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AMI the problem?: A young man presenting with chest pain and dysarthria

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Our case is a 33-year-old man found slumped in our hospital stairwell with cyanosis and dysarthria. He had been having worsening intermittent chest pain for three days, and on the day of presentation he also developed right-sided weakness. His medical history included uncontrolled hypertension, dyslipidemia, and a 1 pack-per-day smoking habit for over 10 years.

The patient was intubated due to acute respiratory failure. His ECG showed typical ST elevation in leads II, III, aVF, V4-V6 with reciprocal changes (image 1), and his cardiac enzymes were elevated (hs-TnT 125 ng/L, CK 199 U/L, CK-MB 15.3 ng/mL). After emergent consultation with neurology to rule out stroke, primary percutaneous intervention (PCI) was arranged.

Coronary angiogram found patent right coronary artery (RCA), but multiple thrombi were visible in the left coronary system (image 2). Aspiration thrombectomy was performed for left circumflex (LCx) and left descending (LAD) arteries, with angioplasty and a drug-eluted stent (DES) for LAD.

Primary PCI was successful (image 3), but after we reviewed of his images, we realized that he had, in fact, multiple thromboemboli. There was a filling defect in his left common iliac artery (image 4) and his right vertebral artery was completely occluded (image 5).

We decided to tackle all three lesions during his staged PCI if conditions allowed, and chose the Inidigo Penumbra system for this purpose. Vascular access via the left femoral artery facilitated survey and treatment of the left common iliac artery first. Angiogram found a huge floating thrombus (Image 6), which was aspirated by a JR4/6Fr catheter (image 7).

Next we performed PCI for LCx (image 8), restoring full patency after aspiration thrombectomy and DES deployment (image 9). We also ran OCT to determine the possible etiology of this event. The third target was then dealt with by endovascular thrombectomy (image 10), which cleared up the vessel (image 11).

This is a young man with concomitant cardiocerebral infarction and peripheral artery disease. At the initial encounter, we stabilized him first by ensuring adequate coronary flow for his acute myocardial infarction. Later, we successfully achieved total revascularization of his cerebral, coronary, and peripheral lesions during the same procedure by choosing suitable tools for the purpose. The patient was discharged home with short-term triple therapy and long-term dual therapy.