Treatment of ACS patients with diffuse long lesions and multiple vessel disease in NSTE-ACS is still challenging. There are many reports which suggest that spot stenting of the narrowest segment is preferable over full lesion coverage\(^1\).\(^2\). We present a 54-year old NSTE-ACS patient with known left bundle branch block, a diffuse long lesion of proximal LCX which included LCX/OM1 bifurcation, and a highly significant stenosis of RCA. LAD was free of stenosis. The patient underwent ad hoc PCI with focal stenting of midLCX, and staged PCI of RCA. During routine LCX reassessment, proximal LCX dissection and plaque progression was suspected. Staged PCI of the LCX and OM bifurcation was done with 2 BMS and 1 DEB in the main branch, and 2 DES in the side branch. Issues of culprit lesion identification, timing and staging of total percutaneous revascularization in a multiple vessel disease in patients with NSTE-ACS are discussed. In addition, issue of focal stenting strategy versus long segment stenting in ACS is also presented and discussed.

**KEYWORDS:** non-ST-segment elevation acute coronary syndrome, spot stenting, bifurcation stenting, drug eluting balloon.

**Literature**