

CARDIOVASCULAR FLASHLIGHT

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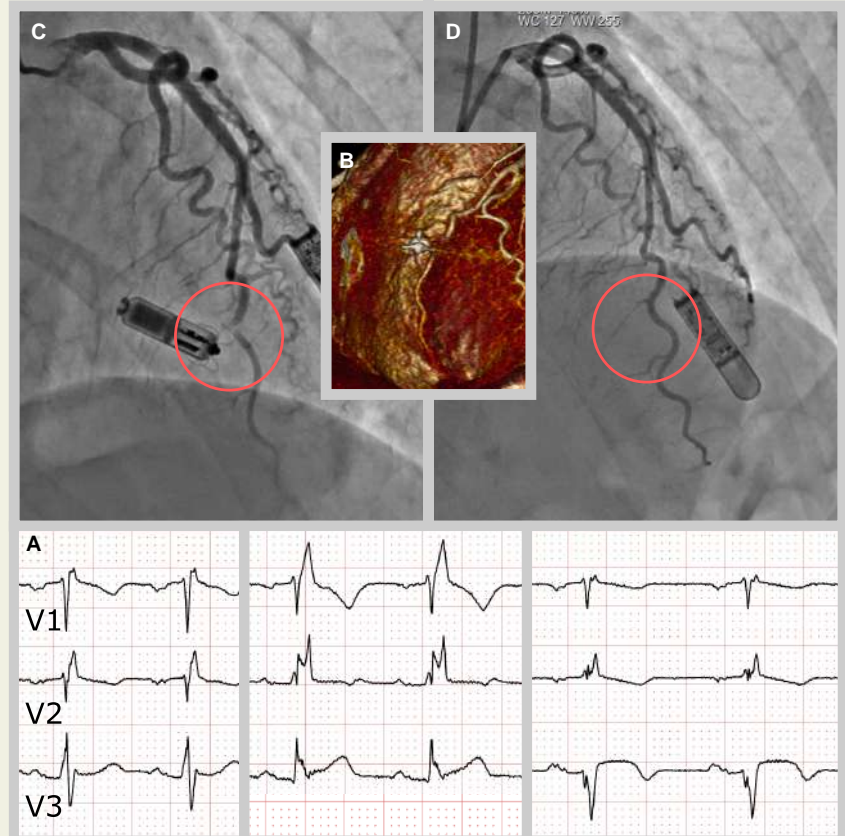
Accidental coronary artery kinking by leadless pacemaker fixation tine

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 The work was performed at the Bordeaux University Hospital (France).

We present a case of a 59-year-old woman who presented with a coronary syndrome soon after an uneventful leadless pacemaker (MicraVR™, Medtronic) implantation. A routine post-operative electrocardiogram (ECG) revealed alteration of the baseline ECG (Panel A, left) with appearance of a complete right bundle branch block (RBBB) and ST-segment elevation in V3 (Panel A, middle). She reported intermittent moderate chest pain which worsened in left lateral position. An emergency transthoracic echocardiogram showed minimal pericardial effusion (<0.5 mm) with a normal systolic left ventricular function. A coronary computed tomography angiogram suggested that the septal anchor of the pacemaker partially occluded the distal segment of the left anterior descending (LAD) artery (Panel B). This was associated with enhancement defects on septo-apical and apical segments, consistent with ischaemia. The coronary angiography confirmed the partial LAD kinking in relation to the device anchor which was considered extravascular (Panel C). After patient consent, pacemaker retrieval was successfully performed using a 26Fr Gore DrySeal™ introducer sheath, a 12Fr Cook Performer™ guiding sheath holding an EV3 Amplatzer™ gooseneck Snare of 15 mm. Once the pacemaker was trapped and before applying traction, a 0.14 Asahi FielderXT™ coronary wire was inserted through the lesion, to protect the vessel in case of injury. The coronary integrity was confirmed after device removal (Panel D). The RBBB disappeared 48 h later, leaving a Q wave in lead V3 (Panel A, right). Systematic postoperative ECG is warranted after leadless pacemaker implantation.



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Conflict of interest: None declared.

The data underlying this article are available in the article.

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