# Catastrophic nightmare in acute inferior wall STEMI.

Wongwaris Aphijirawat

[1]Cardiology Department, Queen Sirikit Naval Hospital, Thailand

A 33 year old man with a history of chronic smoker and history of spinal surgery presented with sudden chest pain at rest with diaphoresis for 1 hour PTA. He went to emergency department. ECG Showed sinus rhythm with ST elevation in II, III, avF. Acute inferior wall STEMI was diagnosed, and he was emergency brought into cath lab.

We access the right radial artery using 5/6 F sheath, Ikari left 3.5 catheter. We performed injection to Left coronary system first. Initial angiogram showed total occlusion at distal segment of OM1 branch. LAD was no significant stenosis. Then we moved to engage the RCA and there was no significant stenosis. At this time, we thought that the culprit lesion was the distal OM branch, and we planned to engage Left coronary system again for PCI to OM. Just a seconds after we prepared to engaged left system again, patient suddenly developed hypotension and then cardiac arrest. Simultaneous CPR and left coronary system injection were performed. At this time, the left system showed the total occlusion of left main coronary artery!!

Due to patient was in cardiac arrest, we advanced the Runthrough wire to cross the left main into LAD. 2.0 x 15 mm SC balloon was predilated at distal left main lesion. After predilate the balloon, slow flow was demonstrated to LA but there was No flow to Lcx. CPR and adrenaline IV bolus were continued. Wiring to Lcx with Sion blue wire was done. Then we deployed 3.0 x 21 mm DES to Left main -LAD upto 18 atm. Angiogram after stent deployment showed TIMI II flow to LAD but Lcx still TIMI 0 flow. We performed POT in the Left main stent with 4.0 x 8 mm NC balloon -> after POT , flow to Lcx was restored but there was new total occlusion at distal Lcx. Due to high dose of adrenaline and levophed were given, IABP was inserted at this time before continued the procedure. 2.0 x15 mm SC balloon was open stent strut to Lcx and inflated at distal Lcx. The flow to distal Lcx was not restored. The DDx was dissection or distal emboli or NO reflow phenomenon. IVUS was used and confirmed that the wire was in false lumen , so we try to be rewiring into true lumen of Lcx -> success. Then we placed 2.5 x 18mm DES to distal Lcx -> there was still haziness in the stent but now the flow was TIMI III flow. BP was 100/60 while on IABP, Adrenaline and noradrenalin. So, we planned to stop procedure at this time. Total contrast volume was 210 ml. We prescribed anticoagulant for 3 days and brought the patient back to second look CAG -> There was TIMI III flow in all vessels without any haziness in the vessels. IABP and vasopressor could be taper off at day 2 and patient was safely discharged at day 6 with full of consciousness.