

**TCTAP C-015**

**A Young Female Case of Acute Myocardial Infarction and Subsequent Stent Thrombosis with Quantity of Thrombus Derived from Multiple Ruptured Plaque with Thin-Cap Fibroatheroma**

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**[CLINICAL INFORMATION]**

**Patient initials or identifier number.** S.K

**Relevant clinical history and physical exam.** Coronary Risk Factors: HTN, DM, DLP, and smoking

Life History: 30 y/o: married

Family History: Mother: Ischemic heart disease

Present Illness

2014/2/17 First chest pain was transient.

2014/2/18 Second chest pain was sustained, she was transported by ambulance.

Physical examination: BH 154 cm, BW 88 kg, BMI 37.1, BSA 1.86 m<sup>2</sup>  
HR 108 bpm, BP 163/106 mmHg, SpO<sub>2</sub> 100% (O<sub>2</sub> 3L)

HS: S<sub>1</sub> → S<sub>2</sub> → S<sub>3</sub>(-) S<sub>4</sub>(+) no murmur RS: vesicular no rale

Jugular vein distension(-), Pretibial edema(-)

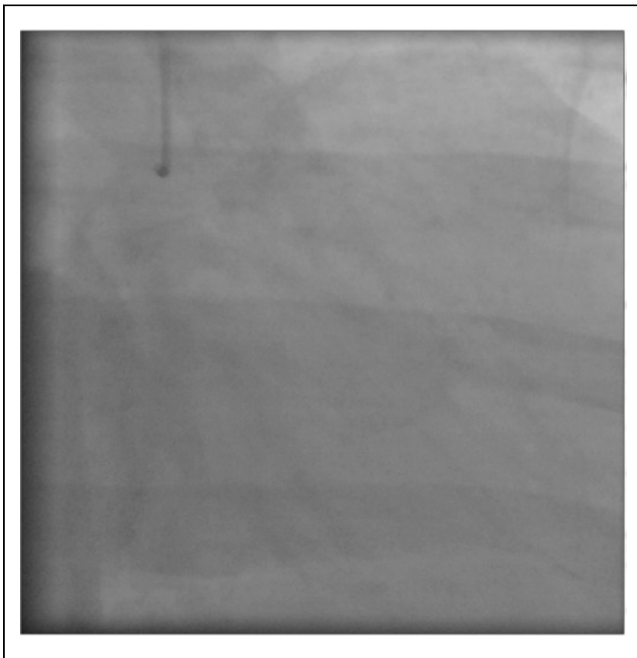
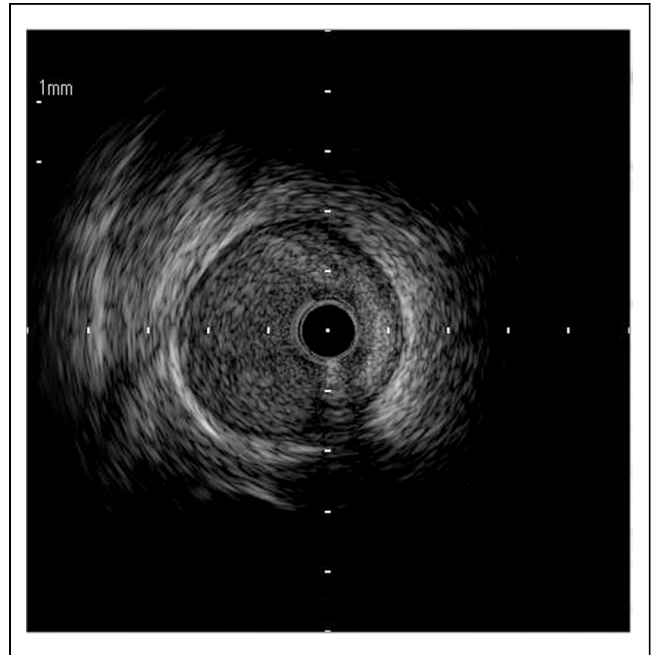
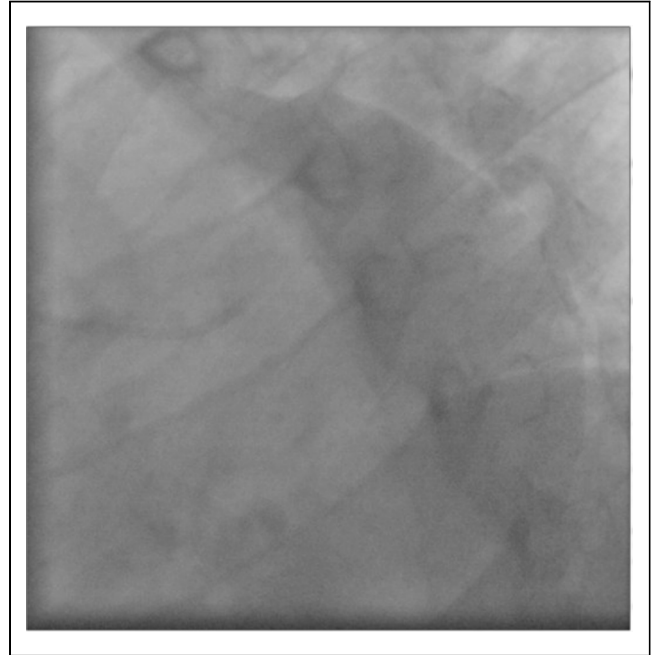
**Relevant test results prior to catheterization.** ECG: HR 100bpm, NSR, CRBBB, ST elevation in I, aVL, and V<sub>1</sub> to V<sub>6</sub>

CX-P: Pulmonary congestion(-)

UCG: LVDd/Ds 51/37mm, IVSth/PWth 10/12mm, LAD 34mm, EF 41%, LVWMAntero-septal severe hypo

Laboratory data: WBC 14920/mm<sup>3</sup>, RBC 494 104/mm<sup>3</sup>, Hb 14.4 mg/dL, PLT 24.1104/mm<sup>3</sup>, CK 173 IU/L, CK-MB 17 IU/L, Tnl 1.35 ng/mL, AST 22 IU/L, LDH 231 IU/L, CRP 0.93 mg/dL, BUN 10.6 mg/dL, Cre 0.45mg/dL, eGFR 128.2mL/min/1.73m<sup>2</sup>, TG 2274mg/dL, LDL-C 55mg/dL, HDL-C 26mg/dL, Glu 343mg/dL, HbA1C 12.4%

**Relevant catheterization findings.** Emergent CAG: LAD proximal site was occluded with thrombus. First diagonal branch was visible. Collateral flow from RCA was not observed. IVUS showed two vulnerable plaques with TCFA and quantity of thrombus in the proximal LAD. Proximal and distal lesions were positioned at bifurcation of the first septal branch and the first diagonal branch, respectively. The proximal lesion was extended to the LMT



**[INTERVENTIONAL MANAGEMENT]**

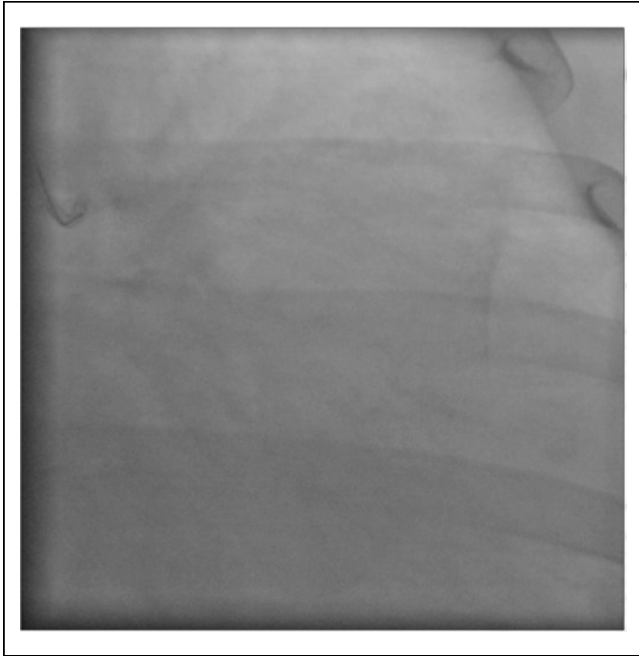
**Procedural step.** Thrombectomy was performed with aspiration catheter. Residual thrombus was persisted in the proximal LAD. According to IVUS findings, the proximal lesion with vulnerable plaque was supposed to be the main culprit lesion. Considering vessel diameter or future pregnancy, we hesitated LMT stenting or long stenting.

Primary PCI was performed stenting with BMS at the proximal lesion focally to fit the LAD ostium after repeated thrombus aspiration.

After the primary PCI, the data from Swan-Ganz catheter was Forester subset 1, peak CK was 2851. Sub-acute stent thrombosis with

abrupt pulmonary edema was occurred after cardiac rehabilitation for 4 weeks.

After the control of pulmonary edema, second CAG was performed. LAD flow was jeopardized because of sub-acute thrombosis. Lumen narrowing was seen in the proximal LAD. TLR was performed with long DES to cover the lesion fully.



**Case Summary.** We experienced a young female case of acute myocardial infarction with a quantity of thrombus derived from multiple ruptured plaques with thin-cap fibro atheroma, which advanced to sub-acute thrombosis with abrupt pulmonary edema.

**TCTAP C-016**  
**“Single” Vessel, “Double” Primary Angioplasty, “Triple” Nightmares**

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**[CLINICAL INFORMATION]**

**Patient initials or identifier number.** YNL

**Relevant clinical history and physical exam.** YNL is a 66 years old chronic smoker who enjoyed well past health. He was admitted for sudden onset severe chest pain without hemodynamic compromise. Physical examination showed normal JVP, clear chest and dual heart sound without significant heart murmur.

**Relevant test results prior to catheterization.** Electrocardiogram on admission showed ST segment elevation over anterior precordial leads. Echocardiogram showed impaired left ventricular systolic function with hypokinetic myocardium supplied by left anterior descending artery. CXR showed normal mediastinum without evidence of pulmonary edema.

