High thrombus burden in PPCI

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1st case

• MALE pt 58y old, HTN, presented with acute ant MI
• ECG, RBBB with ST elevation at ANT leads
• CP 6 h before admission
The Patient shifted to CCU on Gly IibIIia inhibitor for 48 h

Patient discharged after 4d on clopidogrel 75 x2 ASA 2X1 ,Statin ,BB .

2nd case
• Male pt 40 years
• Driver
• Smoker
• Addict on tramadol and Hashish
• Anginal pain three hours before admission
• ECG --- Anterior MI
the patient shifted to CCU on gly IIBIIIa inhibitor for 48 h
Patient discharged after 3 dys on clopidogrel
75 x2, ASA 2X1, Statin, BB

Control Angiography
CONCLUSIONS

• A large thrombus burden is not uncommon in PPCI, and is associated with more frequent complications.
• IC thrombolysis and glycoprotein IIb/IIIa inhibitors may be beneficial in the management of a large thrombus burden.
• The use of thromboaspiration must follow a particular logic and used with rigorous manipulations.
• Stents dedicated to thrombus management can be used.
• Direct stenting should be encouraged Interest and limits of these stents are developed.
• Delayed stenting strategy, preferably coupled with the use of anti-GP IIb /IIIa, may provide better results than a standard intervention.

• 3rd case
• Male patient 45 y old smoker presented with inferoposterior MI
Now stent?
Thrombus aspiration?
Shift the patient to CCU on G IIbIIIa inhibitors with deferred stent?

• The patient shifted to CCU for 48 h GPIIa IIIa infusion + Clopedogeril 150 mg/day in addition to other anti ischemic medication
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Thank you