Case Summary. The prevalence of a culprit lesion in the LMS in patients undergoing primary percutaneous coronary intervention (PCI) is around 0.8–1.7%. Patients with acute myocardial infarction and thrombosis of the unprotected left main coronary artery are a high-risk subgroup with overall in-hospital mortality 21%. If they present in cardiogenic shock, in-hospital mortality will increase to 32%. We reported a rare case received PCI plus TPM + IABP + PCPS with the diagnosis of anterolateral wall STEMI and cardiogenic shock. Finally he was discharged on thirteenth day and had returned to work without neurologic deficit.

TCTAP C-018
Have a Guess for the Infarction Related Artery
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Relevant clinical history and physical exam. This 63 year-old man is a patient with CAD, left main and two vessel disease, status post CABG in 2001, DM, CKD, stage III, HTN, and dyslipidemia. He is a heavy smoker. He receives regular follow up in our cardiovascular, nephrology and endocrine our patient department.

He presented to local hospital with chest tightness. STEMI was recognized and he was sent to our hospital for primary PCI.

Relevant test results prior to catheterization. Review his surgical record, he had LIMA connecting to LAD and SVG connecting aorta to diagonal and OM branch.

ECG showed ST elevation at lead III, aVF, V1, V2, and V3 Reciprocal change was noted at lead I and aVL. Echocardiography showed hypokinesia over septum and inferior wall. No aneurysmal change was seen.

Relevant catheterization findings. Left main: 99% stenosis, LAD: mid total occlusion LCX: proximal total occlusion RCA: proximal total occlusion SVG-Dx-OMx: SVG patent, one diagonal branch 90% stenosis, one OM branch proximal 90% stenosis LIMA-LAD: LIMA patent, but long segment stenosis up to 99% over native LAD distal to anastomosis site Which one should be responsible for this acute event?
**[INTERVENTIONAL MANAGEMENT]**

**Procedural step.** We set up a 7 Fr. sheath at right femoral artery. The right coronary artery was engaged by 7 Fr. JR guiding catheter. Acute thrombosis was suspected so we started with Fielder FC wire. The occluded site was easily passed by our wire. TIMI 3 flow was achieved immediately after wiring RCA. We did not find any opaque lesion in the right coronary artery. The right coronary artery was quite irregular. Multiple critical stenoses were noted along the right coronary artery. Predilatation was done with balloon catheter Sapphire 2 2.0x15mm and Sapphire 3 3.0x15 mm up to 12 atm. A drug eluting stent BioMatrix Flex 3.50 X 36mm was deployed with inflating pressure up to 12 atm. Post dilatation was performed with balloon catheter NC Quantum Apex 3.50 X 20mm up to 22 atm. Final shot showed a collateral branch supplying left anterior descending coronary artery. This may explain the ECG changes.
Case Summary. While an ECG reveals infarction territory involving 2 vessels, an infarction related artery providing collateral branch to another one should always be thought. Under emergent condition, sometimes complex angiography may confuse our target. For this case, the RCA seems has a tapering end. In addition, the RCA is the only vessel that was not bypassed. It might look like a chronic total occlusion. This could be the best shot under limited time. Luckily, the RCA was easily passed. We save a lot of time for this patient.

TCTAP C-019
Persistent Hypoxaemia Complicating Right Ventricular Myocardial Infarction
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[CLINICAL INFORMATION]
Patient initials or identifier number. XX

Relevant clinical history and physical exam. 45-year-old Chinese male.
Cardiovascular risk factors of smoking, hypertension and hyperlipidemia
Had history of inferior STEMI status-post PCI to distal RCA (bare-metal stent) in 2003
Now, 10 Years After Last Myocardial Infarction, Presented with:
Sudden chest pain with shortness of breath for 3 days, worse on exertion
Dyspnea not related to posture
Abdominal bloatedness

Relevant test results prior to catheterization. Creatine kinase 1029 U/L (30-350)
Creatine kinase-MB 28.4 ug/L(1.0-6.0)
Troponin I 24.6 ug/L (0.0-0.039)

Relevant catheterization findings. Coronary angiography: Occluded proximal RCA (at previous stent)
Primary PCI of RCA performed:
6Fr Thrombuster aspiration
Two bol of intracoronary integril in administered
Sequential inflations with Tazuna 3x15mm balloon & Quantum Apex 4.5x15mm balloon
After PCI, the patient developed persistent dyspnea. Cause?
Pulse oximetry 85% on 50% O2 and 92% on 100% O2