with early TIMI grade-0 flow, right femoral venous access, cannula- tion (figure 2C), and PiCSO balloon catheter implantation in the coronary sinus were used (figure 2D) with a 21 min therapy time, and PiCSO doses of 824 mmHg (values > 800 mmHg are advised since they are associated with a reduced infarction size in former studies)\(^4\) (figure 2E). The first electrocardiogram revealed a left ventricular ejection fraction in the middle segment of the left anterior descending coronary artery (TIMI grade-0 flow). Thrombus aspiration and drug-eluting stent implantation led to TIMI grade-3 flow (total ischemia time, 120 min). Since this was also a high-risk anterior STEMI, it was decided to implant the PiCSO system in the coronary sinus via right femoral vein with a 20 min therapy time and a PiCSO dose of 830 mmHg. The patient neurological and cardiologic progression was good. The patient’s LVEF was 55% 10 days after the infarction.

The PiCSO system is a safe and easy to implement tool in the management of STEMI. However, PiCSO will have to demonstrate its efficacy in ongoing randomized trials.

**FUNDING**

None whatsoever.
The 12-lead electrocardiogram revealed sinus rhythm, heart rate of 60 beats per minute, and slight and diffuse ST-segment elevation (figure 1A). Blood biochemistry analysis revealed elevated troponin I levels (37.6 ng/mL; normal values < 0.045 ng/mL). The transthoracic echocardiogram revealed the presence of preserved left ventricular systolic function with normal heart wall motion kinetics, and no evidence of structural heart disease.

Although the early suspected diagnosis was myopericarditis, and the patient was already pain-free, he was referred for elective invasive coronary angiography—via right radial artery—24 hours after hospital admission. We first visualized a dominant right coronary artery with no significant disease. Afterwards, the left main coronary artery angiography showed no significant disease on both the left main or circumflex arteries, but a small filling defect in the proximal segment of the left anterior descending coronary artery causing no flow restriction (figure 1B). To better characterize the lesion, an intracoronary imaging modality—optical coherence tomography—was prescribed (video 1 of the supplementary data). In the corresponding area of the filling defect, we observed a red thrombus that prevented the evaluation of a possible underlying atherosclerotic plaque (figure 1C; minimum lumen area of 9.5 mm² [reference, 12.6 mm²]).

After these findings, the diagnosis of acute coronary syndrome was assumed. Therefore, since no percutaneous coronary intervention was ever performed, the patient remained on triple antithrombotic therapy (acetylsalicylic acid, 100 mg; ticagrelor, 90 mg twice a day, and enoxaparin 1 mg/Kg twice a day). Reassessment with invasive coronary angiography was scheduled in a 7-day interval.

By the time of the second left main coronary artery angiography, no filling defect was seen on the proximal segment of the left anterior descending coronary artery (figure 2A). To confirm the improved status of the lesion, reassessment with optical coherence tomography was also performed (video 2 of the supplementary data). This time, we observed a fibroadipose atherosclerotic plaque with no signs of instability with some reminiscent thrombus on the surface of the plaque (figure 2B). The lesion mechanism was thought to be definite plaque erosion (according to the classification by Kolte et al. 3). The patient was successfully discharged on dual antiplatelet therapy and behavioral restriction regarding drug consumption.

It has been established that cannabis exerts pathophysiological effects on the cardiovascular system. 4 There is a growing number of case reports describing adverse cardiovascular events, specifically, cannabis-induced myocardial infarction. As this situation is most frequently reported in young individuals, it may go unnoticed and, consequently, untreated. Intracoronary imaging modalities play a key role in the definition of the mechanism behind coronary lesions—whether atherosclerotic or not—in patients with suspected acute coronary syndrome/myocardial infarction with non-obstructive coronary arteries. 2 Reassessment after some time of triple antithrombotic therapy may also contribute to clarify the mechanism as the artery lumen may be thrombus-free.

Informed consent and authorization to publish these figures and videos were obtained from the patient.
TABLE 2

<table>
<thead>
<tr>
<th>Authors' Contributions</th>
<th>Funding</th>
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<td>All authors contributed to the genesis of this manuscript, were involved and approved its submission.</td>
<td>None whatsoever.</td>
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None reported. | None whatsoever. |


Role of drug-coated balloon in the management of very late stent thrombosis

*Papel del balón fármacoactivo en el tratamiento de la trombosis muy tardía de stent*

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To the Editor,

Very late stent thrombosis—the one occurring, at least, 1 year after stenting—is a rare complication of tremendous clinical relevance. The mechanisms underlying its physiopathology have been widely studied thanks to the use of intracoronary imaging modalities, especially optical coherence tomography. The 2 main mechanisms of action found are, in the first place, neatherosclerosis, and secondly, no strut endothelization. 1 Despite of this, its approach is still under discussion and focused on resolution or minimization of the factors leading to its appearance.

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