TCTAP C-023
An Amazing Experience of Aspiration Thrombectomy
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[Clinical Information]
Patient initials or identifier number:
Koot, R H A
Relevant clinical history and physical exam:
A 41 years old gentleman, who enjoyed good past health, presented with acute chest pain while he was playing with his son. His ECG showed ST elevation at lead V2-5.
Relevant test results prior to catheterization:
Other blood results were normal.
Relevant catheterization findings:
His coronary angiography showed right dominance system. RCA and LCx were normal looking. Mid LAD acute occlusion was seen.

[Interventional Management]
Procedural step:
Left Anterior Descending (LAD) artery was engaged with a CLS 3.5 guiding catheter (Boston Scientific). Wiring was started with Sion blue (Asahi). It was very difficult shortly after the mid LAD obstruction. Another Pilot 200 (Abbott Vascular) was used. Still cannot pass to distal vessel. Aspiration thrombectomy was performed with QuickCat Extraction Catheter (Spectranetics) at the mid LAD occlusion site. A long piece of whitish material was aspirated out. However, coronary blood flow not regain after performing aspiration thrombectomy. Eagle Eye (Volcano) IVUS was used to define the nature of lesion. With IVUS, a clear picture of dissection of the entire mid-LAD was seen. IVUS-guided wiring of the true lumen was performed and was success. Then the lesion was re-dilatation with semi-compliant balloon, Sapphire 2.0 x 20mm (OrbusNeich), up to pressure 16 atm. A bare metal stent, Skylor 2.5 x 20 mm (INVATEC), was deployed and mid-LAD was post dilated with a non-compliant balloon, Beo 3.0 x 10 mm (Vascularperspectives), up to 18 atm. There is still residual dissection beyond the stent from IVUS assessment. It was decided to manage with prolong balloon inflation with a semi-compliant balloon, Sapphire 2.5 x 20 mm (OrbusNeich), up to 10 atm. Dissection was sealed with good angiographic result. LAD regain TEMI 3 flow after procedure. We had sent the piece of material for pathological analysis. The result turn out to be a part of the intima and media.

In conclusion the patient is likely suffering from mid LAD acute occlusion caused by spontaneous dissection. We misunderstand the pathology to be plaque rupture and thrombosis from the beginning of procedure. And we had aspirated out part of the dissection flap during the procedure.
Case Summary:
A 41 year old presented with acute STEMI. His ECG in emergency department showed ST elevation in anterior leads. His coronary angiogram showed mid LAD occlusion. The patient is suffering from mid LAD acute occlusion caused by dissection, likely spontaneous dissection. We misinterpreted the pathology to be plaque rupture and thrombosis from the beginning of procedure. And we had aspirated out part of the dissection flap during the procedure.

TCTAP C-024
Back to Thrombolytic
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[Clinical Information]
Patient initials or identifier number:
SW Lee
Relevant clinical history and physical exam:
72/M, DM, HT, AF, CRF, Old CVA. Admitted for acute onset chest pain and SOB. Physical exam showed hypotension and bilateral basal crepitation compatible with cardiogenic shock and APO.
Relevant test results prior to catheterization:
Creatinine 203, Initial TnI 0.38
ABG showed metabolic acidosis with pH 7.21, BE -17.4
ECG showed slow AF, AR 46bpm, with new TWI V2-6
Relevant catheterization findings:
RCA diffuse moderate disease
LM total occlusion by big thrombus

[Interventional Management]
Procedural step:
Mechanical thrombectomy was attempted by using Eliminate aspiration catheter. Mild success only despite repeated suction. IC Reopro was administered and POBA with NC trek 2.0/15 was done. However, there was persistent large thrombus occluding the entire LCx. IC TNK 2000 unit was then given which resulted in resolution of the LM thrombus and showing recanalization of the LCx and a 90% stenotic lesion in mLAD. The mLAD lesion was then stented with Nobori 2.5/14. Unfortunately, stenting still resulted in distal embolisation in dLAD which persisted despite medical therapy. Patient remained in cardiogenic shock and finally succumbed 12hrs post-intervention.