

ing-balloon dilatation with 3.0×12 mm and 3.5×12 mm non-compliant balloons, final POT was performed using a 5.0×8 mm non-compliant balloon (Video 1). The patient was prescribed dual antiplatelet therapy with acetylsalicylic acid and clopidogrel. Follow-up coronary angiography was planned for 6 months later. However, approximately 5 months later, the patient died following the development of hemoptysis.

Conclusion: Aorto-ostial stent protrusion can significantly complicate re-entry into the stent lumen, particularly during complex bifurcation procedures. The Side Flap technique may offer an alternative solution in selected cases where re-entry into the original stent lumen is not feasible. This case demonstrates that aorto-ostial stent protrusion in complex LMCA-LAD-CX bifurcation anatomy can be successfully managed using the Side Flap technique in combination with the TAP technique.

Keywords: Excessive ostial stent protrusion, Side Flap technique, aorto-ostial lesion.

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Conservative Management of Dunning Class III Aortocoronary Dissection Introduction and Aim

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Introduction and Aim: Iatrogenic left main coronary artery (LMCA) dissection with retrograde extension into the ascending aorta is a rare but potentially catastrophic complication of coronary angiography and percutaneous coronary intervention (PCI). According to the Dunning classification, Class III dissections (>40 mm extension into the ascending aorta) are generally considered the most severe form and have traditionally been associated with emergency surgical repair. However, recent evidence suggests that conservative management may be feasible in carefully selected hemodynamically stable patients after successful sealing of the coronary entry site. We present a rare case of Dunning Class III iatrogenic aortocoronary dissection that was successfully managed with PCI followed by conservative medical therapy.

Case Report: A 68-year-old man with a history of anterior myocardial infarction one month earlier was admitted for elective PCI of the left circumflex artery (LCx). The left coronary system was engaged with an EBU guiding catheter, and baseline angiographic images were obtained. Following predilatation of the target LCx lesion, angiography unexpectedly demonstrated an iatrogenic LMCA dissection extending to the aorto-ostial region. The left anterior descending artery (LAD) was immediately wired, and a stent was implanted from the LMCA to the LAD, completely covering the LMCA ostium and successfully sealing the entry point of the dissection. Control angiography demonstrated disappearance of contrast staining extending into the aortic root. However, a residual dissection flap remained confined between the LCx ostium and the previously implanted LCx stent. The LCx was rewired and a two-stent bifurcation strategy using the TAP (T-stenting and Small Protrusion) technique was successfully performed, resulting in complete stenting of the LMCA bifurcation without residual dissection or angiographic complications. The patient was admitted to the coronary intensive care unit for close monitoring. Transthoracic echocardiography showed a left ventricular ejection fraction of 45–50% without pericardial effusion. During follow-up the patient developed back pain, prompting computed tomography (CT) aortography, which demonstrated an extensive peri-aortic hematoma extending from the coronary ostium to the aortic arch and proximal left subclavian artery, consistent with Dunning Class III aortocoronary dissection. Cardiovascular surgery consultation recommended conservative management because the patient remained hemodynamically stable without ongoing ischemia. Strict blood pressure and heart rate control were achieved and laxative therapy was added to minimize Valsalva-related increases in intrathoracic pressure. No electrocardiographic changes,

hemodynamic deterioration, electrical instability or pericardial effusion developed during hospitalization. Follow-up CT aortography on Day 4 demonstrated regression of the peri-aortic hematoma, while repeat imaging on Day 20 confirmed complete resolution. The patient was discharged uneventfully on hospital Day 21 with outpatient follow-up.

Conclusion: This case demonstrates that even Dunning Class III iatrogenic aortocoronary dissection can be successfully managed without surgery when the coronary entry site is promptly sealed with PCI and the patient remains clinically stable. Careful patient selection, multidisciplinary decision-making, strict anti-impulse medical therapy and serial CT imaging may provide a safe alternative to surgical intervention in selected cases. This rare case contributes to the limited literature supporting conservative management of extensive iatrogenic aortocoronary dissections.

Keywords: Iatrogenic aortoostial dissection, dunning class III, Left main coronary artery, PCI, conservative management.

SS-20

Diagnostic Pitfall in Hypotension After Complex PCI: Incidental Pericardial Effusion and Femoral Access-Site Perforation

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Introduction and Aim: Acute hypotension following percutaneous coronary intervention (PCI) requires the prompt exclusion of potentially life-threatening complications, including coronary perforation, cardiac tamponade, acute stent thrombosis, and vascular access-site complications. We present a case of hemodynamic deterioration after complex PCI in which a concomitantly detected pericardial effusion created a diagnostic challenge, while the actual cause was a perforation at the external iliac artery–common femoral artery (CFA) junction that was successfully managed by an endovascular approach.

Case Report: A 58-year-old man with hypertension and established coronary artery disease was admitted for elective PCI. He had previously undergone PCI of the left anterior descending artery (LAD) and circumflex artery (Cx) for an acute coronary syndrome in December 2025. During the index procedure, a 4.0×24 mm drug-eluting stent (DES) was implanted from the left main coronary artery extending into the LAD. A 3.5×18 mm DES was implanted in the proximal Cx, and overlapping 3.0×35 mm and 3.5×43 mm DESs were deployed from the distal right coronary artery to the ostium. Following the procedure, the patient was transferred to the coronary intensive care unit for monitoring. After removal of the right femoral arterial sheath, the patient developed tachycardia and hypotension. Bedside echocardiography demonstrated a 1-cm pericardial effusion. Given the recent complex PCI, coronary perforation with hemopericardium was initially considered the leading diagnosis, and the patient was urgently transferred back to the catheterization laboratory. However, serial blood gas analyses also demonstrated a progressive decline in hemoglobin levels, raising concern for ongoing hemorrhage. Repeat coronary angiography via the left femoral artery demonstrated patent coronary stents without evidence of coronary perforation. Subsequently, the right iliofemoral arterial system was assessed using a crossover approach from the left femoral artery. Digital subtraction angiography revealed marked active contrast extravasation consistent with arterial perforation at the external iliac artery–CFA junction. A 10×37 mm BeGraft covered stent was implanted across the perforation site. Final angiography demonstrated complete cessation of contrast extravasation with preserved distal arterial flow. Following the intervention, the patient's blood pressure and heart rate normalized, and hemoglobin levels stabilized. Serial echocardiographic examinations showed no significant progression of the pericardial effusion, confirming that it was not responsible for the hemodynamic deterioration.

Conclusion: The detection of pericardial effusion in a patient who develops acute hypotension after complex PCI may readily direct diagnostic attention