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A STEMI case of SVG bypass graft occlusion that was difficult to detect the true occlusion point.

A 62-year-old man with old cerebral infarction, bilateral vertebral artery dissection, hypertension, and dyslipidemia came to our hospital because of chest pain. He also had undergone CABG 7 years ago (LITA-LAD, RITA-D2, SVG-#14, SVG-RA-#4AV). LITA-LAD bypass had occluded one year after CABG. ECG showed ST elevation at the inferior leads, and emergent CAG was performed. The proximal site of SVG-RA-#4AV bypass occluded completely, then we thought this site as culprit lesion, and performed emergent PCI. Aspiration and balloon dilatation to the flow limit point could not improve flow. And we could not aspirate any thrombus. Then, we shot a small amount of contrast medium with the aspiration catheter at distal of the flow limit point, and found out the true occlusion point at rather distal from the flow limit point. We performed aspiration, balloon dilatation, and stent implantation to that point, got TIMI3 flow finally. In AMI cases, the flow limit point or slightly distal point are generally true occlusion point. In this case, the angiographic flow limit point differed from the true occlusion point greatly. We guess a reason of that was a bypass graft occlusion, and contrast medium could not reach distal even as for the situation that was no massive thrombus because there were not any branches, and small vascular bed.