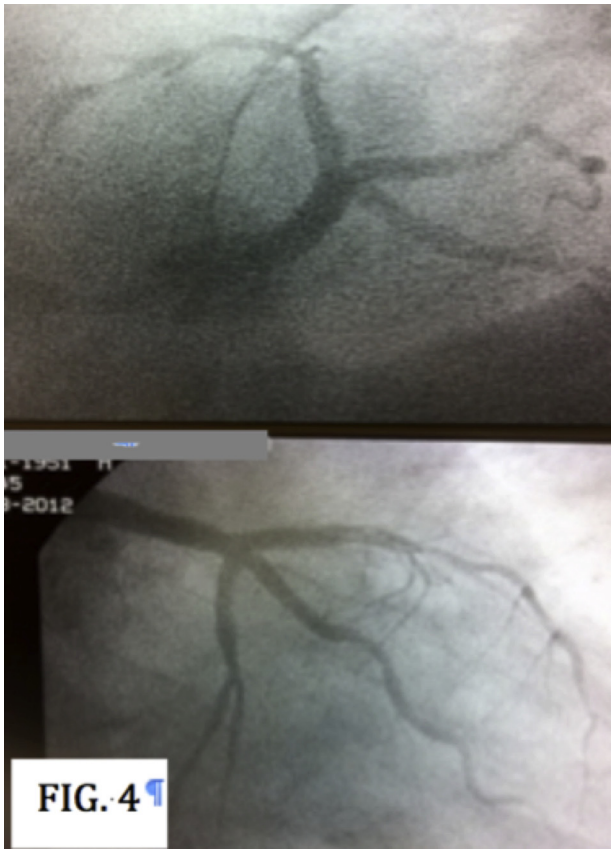
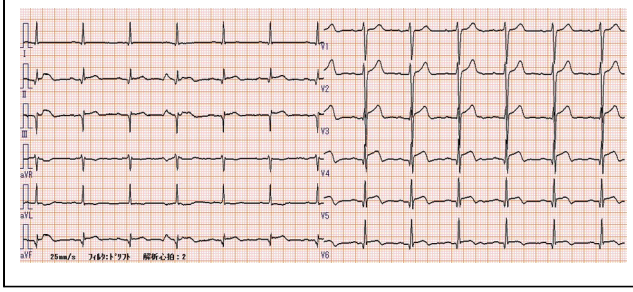
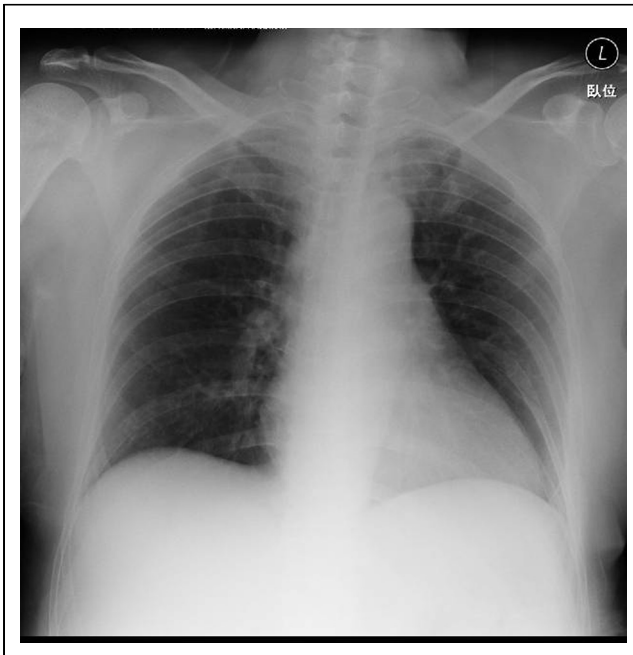






Case Summary. LM trifurcation is rare anatomic finding and if affected with critical stenosis is difficult for treatment, particularly in the setting of STEMI. Another important issue is the stenting technique. In our case we decided to adopt a separate stenting of all branches and then of the LM with good final result as the patient was discharged in good clinical conditions with EF of 40% and only apex akinesia.

TCTAP C-008

Anterior Acute Myocardial Infarction Associated with Trousseau's Syndrome, Successfully Treated with Thrombectomy

Daisuke Furukawa,[1] Satoshi Yamamoto[1]
[1]Chikamori Hospital, Japan

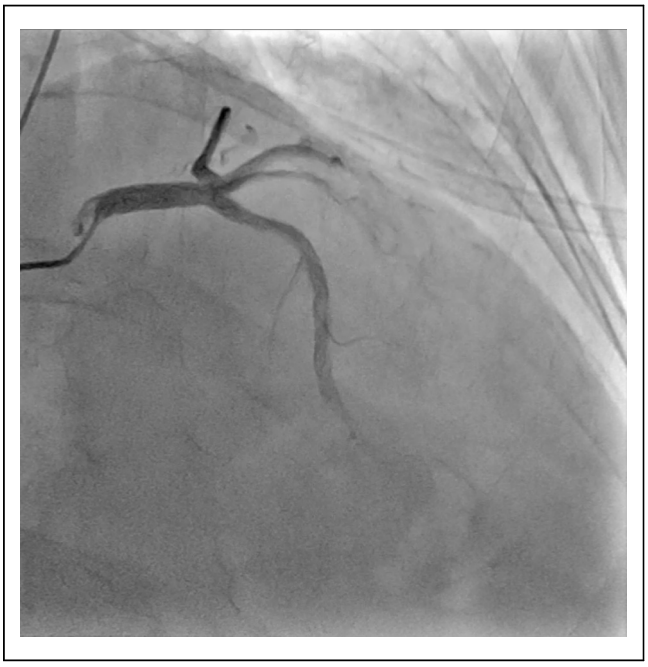
[CLINICAL INFORMATION]

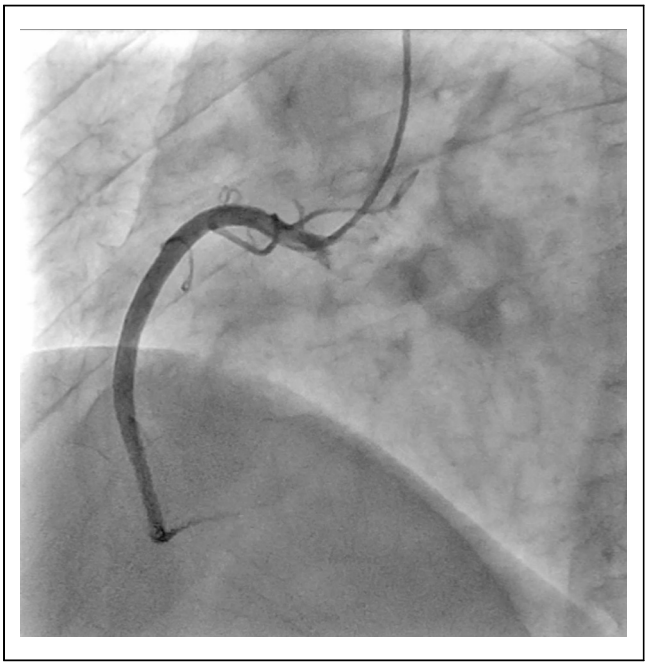
Patient initials or identifier number. O.M.

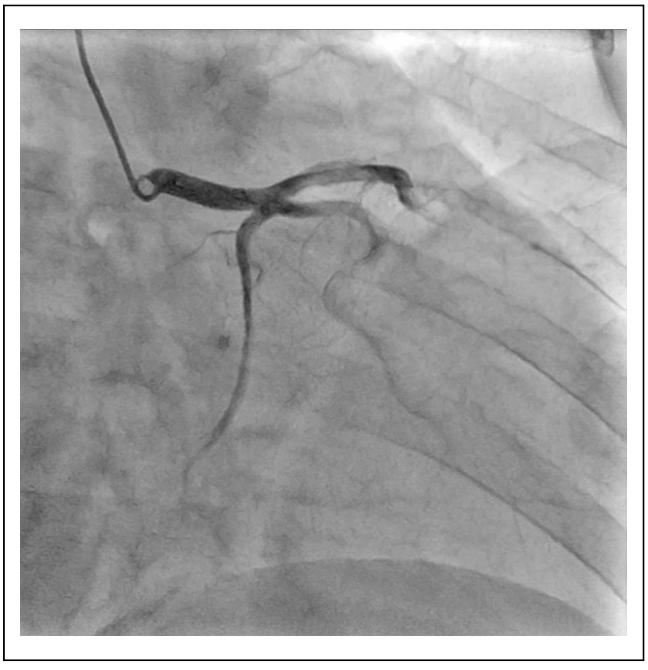
Relevant clinical history and physical exam. Clinical History
She transferred to our hospital because of anterior acute myocardial infarction from a neurosurgical hospital. She had been treated in previous hospital because of multiple repetitive cerebral infractions.
Physical Exam
Blood Pressure: 140/84mmHg, Heart Rate: 75bpm, regular
O2 Saturation: 100% (room air)
Body Temperature: 37.1°C
Lung: clear, no rale
Heart: S1→, S2→, S3-, S4-, no murmur
Left hemiplegia

Relevant test results prior to catheterization. 12 Leads electrocardiogram
Heart Rate: 76bpm, Sinus Rhythm
Q with ST elevation in II III aVF V1-4
Chest Roentgenogram
Cardio-thoracic Rate: 57%
Congestion: -
Effusion: -
Echocardiogram
Left ventricular apical asynergy

Relevant catheterization findings. Coronary Angiogram(CAG)
Right Coronary Artery(RCA): no significant stenosis
Left Anterior Descending Artery(LAD) #8: 100%
Left Circumflex Artery(LCX): no significant stenosis







[INTERVENTIONAL MANAGEMENT]

Procedural step. Rt. femoral artery approach

Guide Catheter: 6Fr. Hyperion SL 3.5ST

Guide wire: Sion Blue

Aspiration therapy using 6Fr. EXPORT Advance could not remove any thrombus, and the lesion still remained totally occluded.

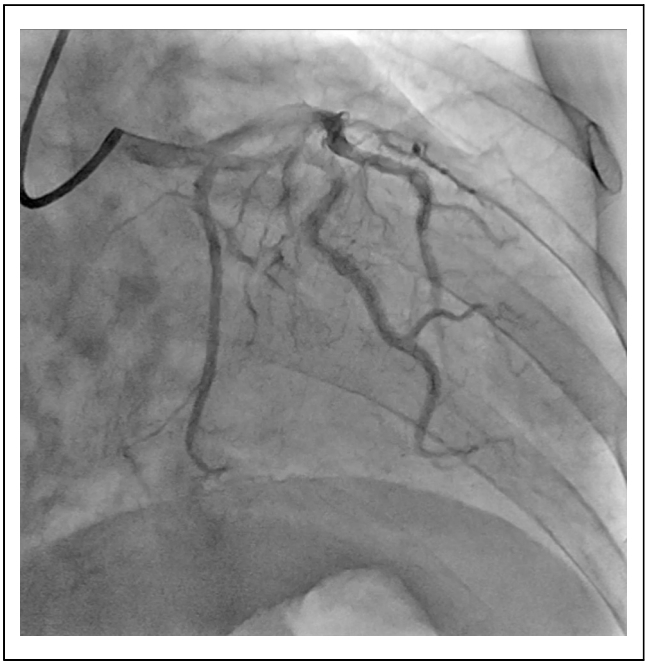
Because there were no atherosclerotic lesions in whole coronary trunk, we thought the filling defect must be thrombus.

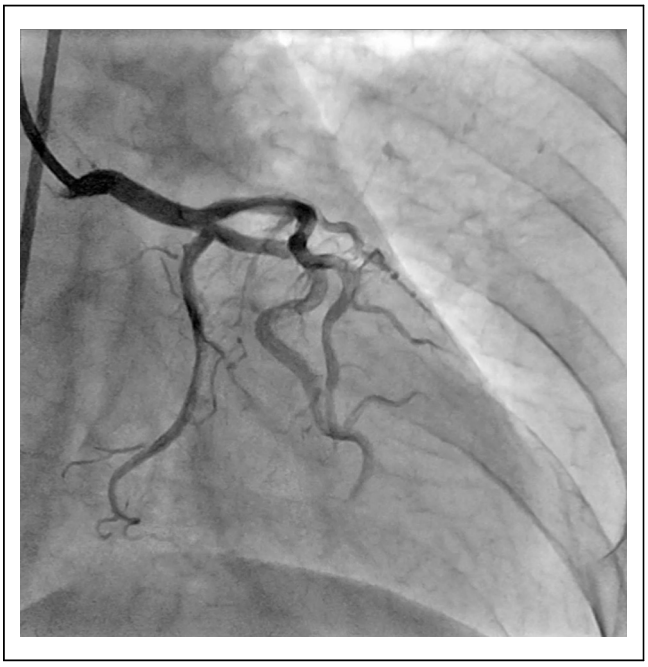
After we crossed a micro catheter Finecross GT distal to the thrombus, we could advance the aspiration catheter more distally.

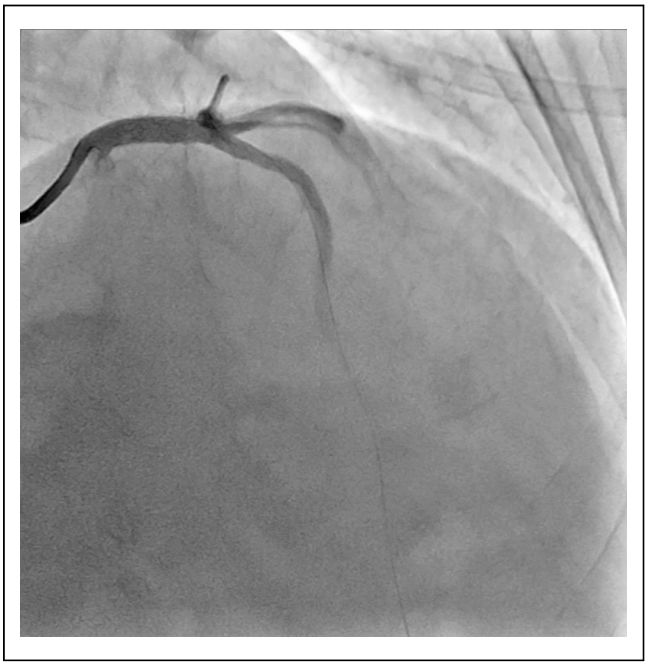
The thrombus was completely aspirated and TIMI III flow was restored.

The final CAG showed another thrombus in high lateral branch.

We successfully remove it using aspiration catheter EXPORT Advance again.







Case Summary. Because multiple thromboembolic events, we searched of malignant tumor with the suspicious of Trousseau's Syndrome.

An ovarial tumor was found and was given a diagnosis of cancer.

Trousseau's Syndrome often present as acute cerebral infarction, non-bacterial thrombotic endocarditis and migratory thrombophlebitis.

Myocardial infarction related with Trousseau's Syndrome is rarely in written literature.

It was unknown whether the thrombus in high lateral branch had come from systemic circulation or slidden from LAD through aspiration catheter.

TCTAP C-227

Misfortunes Never Come Singly - An Unusual Presentation of Repeated Sudden Cardiac Death

Wei-Syun Hu[1]
[1]Shuang Ho Hospital, Taiwan

[CLINICAL INFORMATION]

Patient initials or identifier number. 05827923

Relevant clinical history and physical exam. Mr. Chen, 50-year-old gentleman, denied any systemic disease before (such as hypertension, diabetes mellitus, hyperlipidemia and hyperurecemia, etc.). This patient suffered from tarry stool, poor appetite, nausea, and vomiting for one to two day, and initially he did not pay too much attention to it. Due to worsening symptoms and signs, he came to our emergency department for help in which gastrointestinal bleeding was diagnosed.

[INTERVENTIONAL MANAGEMENT]

Procedural step. Pan-endoscopic examination performed at emergency department revealed multiple shallow gastric ulcers (A2 ulcer) with duodenal ulcers (A1 ulcer), stigmata of bleeding were identified and endoscopic hemostasis injection therapy was done. Emergency physician suggested admission to gastrointestinal ward for further observation and management; besides, NPO with intravenous fluid supplement, blood component therapy and intravenous proton pump inhibitor therapy were prescribed for this patient.

Unfortunately, sudden collapse attacked at ER several hours later when waiting for bed transferal, cardiopulmonary cerebral resuscitation was immediately performed for severe minutes; and after regain of spontaneous circulation, complete electrocardiogram revealed ST segment elevation over inferior leads. Post cardiopulmonary cerebral resuscitation vital signs were hypotension with bradycardia (sinus bradycardia). Fluid resuscitation with inotropic agnet was given. Intubation with mechanical support was done for airway maintenance. Cardiologist was consulted and emergent coronary angiography was performed soon; and the report was patent coronary artery. He was then admitted to ICU for further intensive care. Unfortunately, ventricular fibrillation with loss of consciousness was noted two hours later in ICU; and completes ECG showing ST segment elevation over lead 2, 3 and avF; therefore repeated coronary angiography was done.

TCTAP C-009

Treatment of Acute Closure During PCI for LAD Functional Total Occluded Lesion

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[1]Kaohsiung Veteran General Hospital, Taiwan; [2]Kaohsiung Veteran General Hospital, Pingtung Branch, Taiwan; [3]Kaohsiung Veterans General Hospital, Taiwan

[CLINICAL INFORMATION]

Patient initials or identifier number. 1967823

Relevant clinical history and physical exam. A 56 Y/O male with risk factor of hypertension and hyperlipidemia. He suffered from chest tightness off and on for one month. Coronary angiography showed RCA with discrete lesion over RCA-PDA and -PLV with collateral to LAD-M, LAD-M functional total occlusion and micro channel from LAD-D2 to LAD-D.We planned to cross the lesion to LAD-D1 with soft wire and then use Crusade catheter or reverse wire technique to pass the wire to LAD-D.