A Case Based Discussion

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Background Information

- 20 year old male
- Bicuspid aortic valve, severe AS & AR, dilated aortic root and left ventricular systolic dysfunction
- Bentall Surgery (2005)
- DDDR pacemaker for post operative CHB (2005)
- Class I on drugs

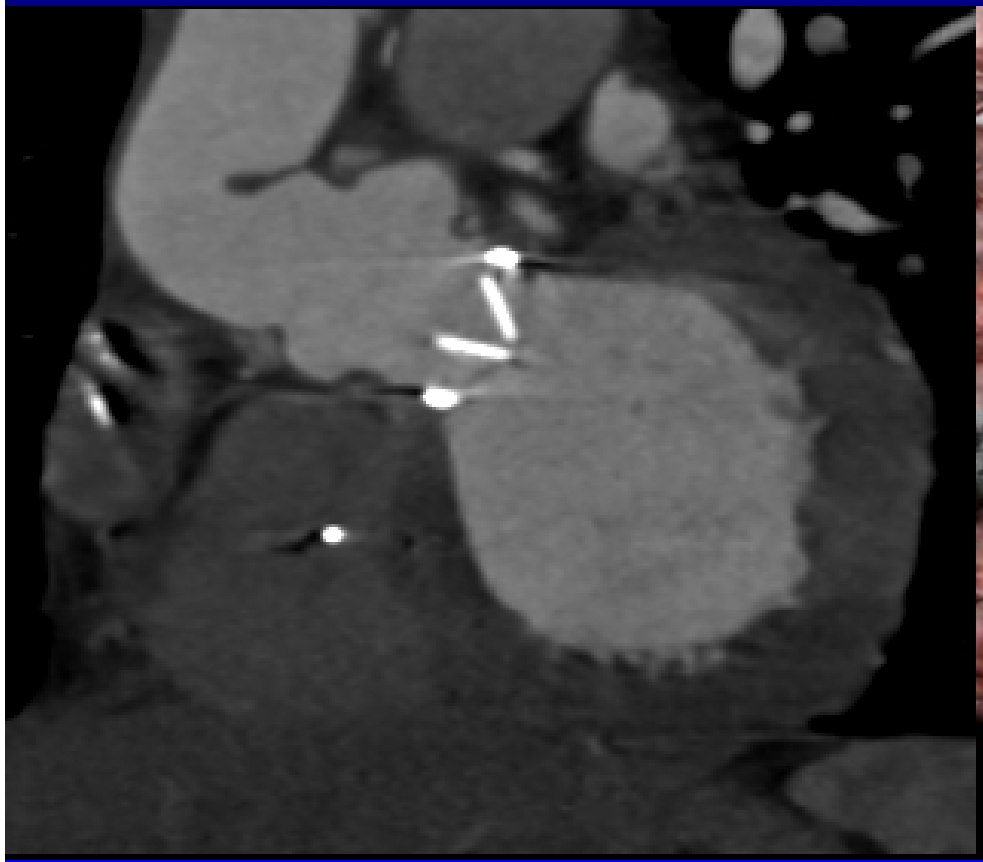
Current Problem

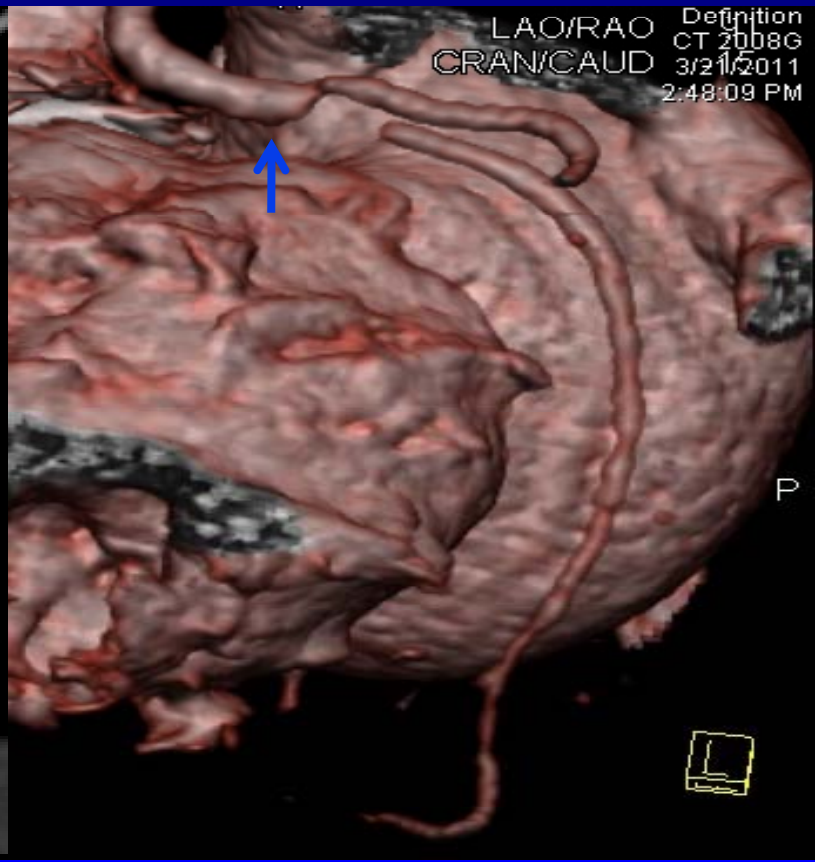
- Chest Pain of 6 hours duration
- B.P-110/80 mmHg
- Left ventricular failure, bilateral basal crepts
- ECG: Paced rhythm, non-contributory
- Enzymes were elevated
- Echo: LVEF 25%, RWMA, Increased gradient across prosthetic aortic valve

Possibilities ?

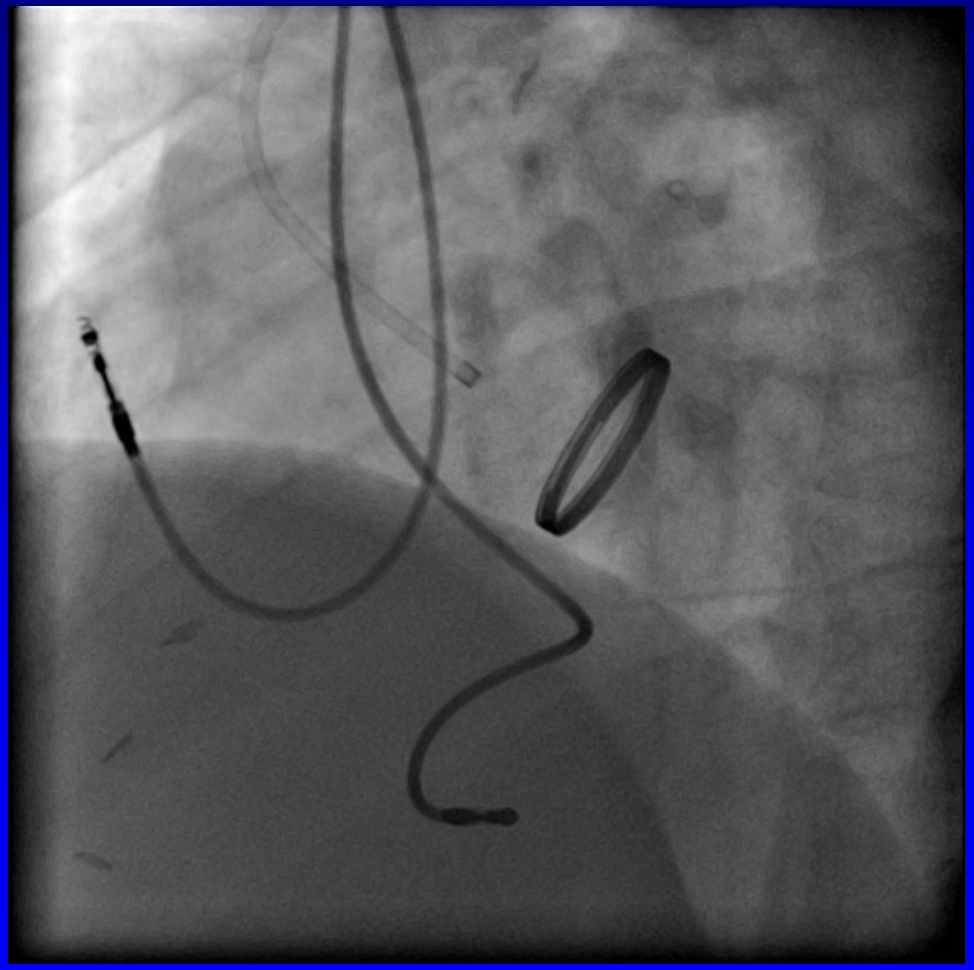
- PHVT
- ACUTE CORONARY SYNDROME
- ACUTE AORTIC DISSECTION

CT-ANGIOGRAM





Confirmation of PHVT



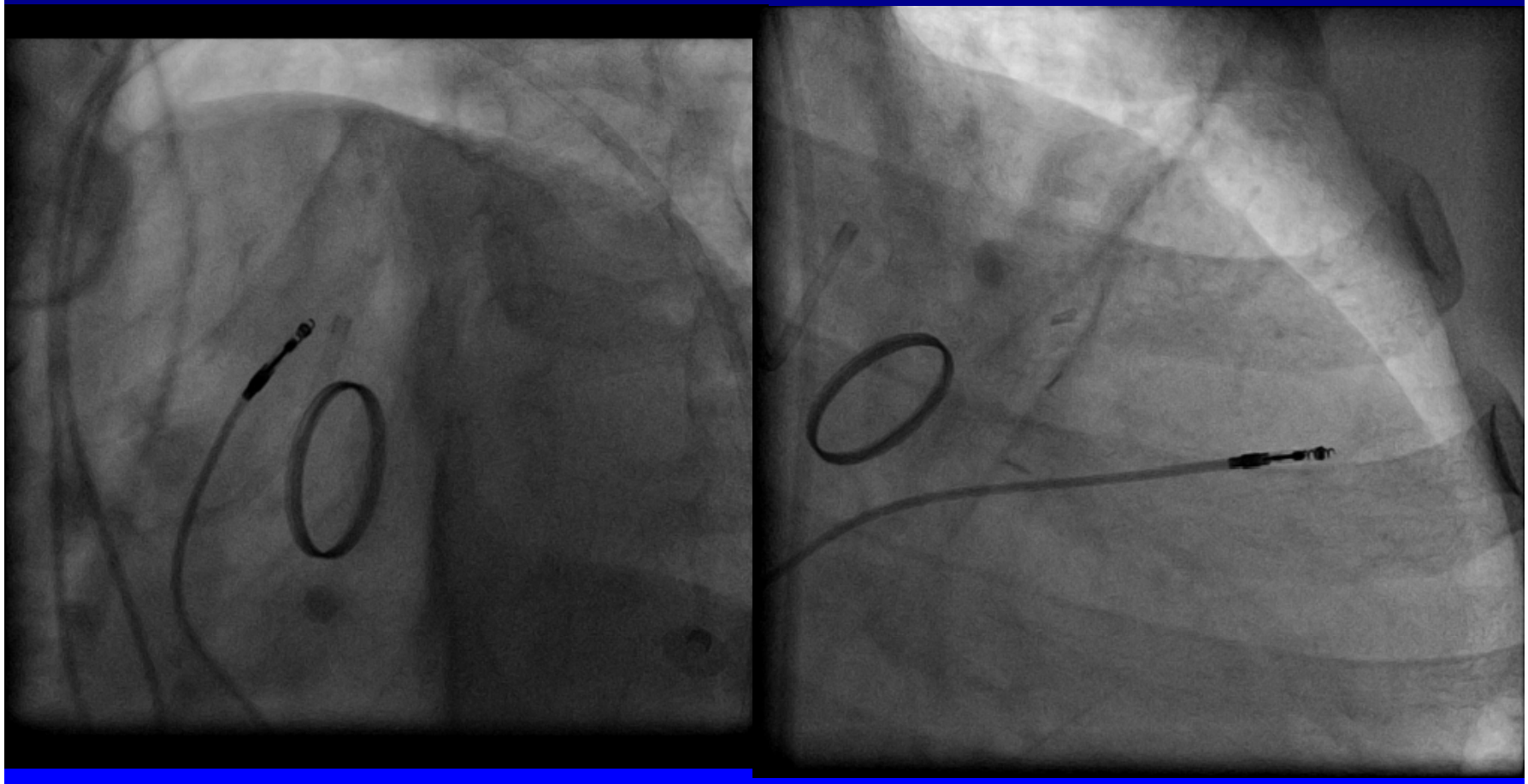
What do you want to do next?

- Systemic thrombolysis
  - Might take care of both PHVT and coronary embolism
  - Ongoing chest pain, 6 hours duration
  - Severe LV dysfunction
  - Impending pulmonary oedema
- Primary PCI, followed by thrombolysis for PHVT
  - Technical issues

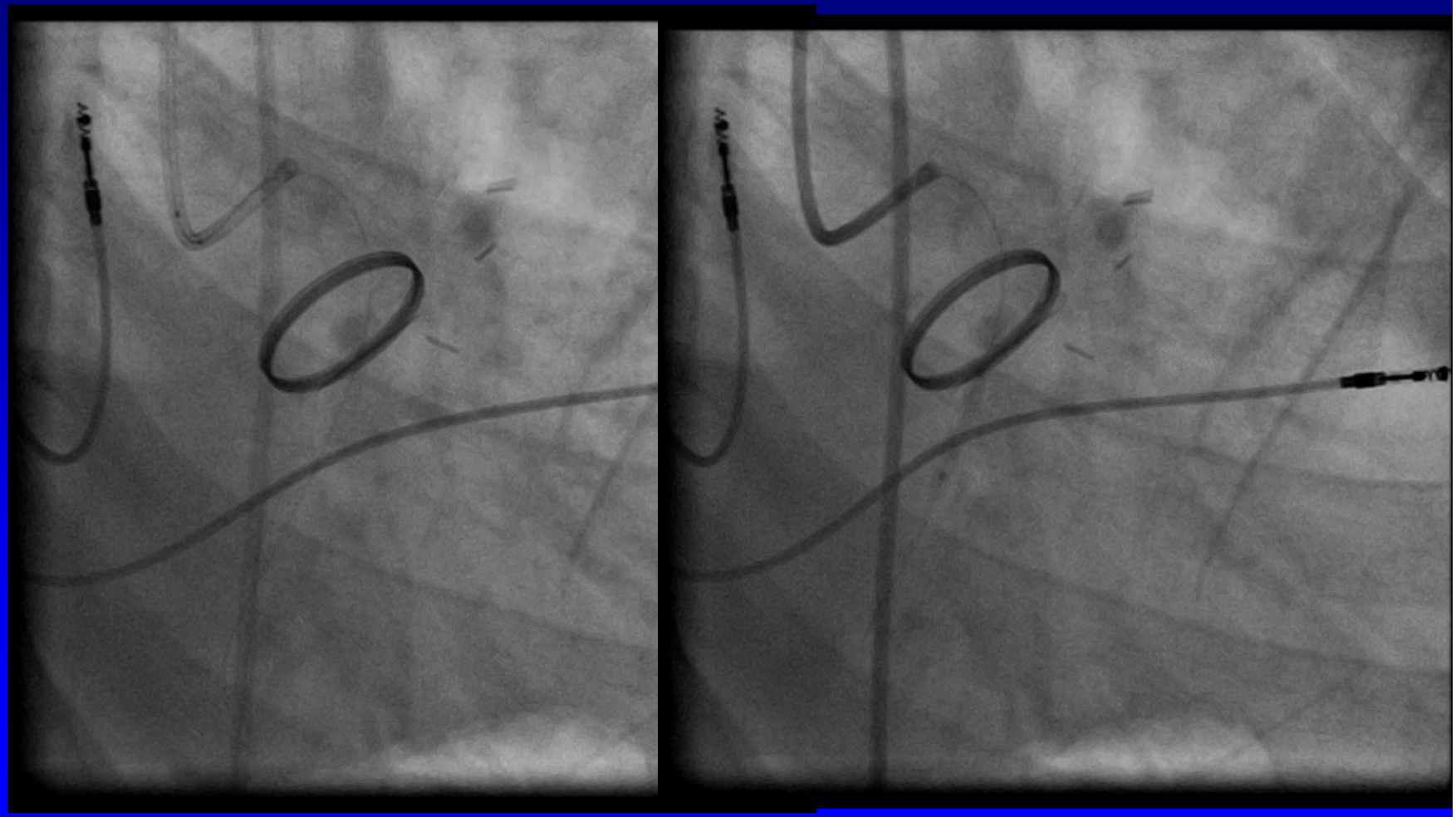
Anticipated problems

- Remedy should not aggravate the malady of the patient
  - The most important challenge was to avoid iatrogenic catheter induced embolism
  - Tortuous ascending aorta
  - Hooking the coronary artery

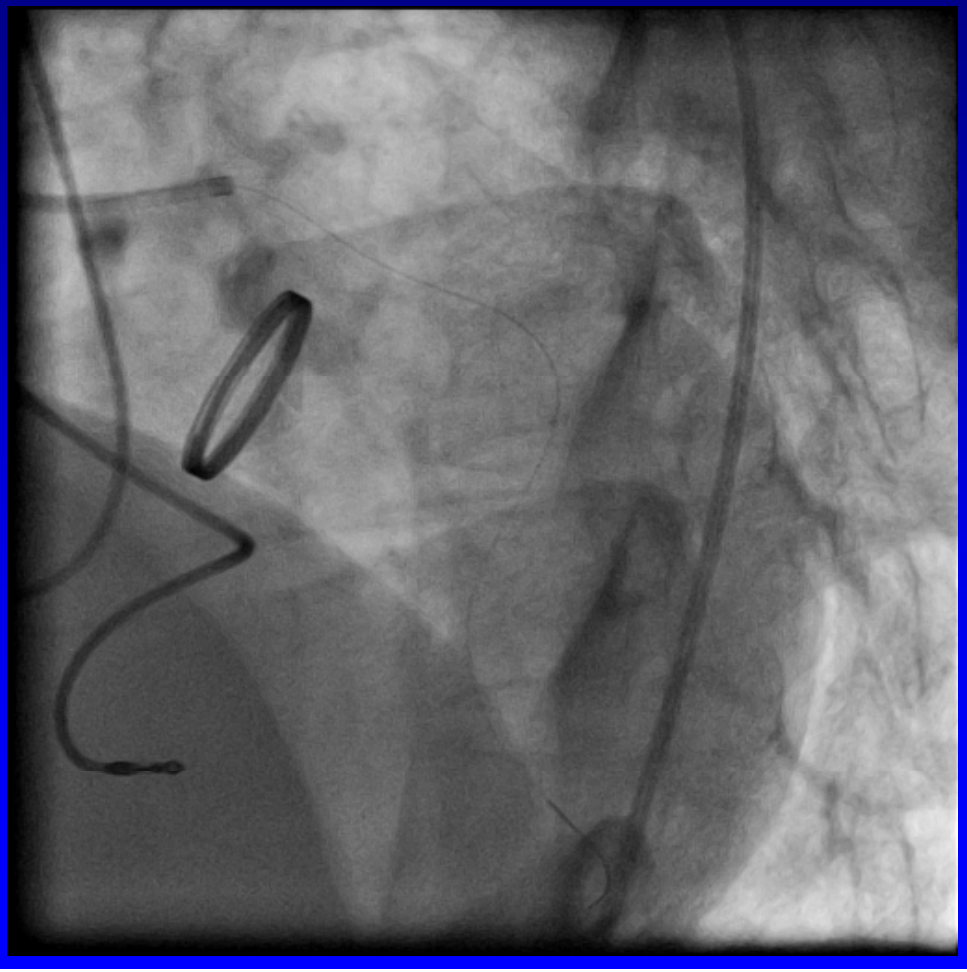
Coronary Angiogram



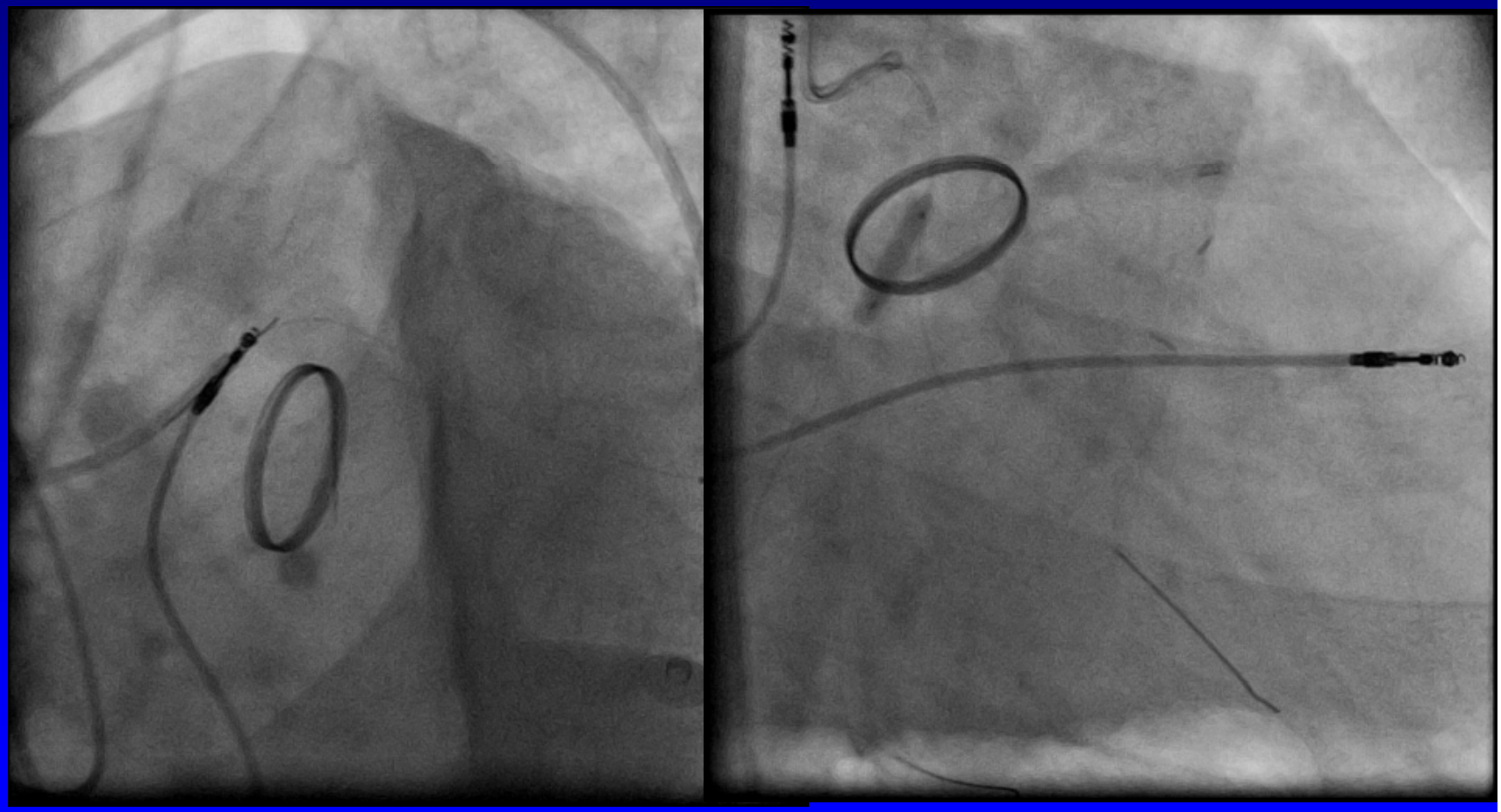
PCI



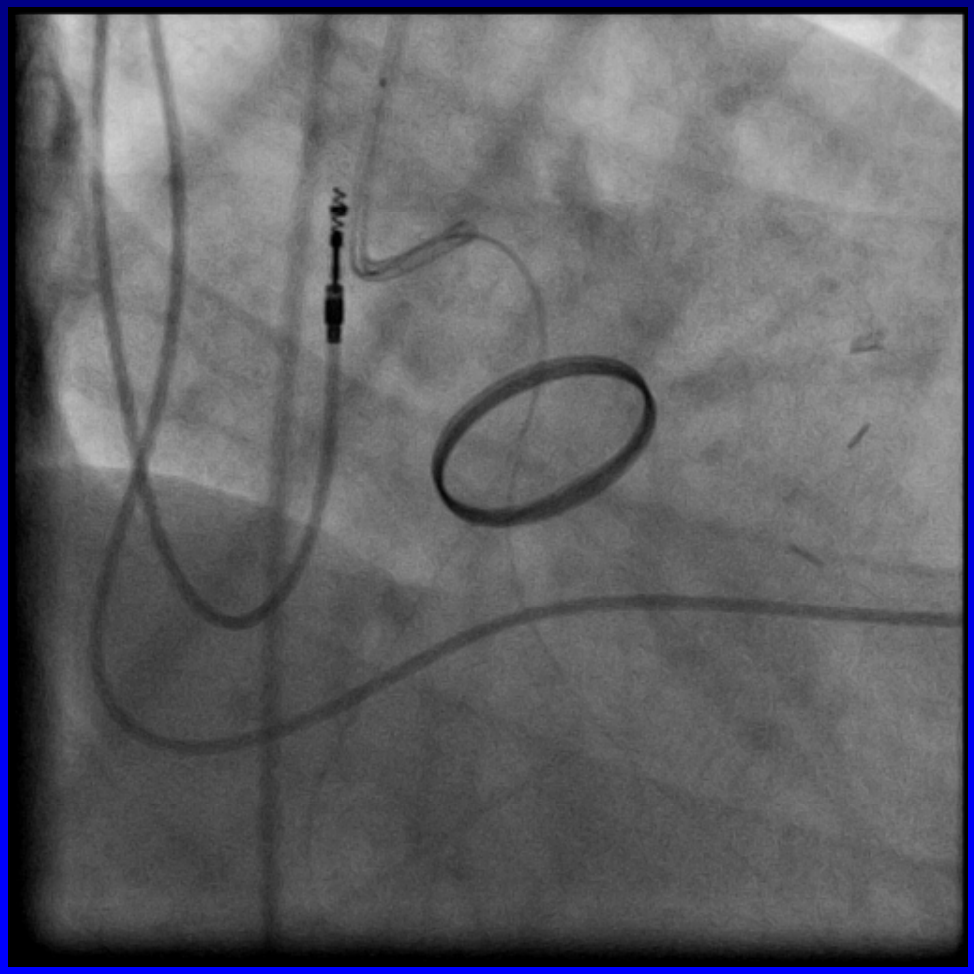
Proximal thrombus migration



Thrombosuction OM1 Branch



Pain Free



What next?

Options available:

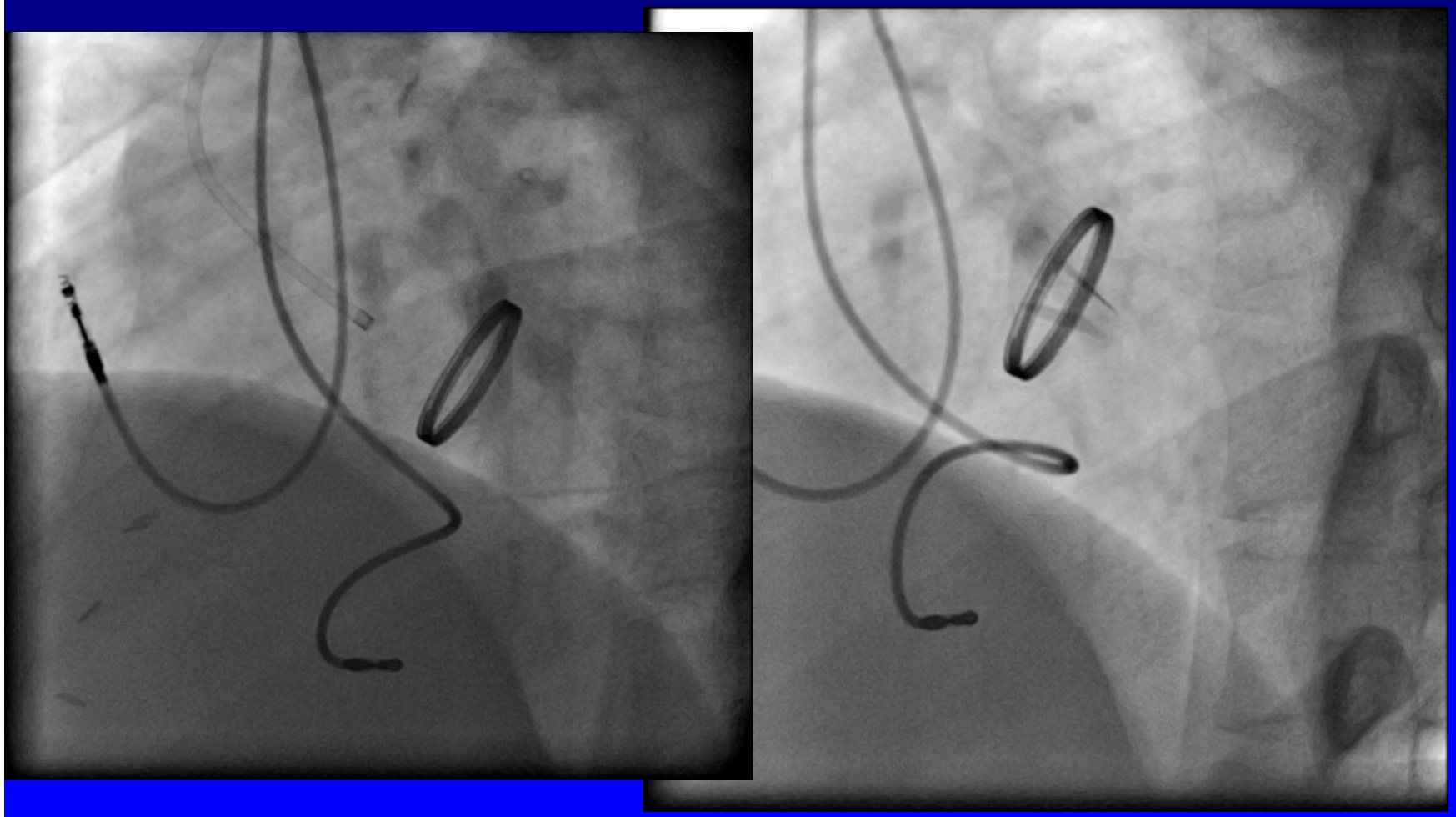
Sometimes, trying for an excellent result is an act of destroying good end results

We accepted the end result as patient also become pain free

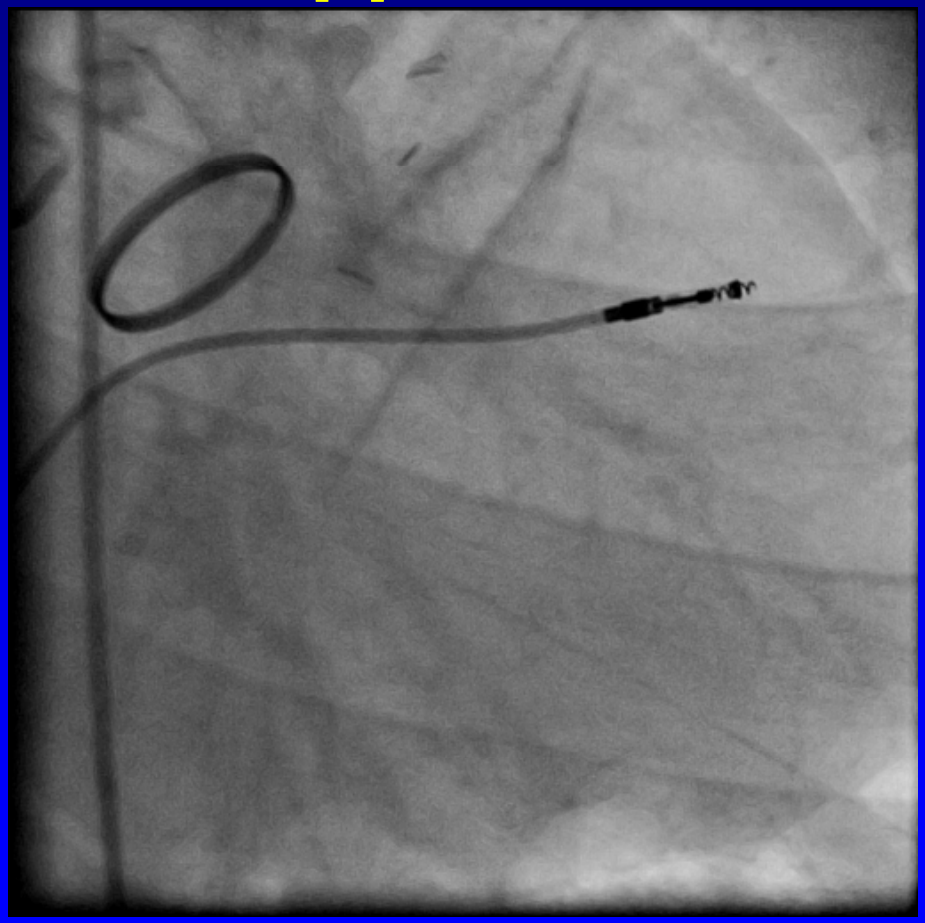
Management of PHVT

- Persisting PHVT after 24 hours
- Systemic fibrinolysis with tPA
  (100 mg for 2 hour infusion)

Post Thrombolysis Cine-Loop



What happened to LCx



Should we have attempted initial systemic thrombolysis without PCI?

A matter of debate

We were extremely happy with this HYBRID APPROACH