EMERGENCY PCI IN LEFT MAIN DISEASE-
RECURRENT VT DURING PCI

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Clinical History

- Mr CK
- 46/M
- DM, Hypertension for 5 years
- AOE II x 1 year
- TMT positive
- Unstable angina
- ECG- T wave inversion V1-V4
- Echo- No RWMA
  - LVEF 55%
Coronary angiogram - Right radial route
Left coronary artery could not be engaged
RCA normal
JR 3.5, 6F diagnostic catheter
ostial to proximal left main haziness
Ventricular tachycardia
Hypotension
cardioversion and inotropes started
What is the Cause?

- Severe Vasospasm of LMCA
- Dissection at LMCA
Right femoral route - 7F Guiding catheter
Left femoral route IABP insertion
Zinger support 0.014 guidewire in LAD, Intracoronary NTG
Inotropes continue...
Complete heart block and VT
Recurrent VT and CHB
Intubation done, Temporary pacemaker insertion, CPR
- Left main – no thrombus seen
- Dissection- NO
- Severe vasospasm

Patient haemodynamically unstable
What is the next option??

- NTG – wait and watch
  Blood pressure low
- Stent the Left Main
  To prevent further Vasospasm

- Gp II b/III a Inhibitors, eptifibatide Infusion started
Second Zinger support 0.014 guidewire in LCX
Stent endeavour resolute 3.5*15 mm deployed at 14 atm from LM to proximal LAD
Post dilated with NC sprinter 3.5*12 mm at 16 atm
Proximal Left Main stent with 4.5*12 mm balloons at 14 atm
Good flow in LM, LAD and LCX
patient haemodynamically stabilised
Extubated after 4 hrs

- Single inotrope – dopamine
- Integrillin infusion for next 18 hrs
- Discharged on the third day
- 6 month clinical F/U doing well
- On Dual antiplatelet Therapy, CCBs and nitrates
Discussion

- Coronary spasm during diagnostic coronary angiography for suspected ACS is 3-4%


- Spasm of LM uncommonly described

Mechanisms:

Alteration in autonomic tone
Catheter induced spasm
Dye induced vasospasm

Coronary spasm, may occur with normal or near-normal coronary arteries but frequently occurs at sites of significant atherosclerosis

Spasm of atherosclerotic lesions is often associated with myocardial ischemia*

*Am J Cardiol 1980;45:882– 6