Antiplatelet Agents and Anticoagulants
(TCTAP C-037 to TCTAP C-038)

TCTAP C-037
Transcatheter Thrombectomy and Anti Coagulant Management in Massive Pulmonary Emboli Patient with Hemorrhagic Stroke
Faris Basalamah
RS Mitra Keluarga Bekasi Timur, Indonesia

[Clinical Information]
Patient initials or identifier number:
JS, 54 years old

Relevant clinical history and physical exam:
Patient was hospitalised for 25 days after suffer from hemorrhagic stroke that underwent decompression craniotomy immediately. He had hemiplegia and partial aphasia. He was training by the physiotherapist, but still in bed not mobilise well. He had not any anticoagulant to prevent tromboembolism until he suddenly had short of breath and decreased BP and peripheral saturation.

Relevant test results prior to catheterization:
ECG: Sinus Tachycardia, T inverted @ III, S deeper @ I,
Echocardiogram: Good LVEF (66%)
Trivial AR
Severe TR, TVG 44mmHg
Laboratory: D Dimer 5.9 ml/L

Relevant catheterization findings:
Pulmonary Artery Angiography Shown: Massive Right Pulmonary Artery Thromboembolism

[Interventional Management]
Procedural step:
1. Puncture right femoral vein then inserted 7Fr sheath
2. PA angiography was performed with 6Fr pigtail catheter in main pulmonary artery
3. Massive right pulmonary thromboembolism was confirmed
4. Thromboembolectomy was planned.
5. Temporary pacemaker (St. Jude lead 6Fr) was inserted to right ventricle apex from left femoral vein.
6. Xpeedior trombectomy catheter set was inserted to right pulmonary artery guided with Merit Laureate 260cm 0.035 inch guide wire.
7. Suction was performed with angiojet(R) ultra thrombectomy system.
8. Heparin 5000 i.u intravenously was given during procedure
9. Post procedural evaluation was performed with pigtail catheter 6F.
10. After thrombectomy patients was receive enoxaparin 0.6ml sc twice daily continued with Rivaroxaban 15mg twice daily for 3 weeks.
11. After 3 weeks rivaroxaban dose was decreased to 20mg once daily.
12. 1 month after thrombectomy Pulmonary artery CT-scan shown minimal residual thrombus in right pulmonary artery. The D-dimer was below 0.3ml/L
13. Patients was underwent second operation to close the craniotomy and the rivaroxaban was suspend for 5 days, 1 days before surgery and 4 days after surgery.
14. 6 months after thrombolectomy (17 December 2013) PA MSCT shown clear in both pulmonary artery, no residual thrombus.

Case Summary:
Successful thrombolectomy with Angiojet in a patient with hemorrhagic stroke post craniotomy continued with Rivarixaban. 1 month after thrombolectomy rivaroxaban was discontinued for 1 week due to patient underwent second surgery to close the craniotomy. 6 months after thrombolectomy (17 December 2013) PA MSCT shown clear in both pulmonary artery, no residual thrombus.

TCTAP C-038
How to Manage the Huge Coronary Thrombus in ACS Patient?
Rei Fukuhara
Hyogo Prefectural Amagasaki Hospital, Japan

[Clinical Information]
Patient initials or identifier number:
M.T and H.Y

Relevant clinical history and physical exam:
During primary PCI of ACS patients, we often face to coronary thrombi which cannot be retrieved by aspiration catheter. I would like to introduce two RCA ACS cases with large amount coronary thrombi.

[Case1] A 71-year old man was admitted with chest pain started four hours ago. His risk factors were dyslipidemia, and former smoking. Physical examination revealed no significant findings.

[Case2] A 55-year old man was admitted with chest pain started 11 hours ago. His risk factors were hypertension, dyslipidemia, and current smoking. Physical examination revealed no significant findings.

Relevant test results prior to catheterization:
[Case1] Chest X-ray was unremarkable. ECG showed ST elevation at V1 to 4. Mildly decreased motion at inferior wall was detected by echocardiogram. Elevation of cardiac enzyme (CK-MB = 71 IU / L) was observed.