remove Etna guide wire, a fracture occurred at the distal tip of the Etna. (Movie 4)
Sion guide wire was inserted to perform a beaded wire rotation, and use of biopsy forces were attempted, in order to remove the fractured guide wire. This attempt, however, was ineffective. Finally, we used a goose neck loop-snare to remove the fractured guide wires. Multiple forward and backward movement of the snare successfully removed all of the fractured guide wire. (Movie 5) Then we could finish safety this strategy.

Case Summary. If we felt a bit of resistance to recross the guide wire, we had better use the microcatheter or small balloon.
This is why deploying the stent. We should exchange the guide wire carefully in order to avoid the guide wire fracture, at that time we confirm no deformation of the guide wire angiographically.

TCTAP C-063
Successful Management of LM STEMI Complicated with Cardiogenic Shock and Multiple Organ Failure
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[CLINICAL INFORMATION]
Patient initials or identifier number. 032371
Relevant clinical history and physical exam. This is a 78-year-old woman who had hypertension with irregular medical therapy. This time, she suffered from sudden onset of dyspnea and orthopnea 1 hour before visiting our emergency room by her family. At ED, initial vital signs revealed blood pressure: 68/44 mmHg, heart rate: 111/min, physical examination revealed bilateral rales breathing sounds and wheezing, pitting edema over bilateral lower limbs with anuria was noted and EKG showed diffuse ST depression with aVR ST elevation.
Relevant test results prior to catheterization. Echocardiography showed anterior and apical wall motion akinesia. Intubation was done for impending respiratory failure. Emergent IABP insertion was done and coronary angiography showed triple vessels disease, with a critical stenosis over left main coronary artery. The laboratory data reported elevated cardiac enzyme level (CPK 439, CK-MB 70.4, Troponin I 6.43, BNP 1050.00) and acute renal failure (BUN 33, creatinine 2.5).
Relevant catheterization findings. Coronary Angiographic Findings:
Left main: LM-M-D 80-90% stenosis
LAD: LAD-OS 50% stenosis, LAD-M 20-30% stenosis, TIMI 2 flow
LCX-P 70-80% stenosis, TIMI 2 flow
RCA-OS 30% stenosis, RCA-M 50% stenosis, PDA 70-80% stenosis,
TIMI 3 flow
**INTERVENTIONAL MANAGEMENT**

**Procedural step.** Details of Primary PCI:

Intubation with ventilator support via endotrachial tube, IABP was inserted via left femoral artery.

We wired an extra floppy wire to distal LAD and another extra floppy wire to distal LCX, and we deployed a 3.0x15 balloon to LM-LAD with 8-10 bars, the blood pressure was around 90/60mmHg during wiring and short-run VT was noted during balloon dilatation. And then we deployed the 3.0x15 balloon to proximal LCX and dilated with 4-8 bars, but coronary dissection was found. Therefore, we deployed a 2.75x23mm bare metal stent (F1 Flex master, 2.75mm at 11 bars and 3.04mm at 16 bars) and dilated with 16 bars. The LCX flow became TIMI3 and residual stenosis was less than 10%. However, the LM to proximal LAD lesion was still noted and the coronary blood flow was still TIMI 2, therefore, we deployed a 3.5x22mm bare metal stent (Hexacath Helistent) with 8-10 bars. The coronary blood flow of LAD became TIMI 3 after stenting, ST depression improved and we finished the whole procedure smoothly.

**Case Summary.** ST elevation over a VR with diffuse ST depression may imply multiple vessel coronary artery disease or left main coronary artery disease.

AMI with culprit lesion over LM coronary artery is life-threatening and critical, cardiogenic shock with SCD may occur and multiple organ failure may occur.

After balloon dilatation to LM to LAD and LCX, if you don’t want to performed any stenting procedure that may cause double layers stents in LM (easily made in stent thrombosis).

Stenting procedure should be arranged to LCX firstly and then LM to LAD, because after stenting to LM-LAD, the ostium of LCX may be partial compression and the stent may be difficult to pass the LM-LAD stent.