Obsessed of the worst expectation

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Patient profile and brief history

- 87 y/o, male
- Chief complaint: Progressive SOB for 2 days
- Past history: HTN, type 2 DM, CKD stage 3

<table>
<thead>
<tr>
<th>Biochemistry</th>
<th>Value 1</th>
<th>Value 2</th>
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<tbody>
<tr>
<td>Cr. mg/dL</td>
<td>1.68</td>
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<td>CK-MB</td>
<td>45.6</td>
<td>109.1</td>
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<tr>
<td>Troponin-I ng/mL</td>
<td>2.584</td>
<td>14.461</td>
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<tr>
<td>BNP pg/mL</td>
<td>410</td>
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ECG
Tentative diagnosis

- Non ST elevation myocardial infarction (NSTEMI), Killip 3, TIMI risk score: 5
- → arrange CAG

Clinical course

- Pulmonary edema and respiratory distress.
- Echocardiography: EF 0.54, antero-apical hypokinesia
- Severe triple vessel coronary artery disease with heavy calcification.
- LM: mild disease.
- LAD: p-LAD 93% stenosis, mid-LAD: chronic total occlusion after big septal and 2 diagonals, collateral vessel from LCx; p-LAD, and epicardial collateral from p-RCA.
- LCX: diffuse diseased with p-stenosis 74%.
- RCA: proximal total occlusion.
- (Syntax score : 39.5, Euroscore II:43.25%).

→ CABG or PCI
Clinical course

• Dyspnea progressed
• Acute respiratory failure two days later
  → IABP support
  → Creatinine elevated (1.68 → 2.23 mg/dL)

His family agree PCI.
Pericardiocentesis

- Due to low BP, dopamine line was dripped.
- Bedside 2D echo showed acute cardiac tamponade with surrounding effusion >100cc.
- Emergent pericardiocentesis was done via subcostal approach and SBP returned to >100 mmHg after bloody effusion drained 250 cc from pig-tail catheter.
- Protamine 50 mg iv was administered (ACT ??).

PCI conclusion

○ Severe triple vessel CAD (CTO from m-LAD)
  - S/P successful recanalization of m-LAD CTO with Fielder FC XT-A GW
  - S/P PCI/drug-eluting stenting to proximal to very distal LAD (Xience Prime 3.0x38, 2.75x38, 2.25x28 mm)
  - S/P PCI/drug-eluting stenting to tortuous p-m-LCx (Xience Prime 2.75x33 mm)

○ Complicated Ellis type III coronary perforation at stented m-LAD with acute cardiac tamponade
  - S/p emergent pericardiocentesis and effusion drainage
  - S/P bail-out covered stent deployment at distal to very distal LAD (Graftmaster 2.8x19, 2.8x16 mm)
Clinical course

- The patient gradually improved under ventilator & IABP support.

Why perforation??

- Oversizing stent ?? Rotational atherectomy??
- Too high pressure ballooning for post dilatation (3.0x15 mm Hiryu HPB at m-p-LAD at 20-24 atm)
- Balloon anchoring (3.0x15 mm Hiryu HPB at m-LAD at 20 atm) at m-LAD for LCX PCI
Thanks for your attention!!