

Bilateral PDA dependent pulmonary circulation with right and left pulmonary artery discontinuity is very rare. Limited data available for bilateral PDA stenting. Bilateral PDA stenting in nonconfluent pulmonary arteries is challenging procedure but can be considered as an option in the management of complex conditions like this. 12 days old Preterm (36 weeks gestation) male baby with birth weight of 2.6 kg developed respiratory distress with severe cyanosis and desaturation upto 50%. Baby was intubated and started on Prostaglandin 0.05 mcg/kg/min. His saturation improved to 80%. Echocardiogram showed complex cyanotic heart disease, Situs ambiguus, dextrocardia, complete unbalanced AV septal defect, pulmonary atresia, nonconfluent small branch pulmonary arteries supplied by the bilateral patent ductus arteriosus (PDA) from right aortic arch and all four pulmonary veins form a confluence and drain into superior vena cava (SVC) through vertical vein with no obstruction. Baby was taken up for PDA stenting. descending aortogram showed right aortic arch with vertical tortuous duct to right pulmonary artery (RPA) and another short duct with acute angle from left subclavian artery to left pulmonary artery (LPA). Both ducts stented with coronary stents. Vertical vein angiogram showed both lungs drain to a confluence and then to SVC via ascending vertical vein with no obstruction. After stenting lung perfusion improved and the baby was stable and maintained 80% saturation on room air. Bilateral PDA dependent pulmonary circulation with right and left pulmonary artery discontinuity is very rare. Our case is unique with Heterotaxy, TAPVC, Dextrocardia and double ducts. Eventhough bilateral ductal stenting is technically challenging it is successful through femoral artery approach.

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54. Radiofrequency perforation of pulmonary valve and PDA stenting in a preterm neonate

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Transcatheter radiofrequency perforation of the pulmonary valve and PDA stenting is considered as a modality for pulmonary atresia and intact ventricular septum with mildly hypoplastic tripartate right ventricle. We present a preterm neonate who has undergone this procedure. We assume that transcatheter radiofrequency perforation of pulmonary valve and PDA stenting is a safer approach for pulmonary atresia with intact ventricular septum in preterm newborns, than surgical approach. We present 5 days old, preterm (36 weeks gestation) baby girl, with 2.2 kg. She was referred to our centre with the diagnosis of pulmonary atresia with intact ventricular septum, mildly hypoplastic tripartate right ventricle. Right ventricle angiography showed tripartate right ventricle with no sinusoids. She underwent successful radiofrequency perforation of pulmonary valve

followed by balloon dilatation. At the same time prograde PDA stenting was done. Repeat right ventricle angiography showed good right ventricular outflow tract forward flow, and descending aorta angiography showed good PDA flow supplying both pulmonary arteries. The baby was extubated on same day, and prostaglandin E1 was discontinued immediately after the procedure. The baby maintained saturation more than 80% on room air. The baby was discharged after 2 days. Our case is peculiar because to our knowledge this is the lowest weight for which radiofrequency perforation and PDA stenting is done as well as being preterm.

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SURGICAL REVASCULARIZATION FOR ISCHEMIC HEART DISEASE

55. Coronary artery bypass graft for cardiogenic shock post STEMI patients

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Cardiogenic shock (CS) complicating AMI continues to have a high mortality of 60–80% despite early revascularization and adjunctive therapies. AMI-CS complicates 5–7% of cases of STEMI and is a leading cause of hospital death AMI. We studied the outcome of CABG for AMI-CS patients. From 10-2013 to 9-2015, 24 patients with post STEMI cardiogenic shock were admitted and underwent emergency CABG. Mean pre-operative ejection fraction (EF) was $29.7 \pm 8.4\%$. 8 patients were on IABP pre-operatively. Operative mortality rate was 21%. Survival rate was 79% and mean follow-up of 10.21 ± 4.8 months. CABG should be considered for patients with AMI complicated by cardiogenic shock when PCI can not be done.

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56. Endoscopic vein graft harvest for coronary artery bypass surgery: Single center experience in Saudi Arabia

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