respectively. In comparison to that our study shows same or no inferior outcome which proves the drug combination is as effective as thrombolysis.
Conclusion: Inj. Heparin along with DAPT on FMC following acute MI yields similar results as thrombolysis with significant improvement in TIMI flow of the IRA and also significant reduction of the slow flow, no flow or other complications during PPCI.

Dual versus triple antiplatelet therapy in patients with acute coronary syndrome undergoing coronary artery stenting

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Background: Triple antiplatelet therapy (TAT) has been found to be superior to dual antiplatelet therapy (DAT) in patients with acute coronary syndromes undergoing percutaneous coronary intervention (PCI) with drug-eluting stents (DES).
Methods: A prospective, double blinded, randomized study was conducted in ACS patients undergoing PCI with DES and control population without any coronary artery disease (CAD). ACS patients were randomized into DAT group (DAT, aspirin + clopidogrel) and TAT group (TAT, aspirin + clopidogrel + cilostazol). Patients in the TAT group were given loading doses of 200 mg of cilostazol peri-procedurally (within 6–12 h prior to the procedure to 1–2 h post-procedure) followed by 100 mg/day for atleast six months. Patients were evaluated at baseline, at seven days and six months intervals for clinical outcomes. ADP, collagen, and epinephrine-induced platelet aggregation was measured at baseline and at seven days interval.
Results: There were no significant differences in the baseline characteristics in both the groups. Comparison between dual and triple antiplatelet groups showed significantly greater inhibition of ADP-induced platelet aggregation in the triple therapy group at seven days interval ($19.05 \pm 14.06\%$ vs $36.20 \pm 25.0\%$, $p = 0.02$) and trend towards greater platelet inhibition at baseline between two groups ($19.2 \pm 27.32\%$ vs $33.0 \pm 22.01\%$, $p = 0.077$), respectively. Triple therapy group had lesser number of patients who had hyporesposiveness to antiplatelet therapy (defined as inhibition of less than 50% of ADP, collagen or epinephrine induced platelet aggregation). The study was underpowered for assessing MACE outcomes.
Conclusions: Cilostazol is a significant add on therapy to standard DAT with aspirin and high maintenance dose clopidogrel. Its loading dose of 200 mg, followed by 100 mg BD provides greater inhibition of ADP-induced platelet aggregation without increase in bleeding complications or tolerance issues.

Alcohol septal ablation therapy for HOCM patients

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The objective of this study is to evaluate outcome of the 20 patients who underwent alcoholic septal ablation for symptomatic HOCM at our hospital.
Background: LVOT obstruction is an important determinant of clinical symptoms in patients with HOCM. Alcohol septal ablation shown to decrease LVOT gradient and resolution of symptoms immediately after the procedure and on midterm follow-up.
Methods: 20 patients with HOCM who underwent alcoholic septal ablation at our hospital and completed one-year follow-up are described. A detailed analysis of clinical examination and Echo Doppler carried out.
Results: The mean age of the study group was 54 ± 16 years (range 26–76 yrs). All patients had refractory symptoms before enrolment. 90% patients had NYHA class III/IV symptoms at baseline compared to none at 1 year. Only 20% of patients were either receiving beta-blockers or CCBs on follow-up. The resting LVOT gradient decreased from 70 ± 20 mmHg to 10 ± 6 mmHg. These changes are associated with decreased septal thickness and preserved systolic function. Three patients (15%) developed complete heart block, two patients improved after TPI and one required permanent pacemaker. One patient (5%) developed acute anterior wall myocardial infarction and taken for emergency CABG, but died during post-operatively.
Conclusion: Alcohol septal ablation associated with decreased septal thickness and preserved systolic function. This procedure is an effective therapeutic procedure with favorable outcome.

Clinical results of indigenous biodegradable polymer sirolimus eluting Yukon Choice Flex stent in all comer patients with coronary artery disease

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One hundred patients who underwent PCI with Yukon Choice Flex (Indigenous stent) between September 2014 to February 2015 have been studied retrospectively. There were 86 (86%) males and 14 (14%) females with mean age 59.12 ± 12.33 (28–84 years). Risk factors were hypertension – 50(50%), type 2 DM – 42(42%), smoking 28(28%), CKD 8(8%), and dyslipidemia 14 (14%). Clinical presentation was ACS with STEMI – 44 (44%), NSTEMI 30 (30%), unstable angina – 14 (14%). Chronic stable angina was present in 12 (12%) patients. Mean LVEF of this group was $50.3 \pm 9.3\%$ (range 21–60%). Three patients with STEMI presented in cardiogenic shock.
Coronary angio profile revealed single vessel disease in 54 (54%) and multi-vessel disease in 46 (46%) patients. PCI was done through femoral artery in 80 (80%) and right radial in 20 (20%) patients. Weight adjusted heparin was used as anticoagulant. Antiplatelet therapy in the form of asprin, clopidogrel, or prasugrel was used in patients at operators discretion.
Primary angioplasty was done in 16 (16%) patients. IABP support was used in 6 (6%). GP IIb/IIIa inhibitors were used in 76 (76%) patients, of which 52 (66%) received tirofiban, while 26 (34%) received abciximab.
All patients received biodegradable polymer sirolimus eluting Yukon Choice Flex stent. Average stent diameter was 2.92 ± 0.44 mm. Average stent length was 24.53 ± 8.47 mm. Average no. of stents deployed per patient was 1.66 ± 0.86. Average duration of hospital stay was 3 ± 1.31 days. One patient who was in cardiogenic shock died during the hospital stay. There was no other MACE during the hospitalization. Two patients were admitted with subacute stent thrombosis at 7 and 20 days, requiring re-dilatation. Patients were followed clinically and telephonically between 6 and 9 months (mean 8.23 ± 7.03 months).