



A Double Whammy-Stent Fracture and Dislodgement During Pci

Punish Sadana* & Preeti Sharma

Max Superspeciality Hospital, Dehradun, India

*Corresponding Author: Punish Sadana, Max Superspeciality Hospital, Dehradun, India.

Submitted: 12 Jul 2025

Accepted: 15 Jul 2025

Published: 18 Jul 2025

Citation: Punish, S., & Sharma, P. (2025). A Double Whammy-Stent Fracture and Dislodgement During Pci. J of Clin Case Stu, Reviews & Reports, 4(4),1-3

Abstract

Coronary stent fracture is a rare complication of stent implantation. The reported incidence of stent fracture among present drug-eluting stents from various studies ranges from 1% to 8%. Coronary stent dislodgement and embolization is also a rare complication in the current era of percutaneous coronary angioplasties. The incidence of stent loss has significantly reduced as stents were precrimped in factory itself. It is often benign and managed conservatively by retrieval by smaller balloon or snare, deployment at appropriate location or crushing of the stent, rarely requiring surgical intervention. We present a case of Elderly female with both the complications during PCI managed effectively

Keywords: Stent Loss/Dislodgement, Stent Embolisation, PCI (Percutaneous Coronary Intervention), In-stent Restenosis, stent fracture(SF), Stent Thrombosis.

Introduction

Coronary stent fracture is a relatively rare complication of stent implantation. The reported incidence of stent fracture among present drug-eluting stents from various data ranges from 1% to 8%. Literature shows that the risk for stent fracture was higher in right coronary artery location, increased vessel tortuosity severe angulation prior to stenting, use of overlapping stents, and use of longer stents. It can cause thrombosis, ISR, aneurysm .. The incidence of stent loss has significantly reduced as stents were precrimped in factory itself. It is often benign and managed conservatively by retrieval by smaller balloon or snare, deployment at appropriate location or crushing of the stent, rarely requiring surgical intervention. However, dreaded complications can occur if the stent embolizes into the vital organs [1-4].

Case Report

A 64 year old female a known case of Diabetes Mellitus, hypertension and hypothyroidism presented with chest pain on exertion for two months for two hours duration. On Evaluation her vitals were stable, systemic examination doesn't showed any abnormality. ECG showed sinus rhythm with no significant ST-T changes and echo showed EF of 55%.

CAG done which revealed single vessel disease with mid LAD 80% stenosis (Fig 1). Patient was taken for PTCA to LAD. Stenting was done with 3x24mm DES. Post dilation done with 3mm balloon upto 18atm. Check shot revealed some haziness and stent boost and IVUS revealed stent fracture (Fig 2,3,4). Then

3x12mm DES was taken to cover the fractured part but it was small in length, while taking it out it got dislodged in distal left main and prox LAD so deployed there itself. In the next angio shot 3x12mm DES dislodged slight distally, it was postdilated with 3.5x8mm balloon and fixed there itself (Fig 5). There was severe spasm in radial artery and during maneuvering whole of the system including guiding catheter and wire came out. Rt femoral puncture done and Left coronary artery was hooked using 6F EBU catheter. Several attempts were made to cross guidewire but failed so double lumen catheter taken to cross the distorted stent. With the help of guideliner another 3x33mm DES deployed from proximal to mid LAD with TIMI III flow (Fig 5,6)



Figure 1: Mid LAD 80% stenosis



Figure 2: Post stenting

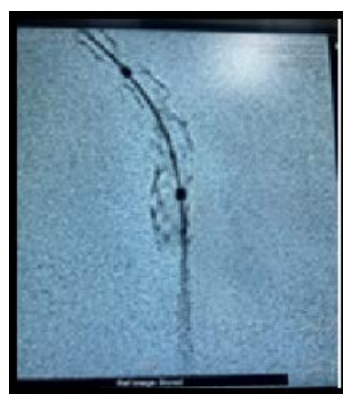


Figure 3: Stent boost-stent fracture



Figure 4: Stent distortion increased



Figure 5: Overlapping stent



Figure 6: Final shot-TIMI III flow

Discussion

Coronary stent fracture is a relatively uncommon and rare complication of stent implantation. The reported incidence of stent fracture among drug-eluting stents ranges from 1% to 8%. Literature shows that the risk for stent fracture was higher in right coronary artery location, increased vessel tortuosity, angulation prior to stenting, use of overlapping stents, and use of longer stents, higher postdilation pressure. Stent fracture does not happen equally among different stents, and more frequent stent fracture was seen with stainless steel stents comparing with cobalt-chromium platform stents signaling less sturdiness with stainless stents, which should somewhat explain why cobalt-chromium stents are associated with improvement of clinical outcomes. There is no consensus on the best diagnostic imaging modality for detection of stent fractures, but conventional angiography is not sufficiently sensitive for this purpose. Other imaging modalities can be used, including IVUS, stent boost, MDCT, and OCT [5-8].

Depending on the diagnostic tool that is used, numerous classifications of SF have been suggested. As per Allie et al. there are four types of SF- type I - single strut fracture, type II - multiple strut fractures at different sites, type III - complete transverse linear fracture without displacement and type IV -complete stent displacement. There is an additional type V with formation of a gap between stent fragments by Jaff et al. It may be asymptomatic, can cause acute vessel closure due to thrombosis, ISR, aneurysm formation and TLR. Treatment includes conservative management, restenting, DEB (drug eluting balloon) or surgery.

Among coronary devices, Coronary stents are most commonly embolized with an incidence of approximately 0.9%-8.3%, during Percutaneous Coronary Interventions (PCI). Stent dislodgement was more frequent in old times when stents were crimped manually onto the balloon but now a days they were precrimped in factory itself and dislodgement rates are drastically reduced. Although rare, stent dislodgment can cause cerebral embolism or intracoronary thrombosis and lead to life threatening complications like Cerebrovascular Accident (CVA) and Myocardial Infarction (MI). Angulated, severely calcified lesion, inadequate lesion preparation, non coaxial guidecatheter, forceful pushing or pulling of the stents are the common causes of stent dislodgement. It can be partial or complete stent loss with

or without guidewire in situ. Position of dislodged stent also is very important. Management varies from retrieval using small balloon, multiple wire technique or snare or surgical, crushing the stent along the vessel wall, sequential dilation and deploying the stent there itself [9, 10].

Conclusion

Coronary artery stent dislodgement and fracture are rare but sometimes fatal complications during PCI. Stent fracture treatment includes conservative treatment, DEB or restenting and in rare case bypass surgery. Treatment of stent dislodgement includes retrieval by various available techniques, deploying it there itself or crushing against the vessel wall.

References

1. Shaikh, F., Maddikunta, R., Djelmami-Hani, M., Solis, J., Allaqaband, S., & Bajwa, T. (2008). Stent fracture: An incidental finding or a significant marker of clinical in-stent restenosis? *Catheterization and Cardiovascular Interventions*, 71, 614–618. <https://doi.org/10.1002/ccd.2141>.
2. Betriu, A., Masotti, M., Serra, A., Alonso, J., Fernandez-Aviles, F., Gimeno, F. (1999). Randomized comparison of coronary stent implantation and balloon angioplasty in the treatment of de novo coronary artery lesions (START): A four-year follow-up. *Journal of the American College of Cardiology*, 34, 1498–1506. [https://doi.org/10.1016/S0735-1097\(99\)00373-4](https://doi.org/10.1016/S0735-1097(99)00373-4).
3. Al Suwaidi, J., Holmes, D. R., Jr., Salam, A. M., Lennon, R., & Berger, P. B. (2004). Impact of coronary artery stents on mortality and nonfatal myocardial infarction: Meta-analysis of randomized trials comparing a strategy of routine stenting with that of balloon angioplasty. *American Heart Journal*, 147, 815–822. <https://doi.org/10.1016/j.ahj.2003.10.015>.
4. Bae, J. H., Hyun, D. W., Kim, K. Y., Yoon, H. J., & Nakamura, S. (2005). Drug-eluting stent strut fracture as a cause of restenosis. *Korean Circulation Journal*, 35, 787–789. <https://doi.org/10.4070/kcj.2005.35.10.787>.
5. Alexopoulos, D., & Xanthopoulou, I. (2011). Coronary stent fracture: How frequent is it? Does it matter? *Hellenic Journal of Cardiology*, 52, 1–5.
6. Brilakis, E. S., Maniu, C., Wahl, M., & Barsness, G. (2004). Unstable angina due to stent fracture. *Journal of Invasive Cardiology*, 16, 545.
7. Alomar, M. E., Michael, T. T., Patel, V. G. (2013). Stent loss and retrieval during percutaneous coronary interventions: A systematic review and meta-analysis. *Journal of Invasive Cardiology*, 25(12), 637–641.
8. Nikolsky, E., Gruberg, L., Pechersky, S. (2003). Stent deployment failure: Reasons, implications, and short- and long-term outcomes. *Catheterization and Cardiovascular Interventions*, 59, 324–328. <https://doi.org/10.1002/ccd.10496>.
9. Hussain, F., & Moussa, T. (2010). Migration of an embolized deployed stent from the left main with subsequent crushing: A new use for the IVUS catheter? *Journal of Invasive Cardiology*, 22, E19–E22.
10. Yang Soon, C., Chong, E., & Sangiorgi, G. M. (2010). A challenging case of dislodged stent retrieval with the use of Goose neck snare kit. *Catheterization and Cardiovascular Interventions*, 75, 630–633. <https://doi.org/10.1002/ccd.22246>.

Copyright: ©2025 Punish Sadana. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.