There's Nothing Left: Acute Left Main Occlusion

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50 year-old man, who is an active smoker, presented to General Hospital with acute onset of epigastric pain after playing football. ECG showed ST elevation V2 to V5 with reciprocal changes in the inferior leads. He was diagnosed to have Acute extensive anterior MI and was referred to our center for primary PCI.

On arrival to our emergency department he was in distress, NYHA class II. Bp: 140/70, HR 100

CVS dual rhythm no murmur. Lungs auscultation revealed bibasal crepitations

Chest Xray: no cardiomegaly, ground glass opacities at right upper lobe lung, consolidation at right lower lobe and left lower lobe lung suggestive of pulmonary edema

Bedside Echocardiogram: EF 40-45%, no dissection flap at aortic root.

Proceeded with Primary PCI and diagnostic shot reveal an acute occlusion at left main stem with copious thrombus. RCA was dominant vessel with mild proximal disease

As soon as acute total occlusion was detected, left system was engaged with EBU 3.5 6FR, lesion was crossed with RTF into the LAD. Export catheter was sent down for thrombus aspiration, however only minimal thrombus. Decided to proceed with Penumbra aspiration in view of heavy thrombus burden. Lesion was then predilated with SC 3.0X15mm. After pre-dilatation, flow to distal LAD was restored, decided to stent distal lesion with Cre8 2.75X33mm and then post-dilate with NC 3.0X15mm. Lesion was further prepared at the proximal LAD into distal LM with the same NC balloon. After preparation, noted residual thrombus in the proximal LAD and diagonal branch. Decided to stent the proximal LAD into proximal LM with Cre8 3.5X33mm, and post dilate with NC 3.5X15mm.

Post LM stenting noted TIMI 1 distal flow and hence proceeded with aspiration with Penumbra, followed by IC Aggrastat 12mls over 3 minutes. Decided to POT LM with NC 3.5 again. We performed a post IVUS run that showed well opposed stent with no dissection.

Final result showed TIMI III flow with no immediate complications.