1026 "LEFT MAIN PRIMARY PCI-THE GREAT ESCAPE WHEN ALL ROADS WERE BLOCKED" - "DOES INHOUSE PRIMARY PCI TEAM MATTER ?"

History:

52 Y/M
Risk factors ? Tobacco Chewing
Chest Pain & Breathlessness since 3 hours
At Outside hospital diagnosed to have QRBBB Anterior STEMI
Came to Our ER in gasping state, pulse 40/min and BP not recordable.
Immediately intubated.
ECG confirmed STEMI and ECHO showed anterior and anterolateral wall akinetic, severe LV dysfunction.
Immediately taken for primary PCI

Hardware:

Guiding System ? XB3 7F
GW ? BMW
Balloon: Predilatation ? 2.5x12,
Post dilatation- 3.5x12, 4.0x12, 4.5x8
DES: 3.0x38
IABP & temporary pacemaker

Pharmacotherapy:

DAPT: Aspirin, Ticagrelor
GP2b/3a Intracoronary bolus plus infusion.
Anticoagulation Heparin.

Course in ICCU:

Metabolic acidosis ? CRRT started
Worsening acidosis on CRRT. Echo showed localised anterior pericardial effusion with suspected early cardiac tamponade.
In view of worsening clinical status and hemodynamics pericardiocentesis done and 150ml serosanguineous fluid was aspirated (possibility of TP lead induced perforation, and remote possibility of cardiac rupture) was kept in mind.
Hemodynamics and metabolic acidosis started improving .
CRRT was discontinued after 24 hours.
Inotropes and IABP was discontinued after 96 hours.
Patient was extubated on day 5. Echo showed significant improvement in LV function with EF 45% and RWMA localised to distal LAD territory.

Day 5 patient was extubated.

3 hours after the extubation patient developed significant delirium and irrelevant talk.

Hypoxia was ruled out, CT brain was done to rule out CVA which was normal.

Psychiatry consultation was sought and probable diagnosis of ICU psychosis was contemplated.

Patient responded antipsychotic medications and shifted out of ICCU on Day 9.

Subsequently he made a good recovery in the wards and was discharged in stable condition with mild LV dysfunction on day 12.

On first follow-up after 3 months(Last Telephonic follow up) patient is doing well.

Conclusion:

In ACS, Left Main occlusion is uncommon and incidence is from 0.8 - 1.7%.Because of the catastrophic nature of the disease these patients present in cardiogenic shock, sudden cardiac death and carry high mortality up to 80%.

High index of anticipation is required to perform LMCA PPCI

PCI is preferred modality of revascularization than CABG as it is faster to achieve TIMI III flow.

Though LV assist devices like impella are preferred for hemodynamic support, In real life practice IABP is easily available and can be used.

Availability of in-house 24x7 PPCI team reduces the door to balloon time considerably shorter to achieve successful outcome in such cases.