechanically distorted in the left circumflex artery (LCX) while being delivered to the proximal LCX lesion. Firstly, Two 0.014 runthrough wires were inserted into the stent.(a double wire technique) But this technique could not retrieved dislodgement stent because very weak power. Second, We tried trapping using 1.5 X 15 mm balloon 2.5 X 15 mm balloon between the dislodgement stent(small balloon technique). But the dislodgement stent could not be entered into the guiding catheter because insufficient power. Third, We tried using the Biopsyforcep (1.2mm FB-56D-1, Olympus) that was available at 6F guiding catheter. But the Biopsy forcep could not be catch complete the dislodgement stent only small part of stent strut.
Case Summary. So it was that only small part of stent strut torn out. And then, we try using amulti-snare set(30mm, pfm medical), but the dislodgement stent could not be entered into the guiding catheter because GC tip is soft, so it was bended. So we cut off the GC torque/support segment, the dislodgement stent was successful retrieved with only 7F GC. (Cut GC technique) We deployed a Biomatrix stent 3.5x14mm at proximal to distal LCX. After angioplasty, final angiogram showed that the procedure was successful.

TCTAP C-121
To Treat or Not to Treat?
Chun-Wei Lee1
1Mackay Memorial Hospital, Taiwan

[Clinical Information]
Patient initials or identifier number. 34497294
Relevant clinical history and physical exam. 63 year-old male with progressive left intermittent chest tightness in the recent months (CCS class III-IV). CAD risk factors: male, age, age, smoking, hyper lipidemia. His symptom is too severe for receiving stress test. We then first arrange the first time of CAG.

Relevant test results prior to catheterization. We first arrange treadmill exercise test, but his symptom is too severe for the stress test. General lab exam including cardiac enzyme, renal function test and others all showed unremarkable.

Relevant catheterization findings. The 1st time CAG showed LM bifurcation lesion with two critical lesion over LAD and LCX. We performed IVUS check and the minimal lumen area of LAD, LCX and LM were all above 5.0 mm². So we decided to, treat the critical lesion in LAD and LCX first. However, 3 months later he still complaint of effort angina. Myocardium perfusion test showed large extent of reversible myocardial ischemia. We then plan for the second time of CAG.