Acute Coronary Syndrome: STEMI, NSTEMI
(TCTAP C-001 to TCTAP C-022)

TCTAP C-001
At the Crossroad of Primary PCI
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[Clinical Information]
Patient initials or identifier number:
AA, 38773
Relevant clinical history and physical exam:
Mr. X, 40 years old male, smoker, normotensive, incidental diabetic, presented with STEMI (Inf) for 4 hours. Then he was sent into cath-lab and underwent PPCI. He had no history of significant cardiovascular risk factor except smoking & incidental DM. His vital sign on CCU showed stable state.

Relevant test results prior to catheterization:
His initial ECG showed marked ST segment elevation in lead II, III, aVF. RBS-12mmol/L.

Relevant catheterization findings:
Left coronary artery system normal & right coronary artery 90% mid segment disease.

[Interventional Management]
Procedural step:
Transfemoral.
Guide Cath: JR 3.5 7F
Guide Wire: All star
Balloon Cath: Instent balloon
3.5x20 at 14 ATM
Stent: 3.5x30 BMS at 12 ATM
3.5x20 BMS at 12 ATM
3x19 PTFA covered stent at 22 ATM

Case Summary:
We performed PPCI into RCA mid segment by BMS 3.5x30mm at 14 ATM. However, after immediate deployment type three perforations was happened. Then we inserted stent balloon into perforation site for prolong inflation. Simultaneously, TPM was done and we performed auto perfusion. After several times in stent balloon inflation no improvement, but immediately, we don’t managed PTFA covered stent. So we put another 3.5x20mm BMS stent at perforation site with the hope to minimize perforation and buy some time. After 90 minutes, we put 3x19mm at 22 ATM covered stent (PTFA). Consequently, we started ionotropic support and continued auto perfusion. Then flow minimized. Then we did post dilatation and established TIMI flow III with nitrates & adenosine. After stabilization of the patient again send into CCU with stable hemodynamic condition.

TCTAP C-002
Rescue Angioplasty After Failed Thrombolysis in a Case of Myocardial Infarction with Large Coronary Aneurysm with Thrombus
Saurab Goel
Cumballa Hill Hospital, India

[Clinical Information]
Patient initials or identifier number:
PK
Relevant clinical history and physical exam:
71 years old male
Non diabetic, non hypertensive, no history of IHD
One hour history of acute chest pain with sweating
ECG showed acute anterior wall MI
Thrombolysed with tenecteplase (metalyse) 7000 i.u.

Relevant test results prior to catheterization:
ECG - Hyperacute anterior MI, thrombolysed with tenecteplase, failed thrombolysis with further ST elevation

Relevant catheterization findings:
Large LAD aneurysm with total occlusion, localized RCA aneurysm

[Interventional Management]
Procedural step:
LAD crossed with fielder wire and another wire placed in diagonal
Clot suction done using thrombuster device, antegrade flow estatentiniblished, high grade lesion noted at distal end of aneurysm
Due to reformation of thrombus, intracoronary tiroliban administered
Stenting performed with 3.5 X 18 metallic bionert stent
TIMI III flow achieved in LAD, patient made uneventful recovery
Patient had uneventful post procedure recovery

2d echo showed well preserved myocardial function with lv ejection fraction of 45%
Patient was discharge on oral anticoagulation with acitrom
Doing well 6 months after procedure with good lv function on 2 d echo and normal treadmill stress test

Conclusion:
This case illustrates an unusual presentation of large lad aneurysm with high grade lesion at distal end and thrombosis causing complex anterior wall myocardial infarction. Rescue angioplasty was successfully performed after failed thrombolysis. A large thrombus burden required frequent clot suction. Reformation of thrombus within the aneurysm was tackle by administering intracoronary tiroliban. Due to thrombus burden and large vessel diameter non drug eluting stent was used. Patient maintained on long term oral anticoagulation.