# **You Did It, You Fixed It.**
# Case Presentation

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# Case Presentation

- 56 year old man with acute inferior STEMI was referred for rescue PCI.
- 5 hrs: acute chest pain for 30 min
- Initial BP 75/57 P60 R24
- ECG: Acute inferior STEMI, normal V3-4R
- Initial treatment:

  NSS loading

  Dopamine 20 ugm/kg/min IV drip

  Adrenaline IV drip 200 ugm/hr

  ASA 324 mg and Clopidogrel 300 mg

  then BP 110/60

- Rx: Streptokinase 1.5 mu in 60 min
  → Failed Fibrinolysis
  Referred for rescue PCI
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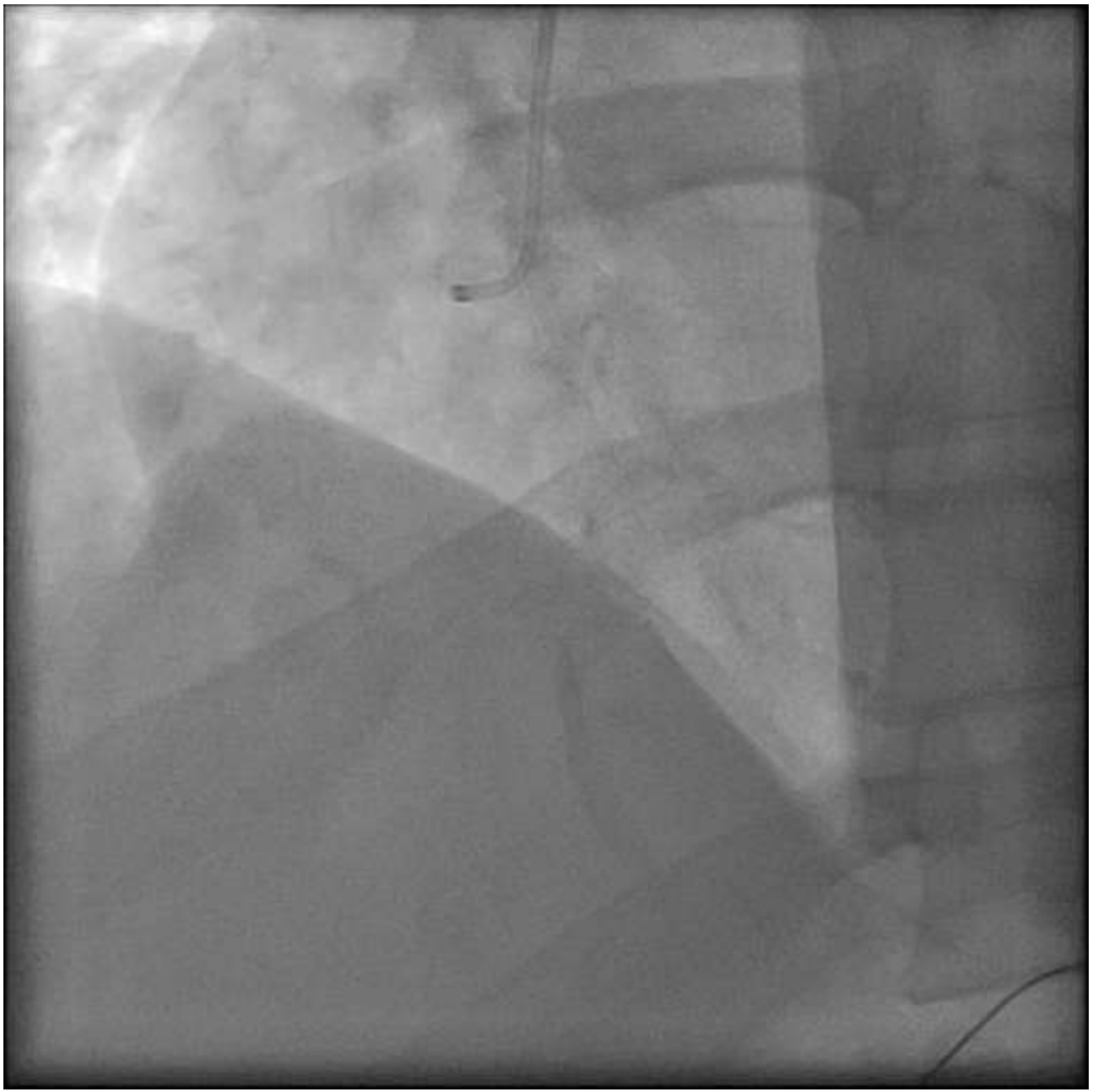
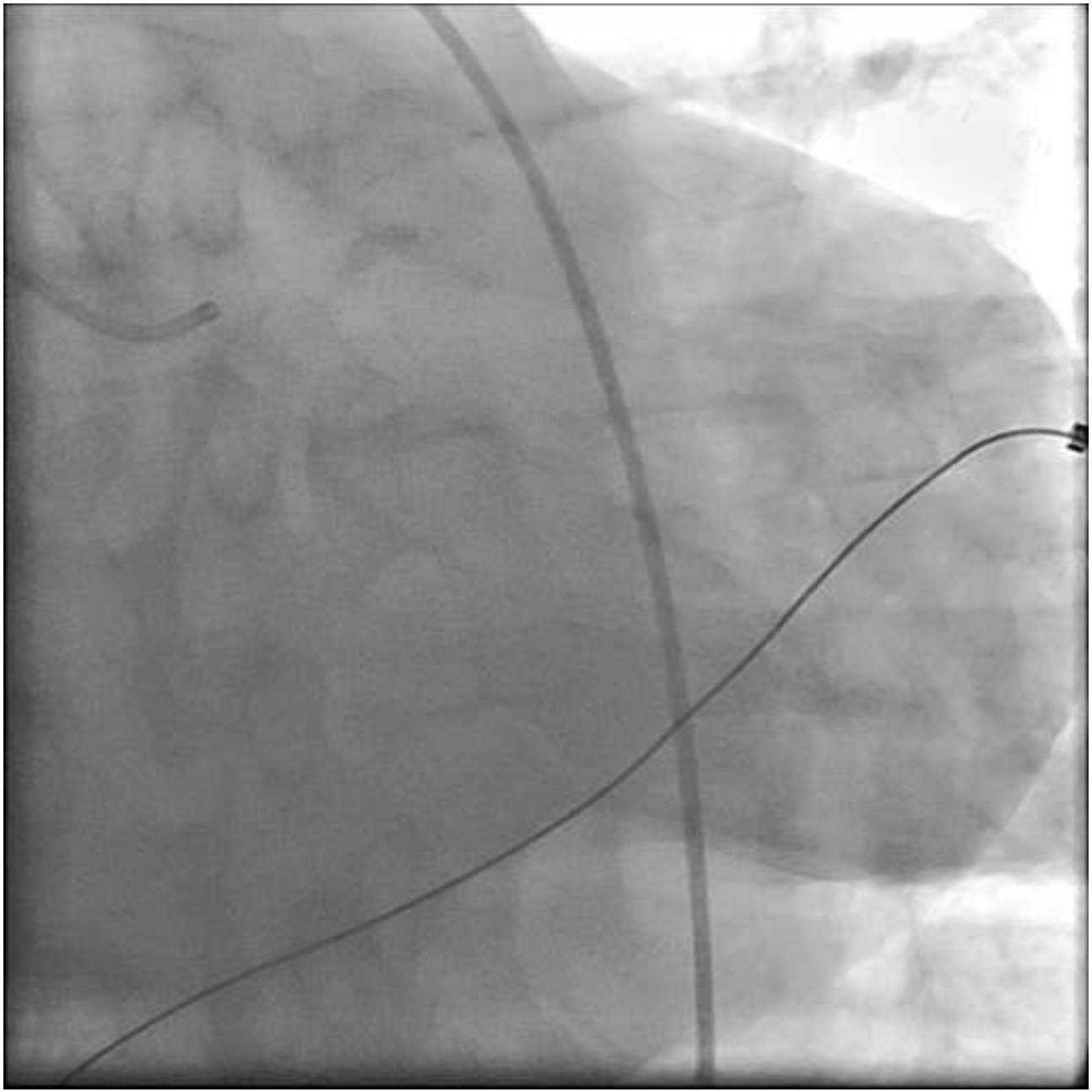
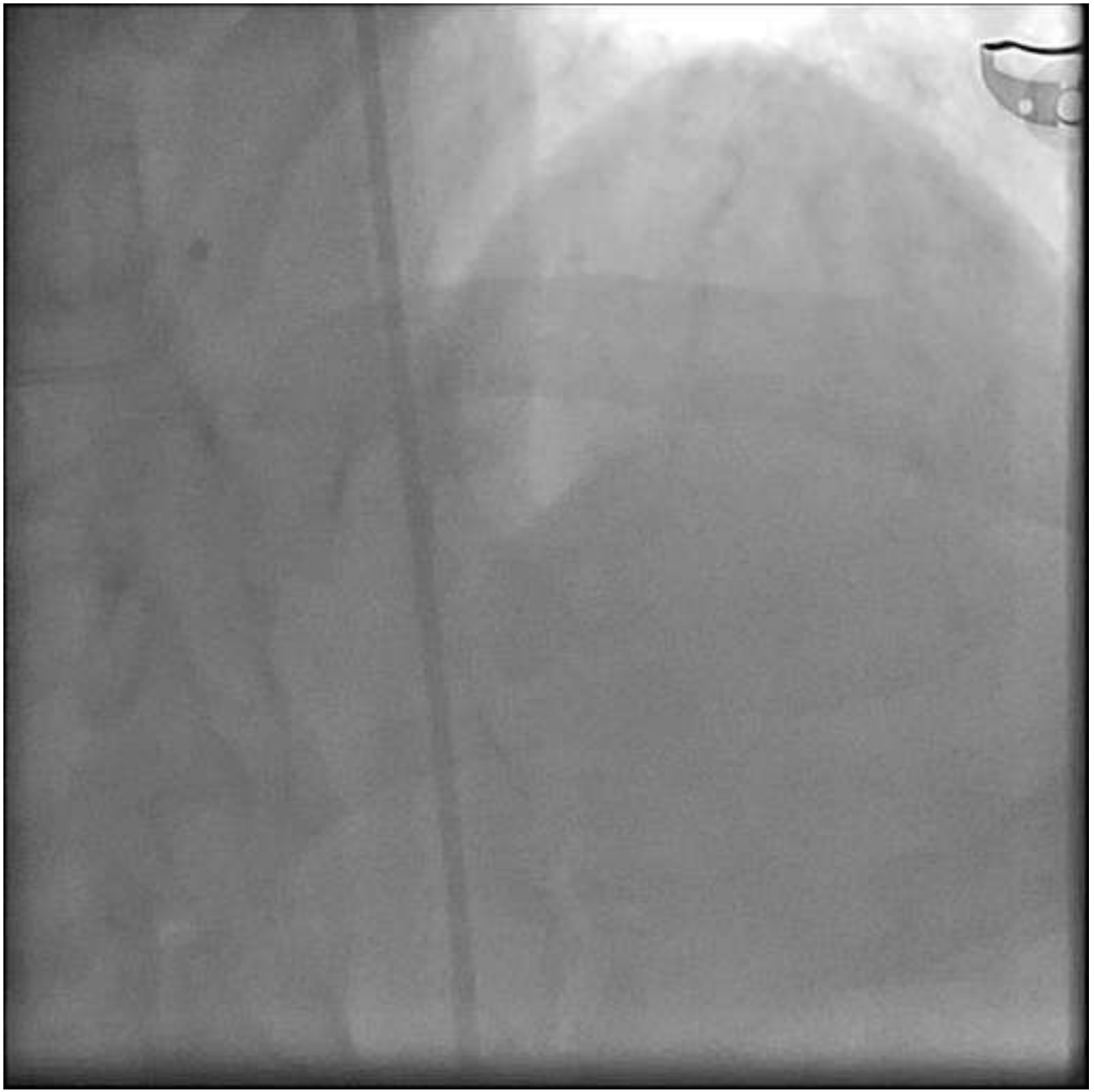
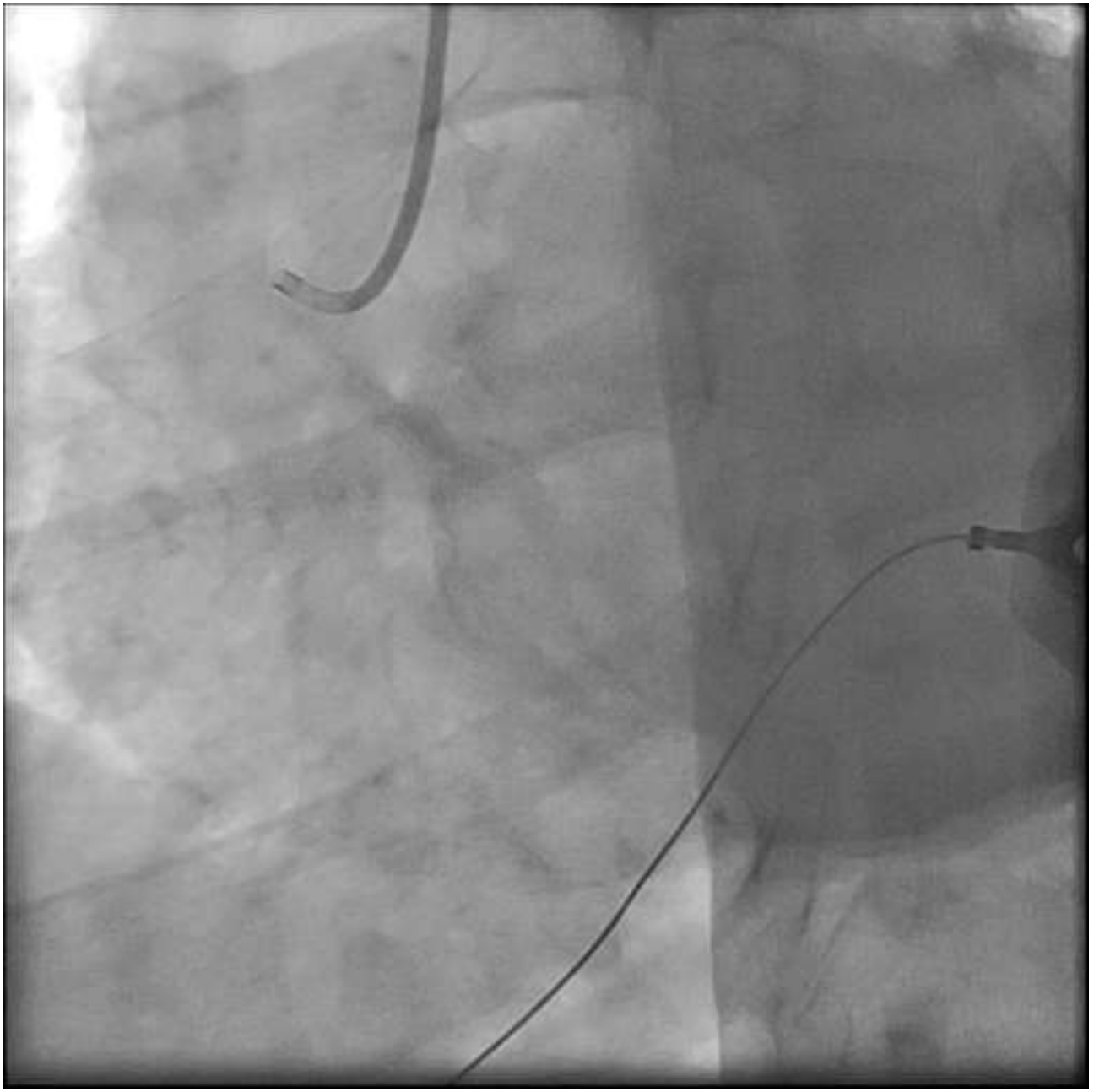
  refer time was 140 min
  at cath lab: BP 136/80
  Chest pain 3/10
  ECG persistent ST elevation

Rx: another 300 mg of clopidogrel
Transfer to cath lab





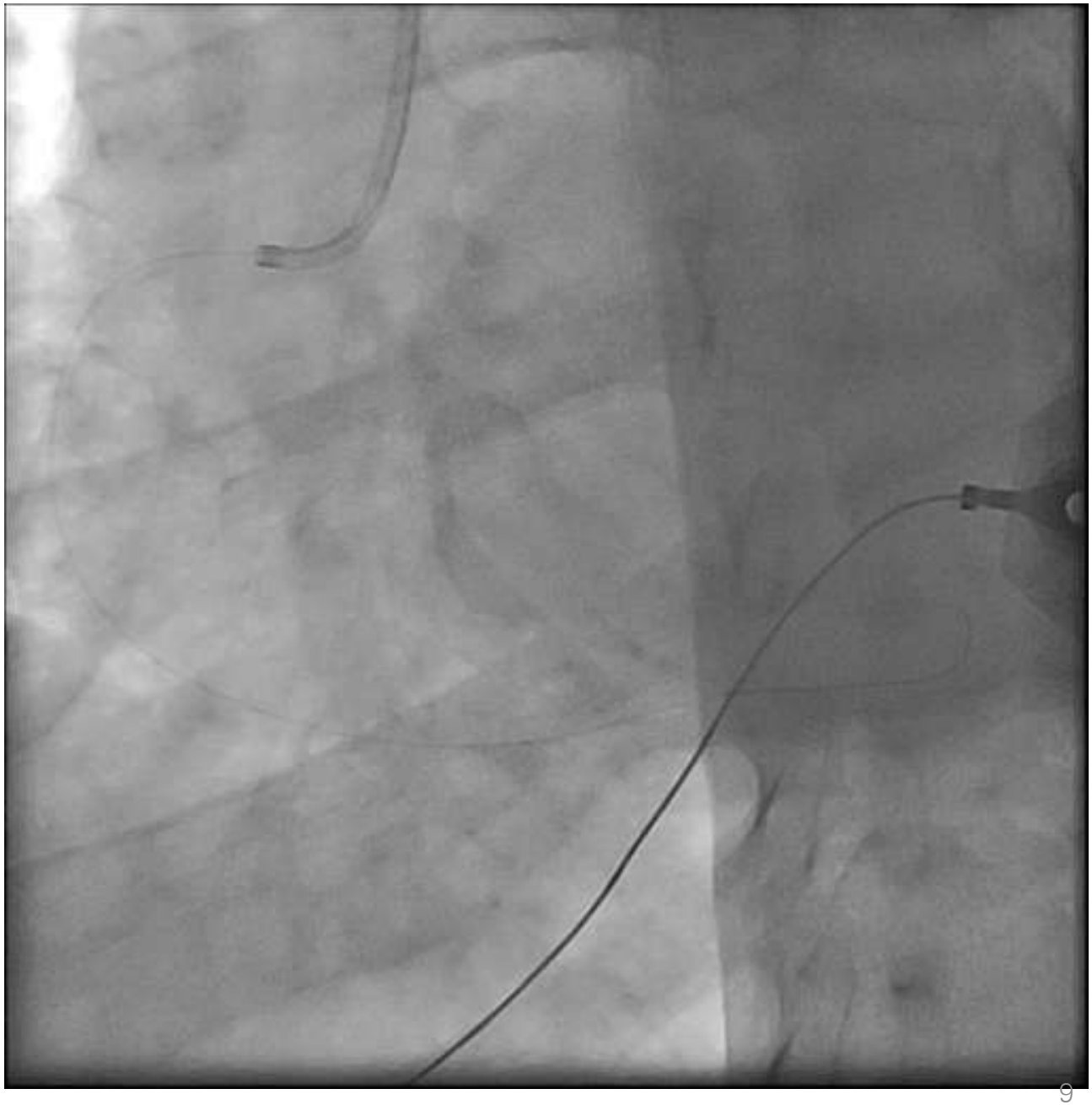




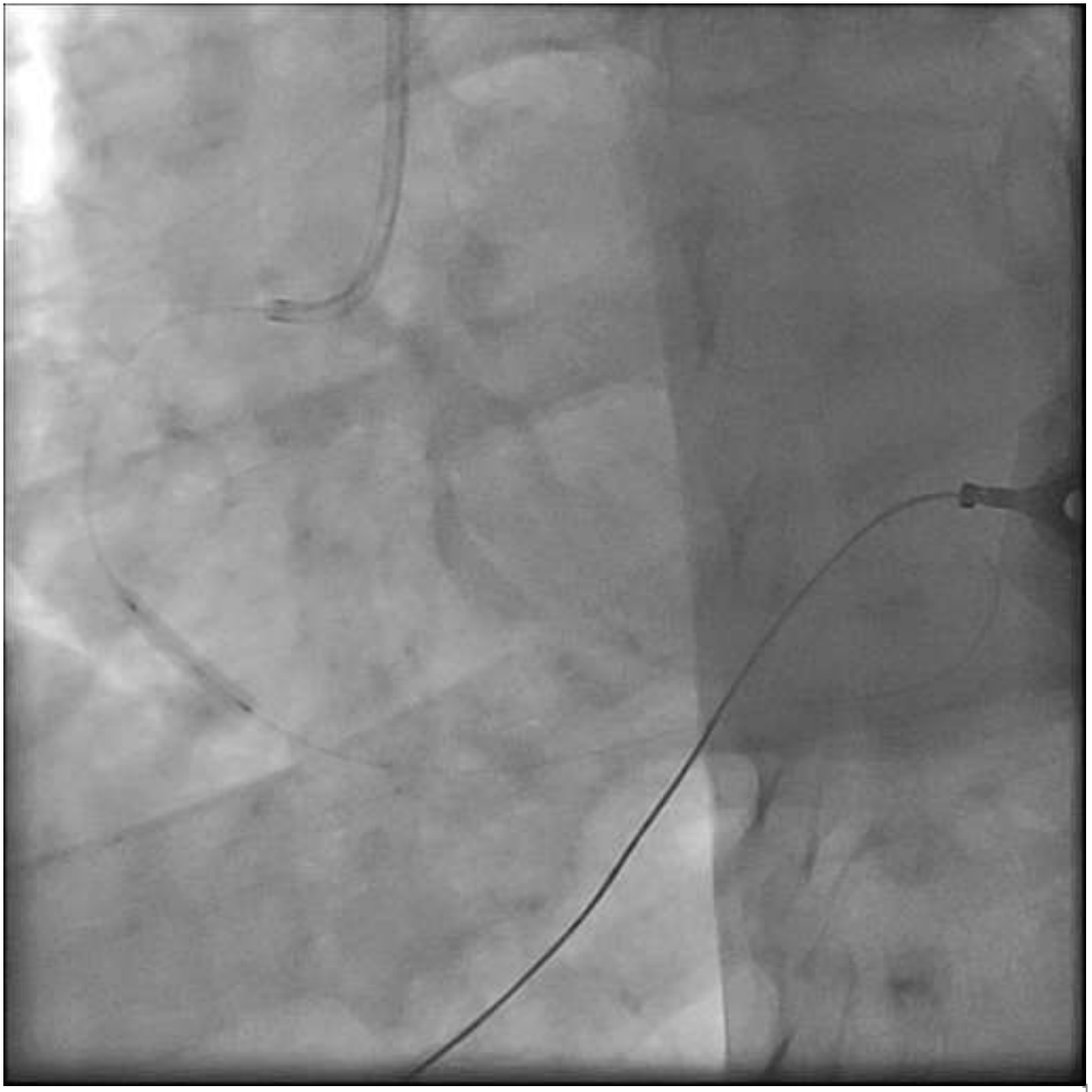
# What are you going to do ?

A. Nothing now
B. Thrombus aspiration and…..
C. PCI to RCA
D. PCI to RCA and LCX
E. Triple vessel PCI

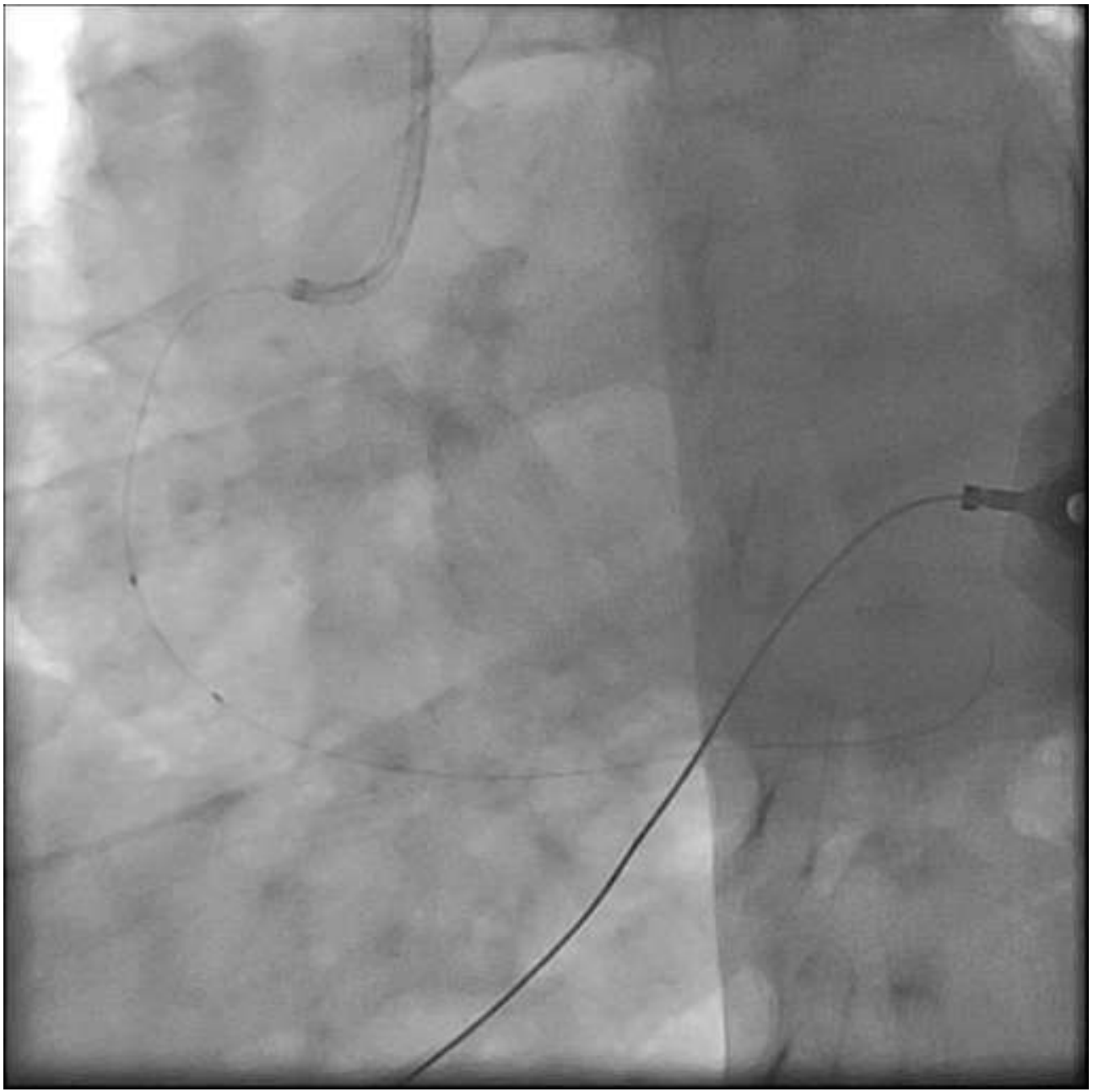
5,000 u UFH
6 Fr-JR 4 guide
Whisper wire



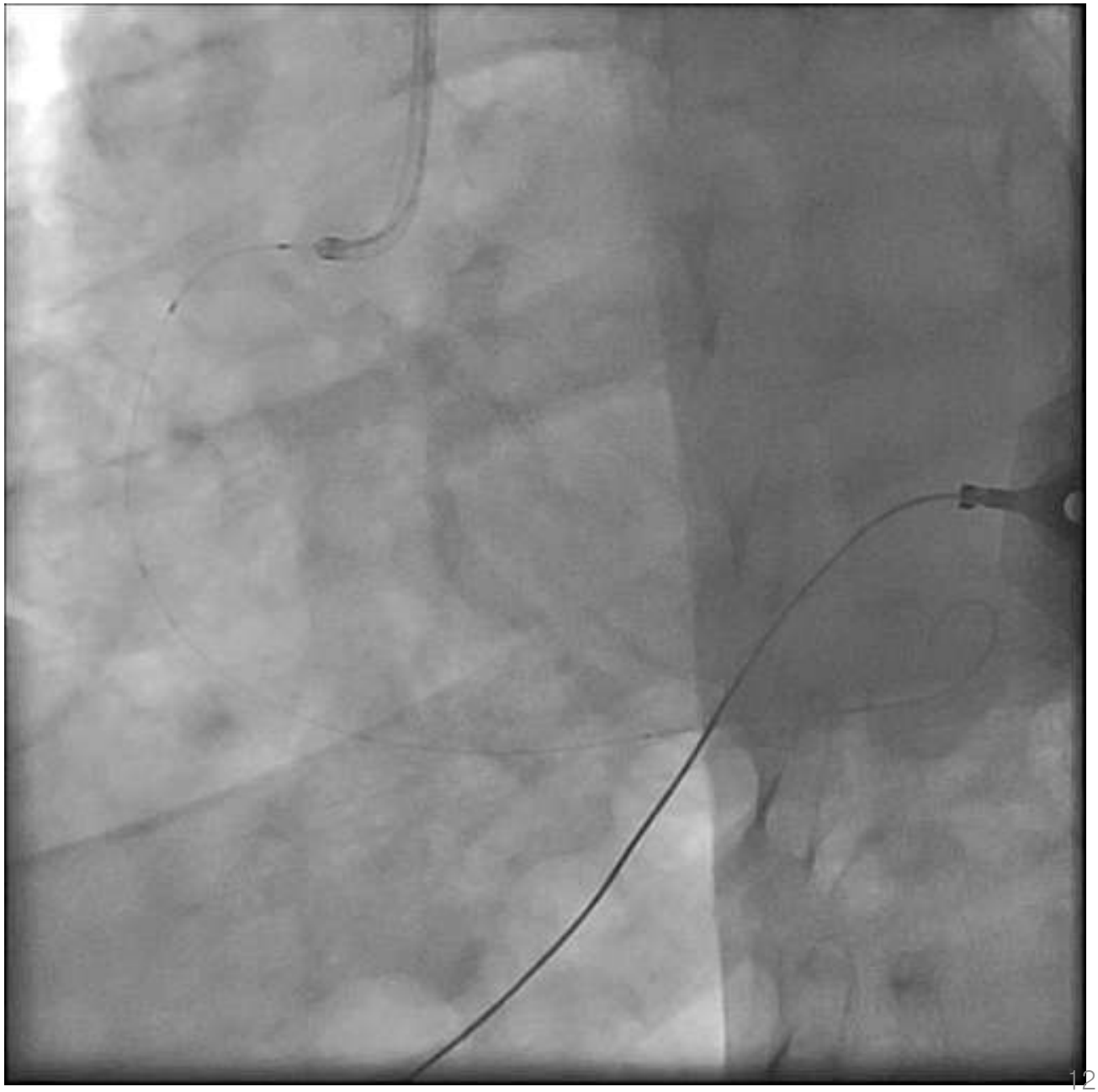
TREX
2.75x15 mm
up to 12 atm



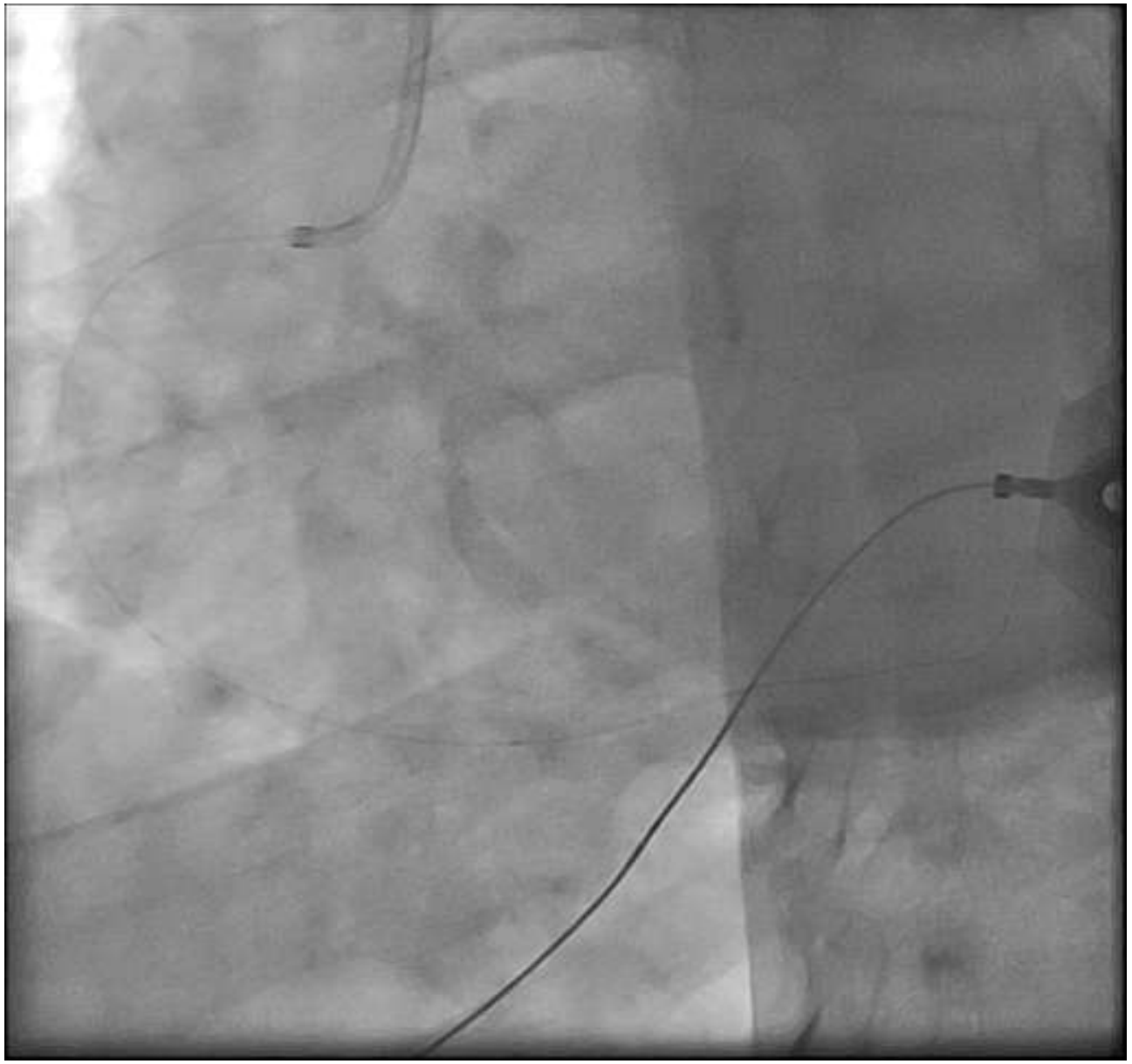
Flow ?



After balloon to proximal RCA



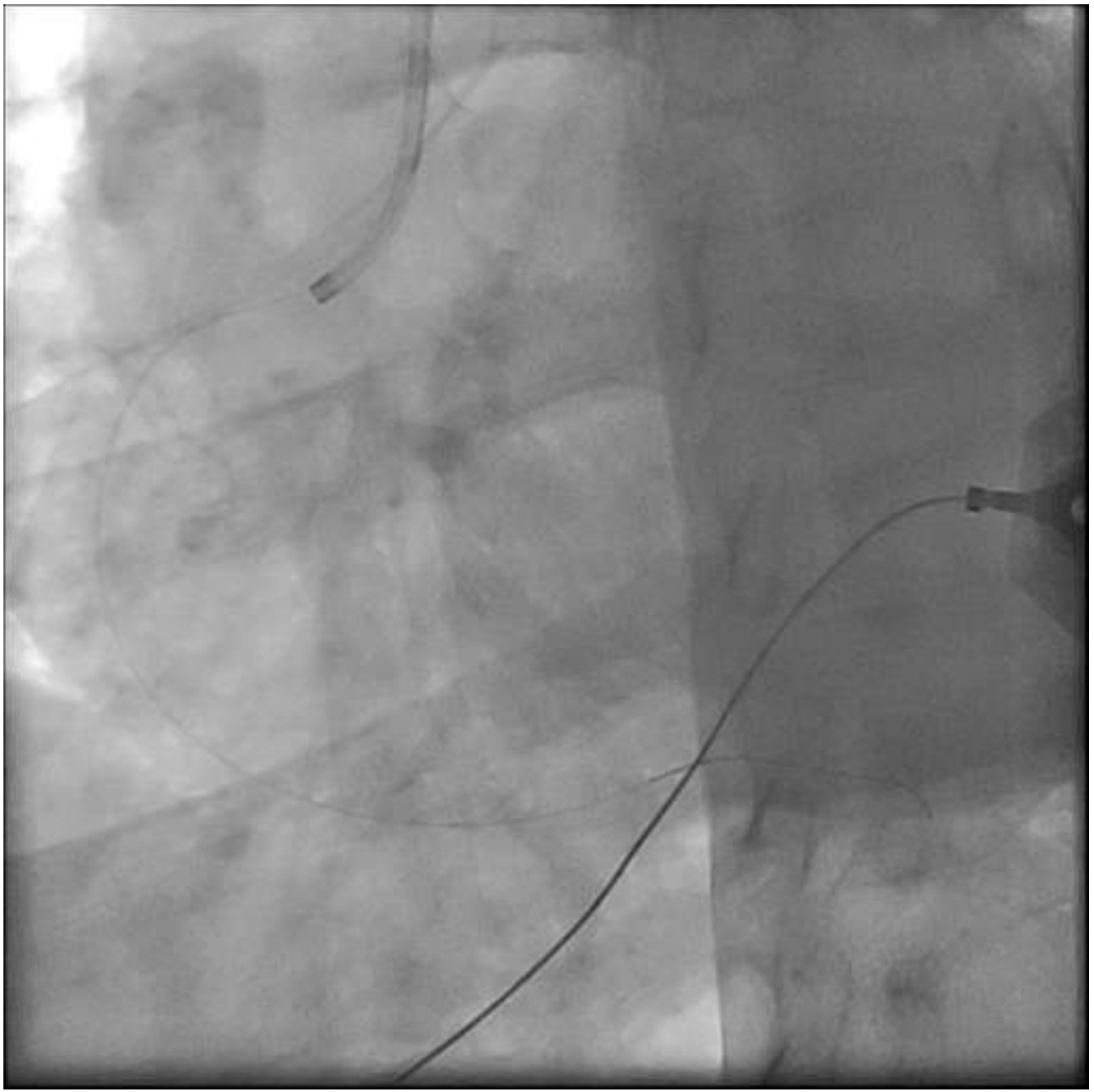
BP 80/60



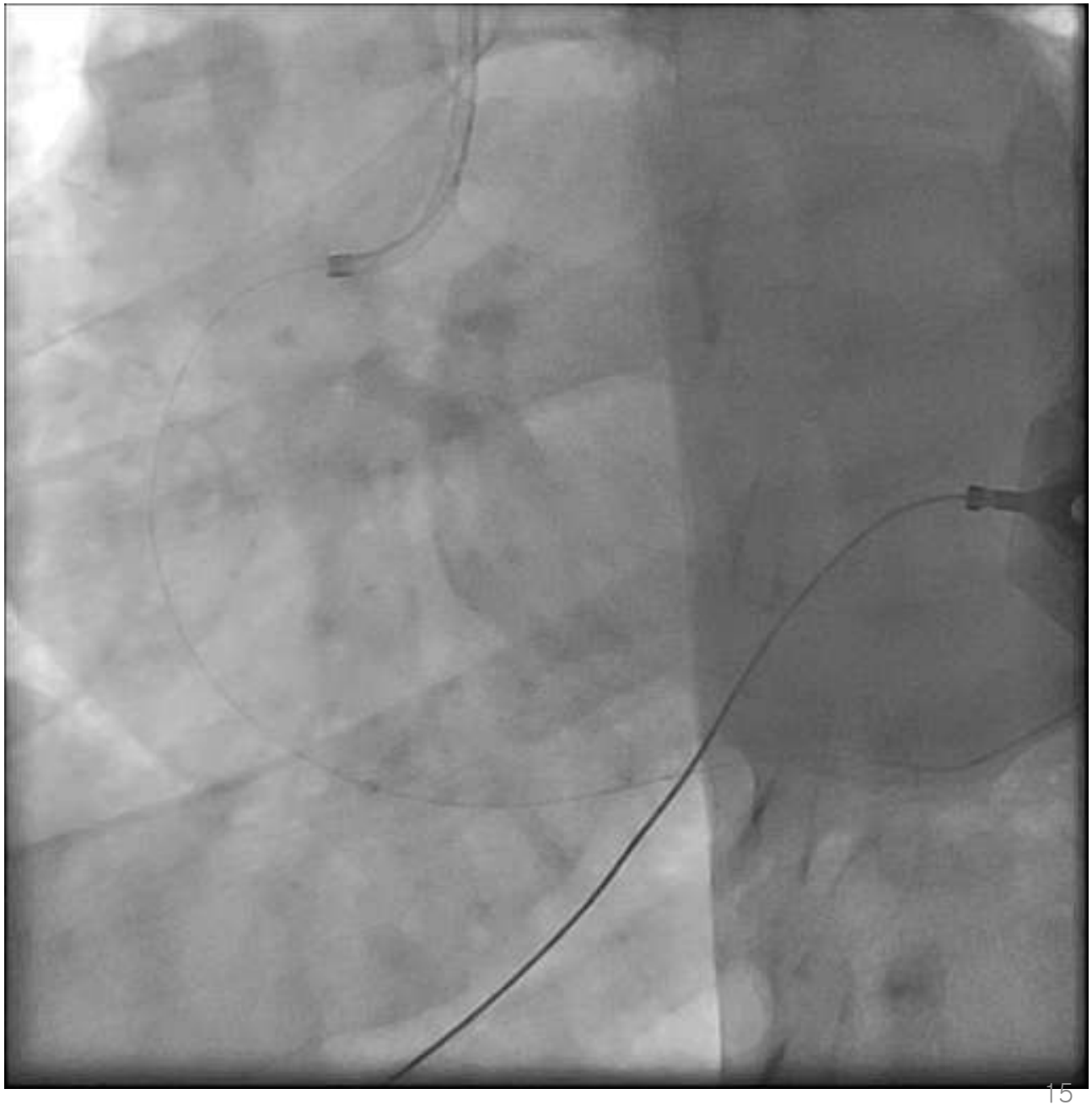
What to do next ?

Brady cardia

After 6 Fr Export catheter

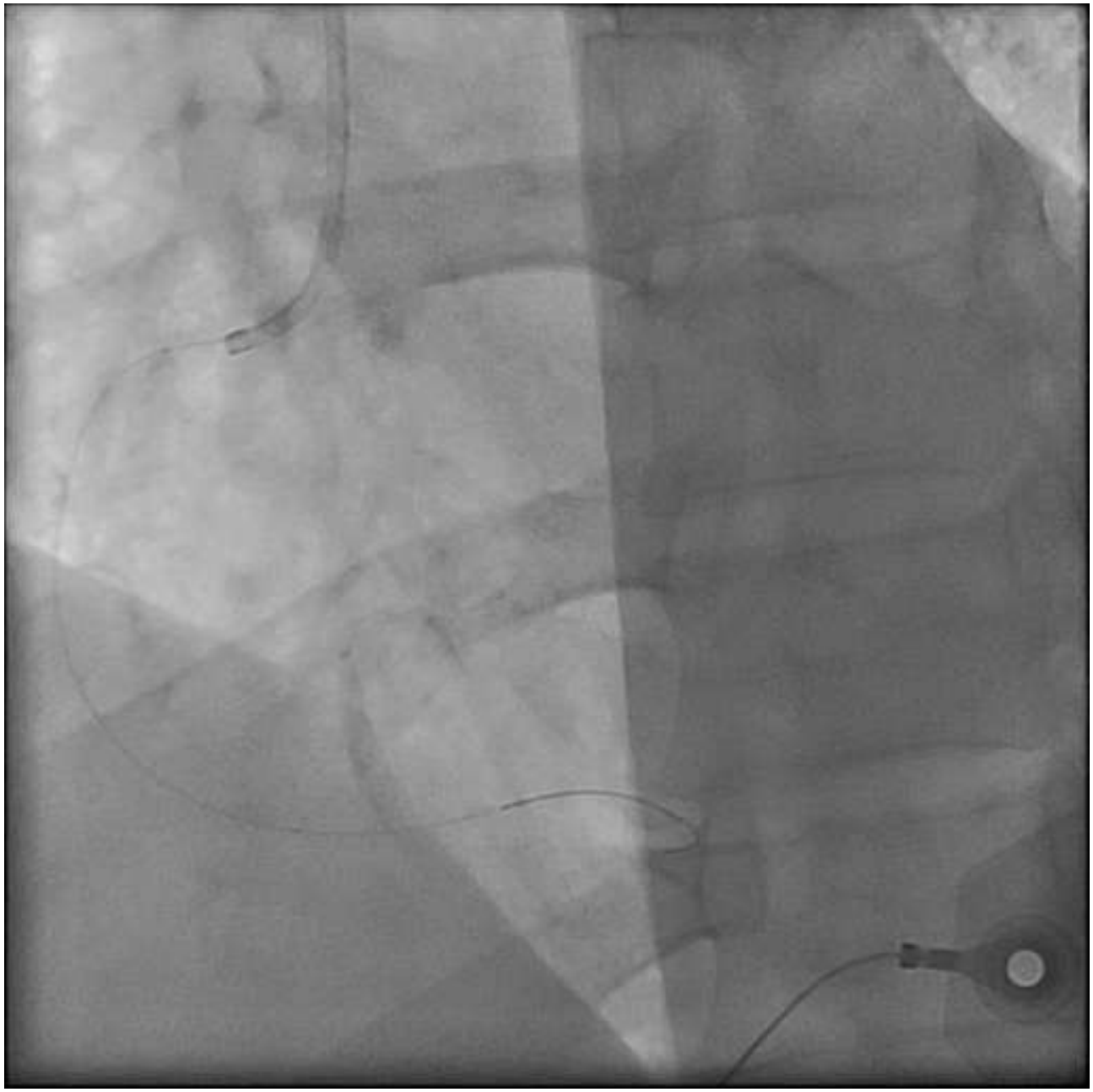


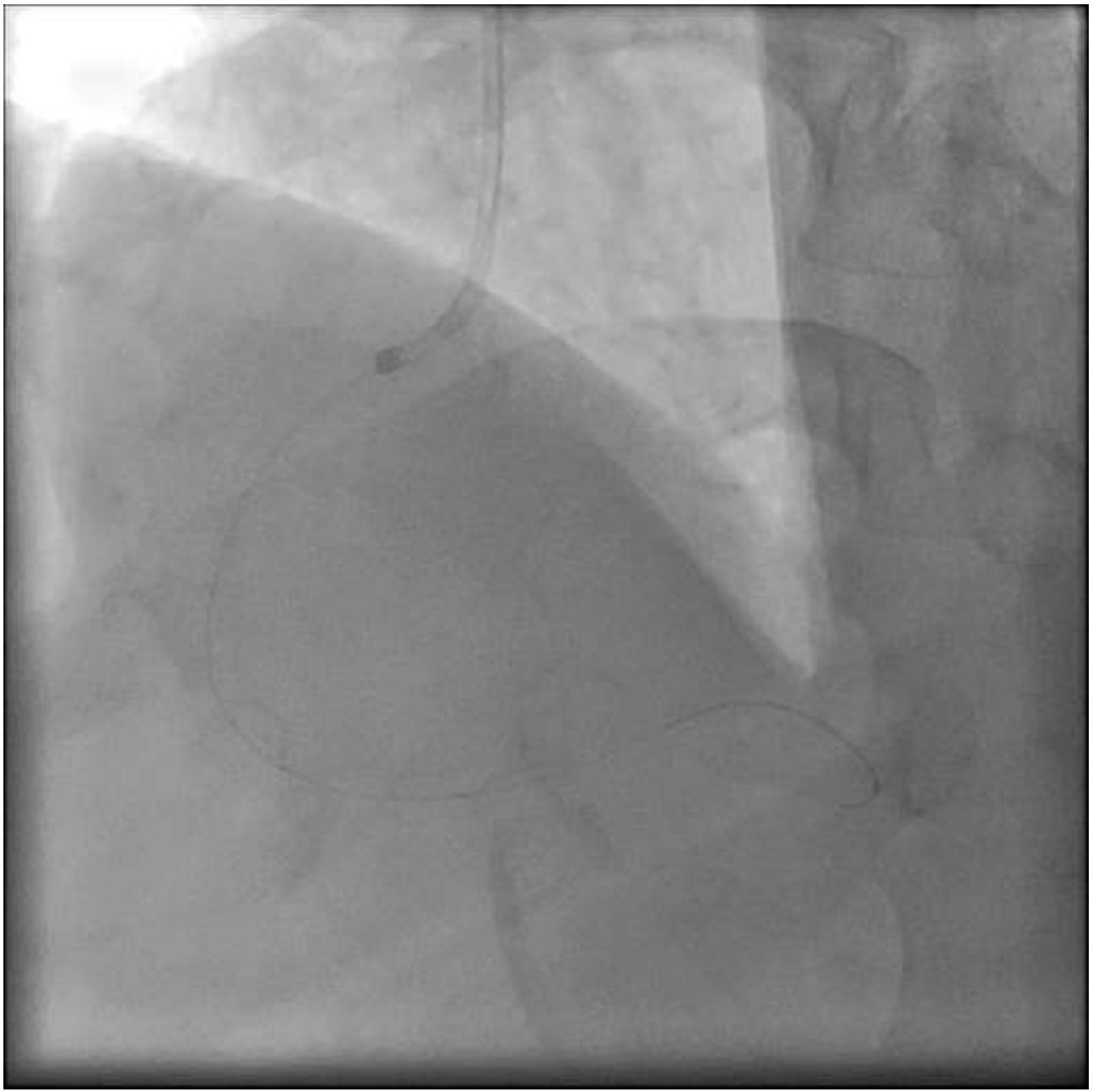
Retrieved few thrombus
CAG after 2nd and 3th
6 Fr
Export



Adrenaline
100 ugm IC

AIVR
Improved
BP and HR





## *If I can could turn back time*

- Do nothing except Clopidogrel and LMWH
- Thrombus aspiration followed by PTCA/ stent results in better reperfusion and clinical outcomes: lower mortality rate at 1 year.

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- IC adrenaline/ Epinephrine can be used in case of no reflow especially patient with bradycardia.
- Low dose 50-200 ugm IC -> Beta adrenergic receptor results in vasodilatation.

Thank you.