1035　Coronary Stent Fracture: A case of after bioabsorbable sirolimus-eluting stent

Case 81 y.o. male

We performed PCI with LMT to LAD CTO lesion because he had been repeated chest and back pain 1 year ago. We deployed bioabsorbable sirolimus eluting stent (ultimaster, U-SES) in LAD.

He had undergone the coronary artery bypass graft operation and recieves saphenous venous graft (SVG) on the LAD about 30 years ago.

Eight months follow-up coronary angiography (CAG) revealed in-stent restenosis (ISR) and stent fracture at segment7.

Fractional flow reserve (FFR) revealed functional single vessel disease (left anterior descending artery (LAD); 0.78).

We watched to OCT in LAD. OCT revealed stent fracture type Ⅳ in LAD. Then, we performed to PCI at this site.

We used Guiding catheter Hyperion PB3.5 but engage was very difficult. Then we used microcatheter teleport, SION blue guidewire crossed to the LAD without engaged guiding catheter. Drug coating balloon dilatation for #6 to #7 were performed.

Stent fracture is usually associated with binary restenosis, thrombosis, aneurysm, embolization, ischemic events, and target lesion revascularization (TLR) and could thereby increase morbidity and mortality. PCI strategy after stent fracture is unclear. Stent deployment is risk of any further fracture. Therefore, in this case, we chose DCB dilatation after stent fracture.