Case Summary. Difficult vascular access is known to be one of the non-system reasons for delay in door-to-needle time (D2BT) and associated with higher in-hospital mortality. We described a case of primary percutaneous coronary intervention with difficult vascular access. Fibrinolysis should be considered as an alternative therapy in patient with acute myocardial infarction with difficulty in obtaining vascular access.

TCTAP C-022
Worst Fatal Cath Lab Case Scenario of 58 Years Old Male with Acute Infero-posterior Wall Myocardial Infarction Who Underwent Right Radial Primary PCI Followed by Subacute Scaffold Thrombosis After 36 Hours with Totally Occluded Abdominal Aorta
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[CLINICAL INFORMATION]
Patient initials or identifier number. Mr. N
Relevant clinical history and physical exam. 58 years Male who is known smoker & Alcoholic with Type II Diabetes Mellitus, Systemic Hypertension came to emergency room with the complaints of Chest pain for past 14 hrs duration and worsened for past 2 hours duration with mild dyspnea for which clinical examination was done which showed mild bilateral basal crepitation with Hypotension and subjected to surface ECG.

Relevant test results prior to catheterization. His surface ECG showed acute infero posterior wall myocardial infarction and his blood sugars were increased. His echocardiogram showed mild left ventricular dysfunction with regional wall motion abnormality involving infero posterior, posterobasal wall with ejection fraction of 45%.

[INTERVENTIONAL MANAGEMENT]
Procedural step. Patient was started on Tirofiban infusion as per weight. LMCA was engaged with extra backup guiding catheter and lesion was crossed with 0.014 inch wire and thrombus aspiration was done, TIMI III flow seen. Since Proximal left Circumflex lesion was calcified and could not able to cross the balloon, Predilatation was done to proximal LCx and then predilated the Circumflex PDA lesion sequentially. Since guiding catheter and wire was not supported to take the drug eluting stent across the proximal LCx lesion, AL guiding catheter was exchanged and drug eluting stent to Circumflex PDA was done. Proximal LCx lesion was adequately predilated and Biovascular scaffold was done with adequate post dilatation. Patient develops acute onset of chest pain and dyspnea and his ECG revealed acute re Myocardial infarction diagnosed as probable Acute stent thrombosis. Since patient was hemodynamically unstable with pulmonary edema and cardiogenic shock, He was electively intubated and with inotropes shifted to the cath lab. Femoral artery access was made and diagnosed as abdominal aorta 100% occlusion and radial artery access was made and repeated thrombus suction was done and post dilatation of proximal LCx to distal LCx was made. Persistent thrombus occlusion was seen with no flow reflow phenomenon for which intra coronary pharmacootherapeutics were used. Patient went in for cardiac arrest and could not able revive, was declared.
**Case Summary.** First point is to choose right supportive guiding catheter, Second point is Bio vascular scaffold in calcified lesion and in acute myocardial infarction needs more data, Third point is despite of maximum antiplatelets, GPIIbIIIa inhibitors repeated thrombus occlusion needs further study, Fourth point is we need more data on Clopidogrel resistance because this patient was used clopidogrel after primary PCI, Fifth point is cause for 100% occluded aorta and difficult access of IABP support and how to manage in these kind of highly complicated situations as happened in this patient is questionable.

**TCTAP C-023**

Bleeding and Primary PCI

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**[CLINICAL INFORMATION]**

Patient initials or identifier number. Mr. R

Relevant clinical history and physical exam. A 60 years old gentleman referred from other hospital for Acute Inferior MCI of 7 hours duration. He was also presenting with acute upper GI bleeding, with gross melena. He has history of chronic peptic ulcer for 4 years.

Relevant test results prior to catheterization. Hb 8.4 from 13.2 (at other hospital) ECG showed ST elevation at inferior leads

Relevant catheterization findings. RCA subtotal occlusion LAD mid stenosis 80% LCx mid thrombus (+) with TIMI 2