# Anomalous infarct related RCA not canulated: on-table conversion from primary angioplasty to pharmaco-invasive approach

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☑ I do not have any potential conflict of interest


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- 45 year male
- Non diabetic, non hypertensive
- Presented with acute IWMI (window period: 3 hours)
- 2D Echo- RWMA+, LVEF: 45%
- consented for primary angioplasty


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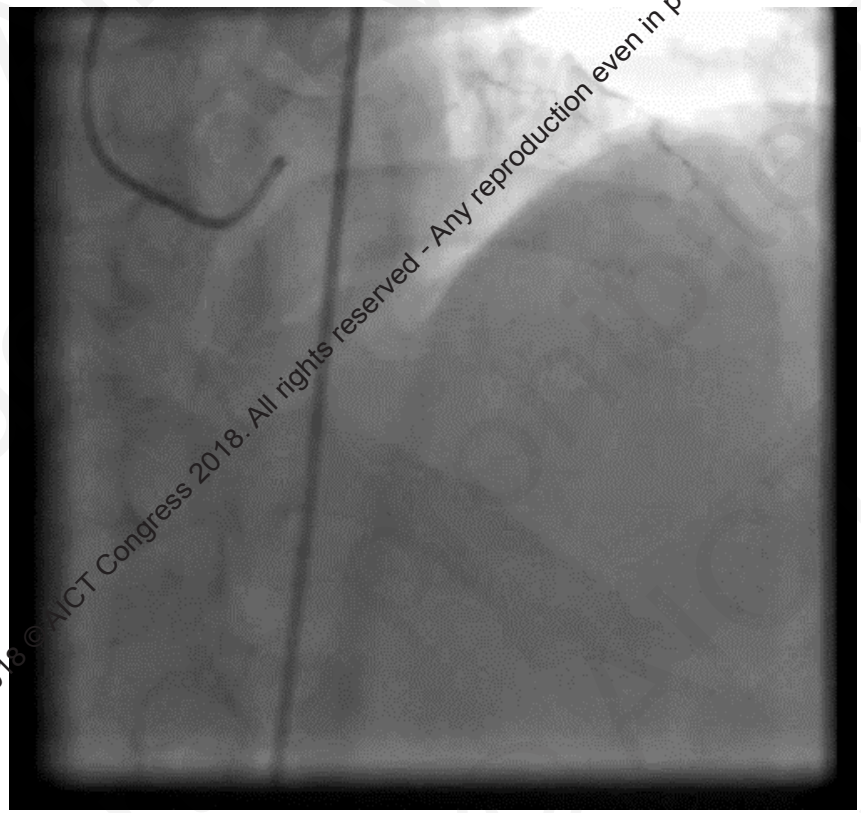
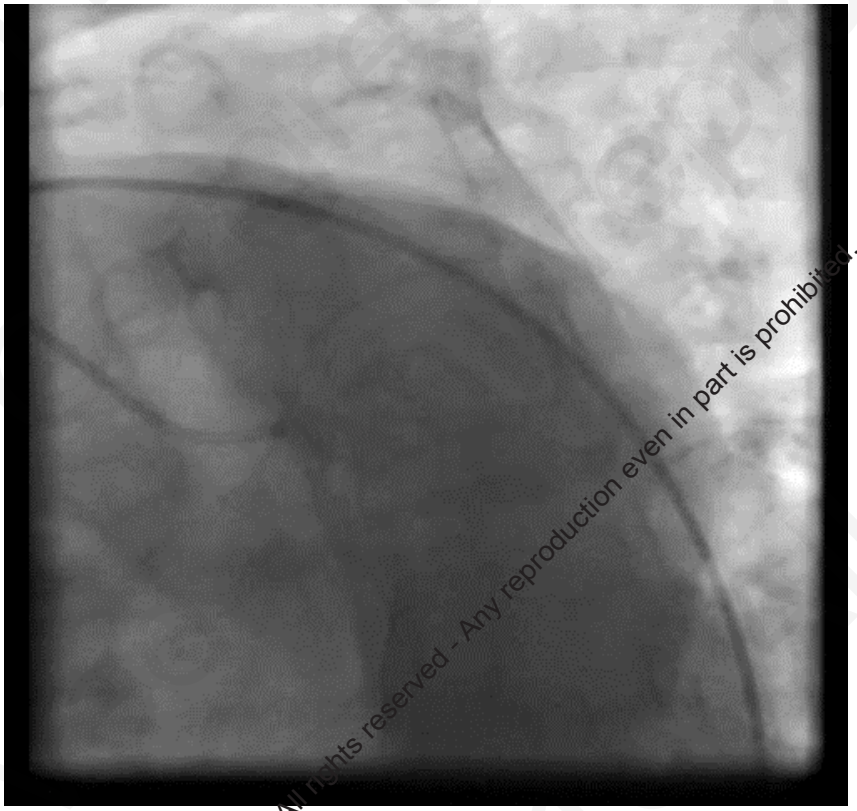
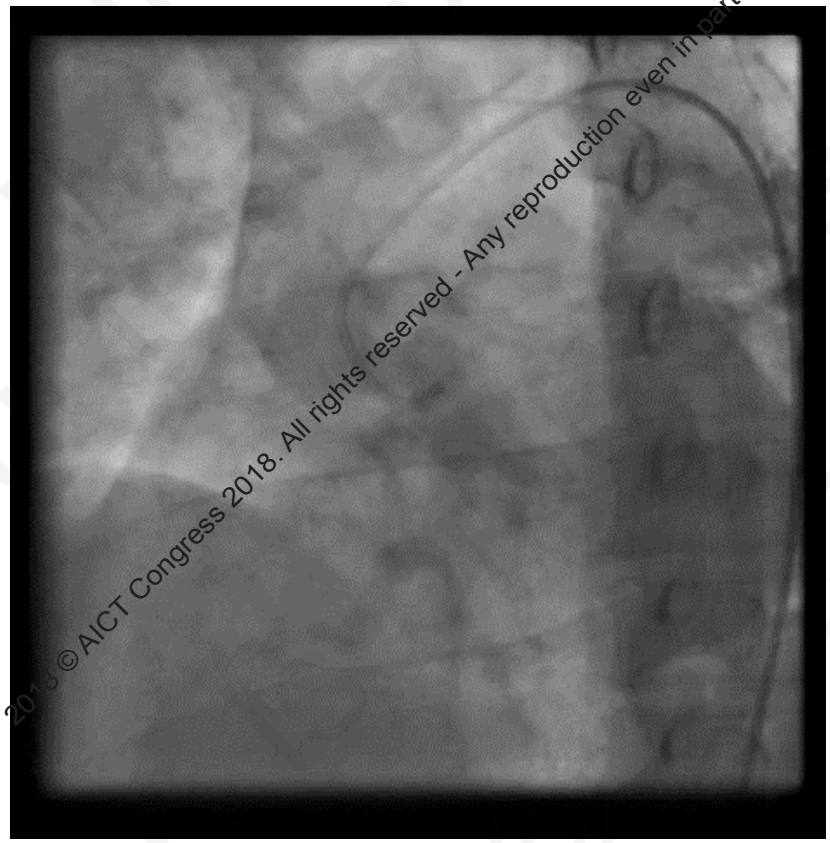
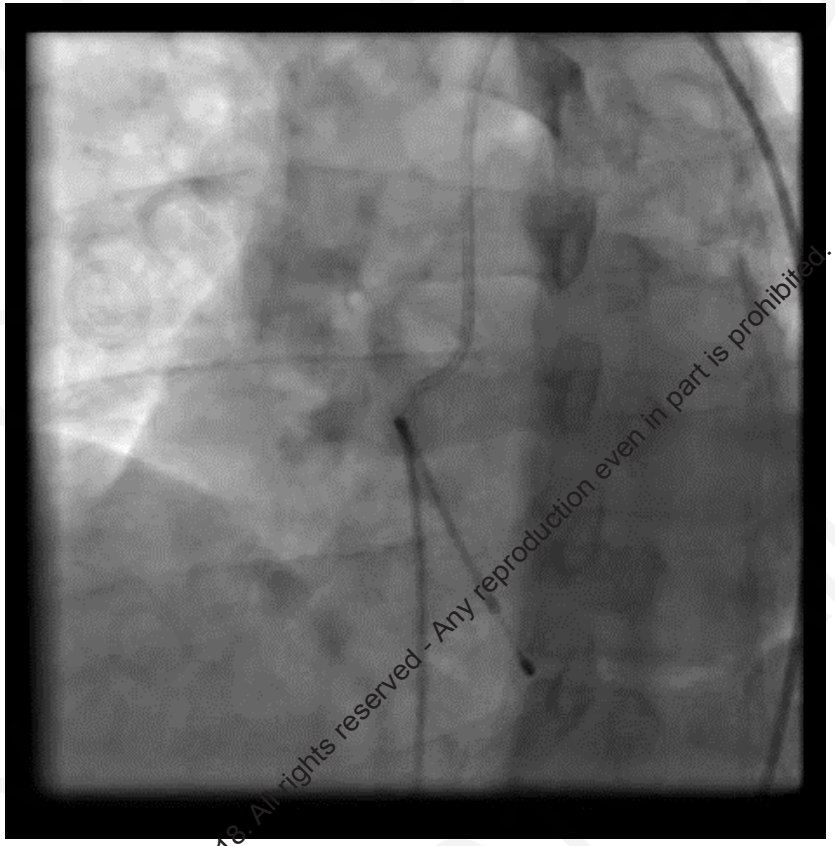


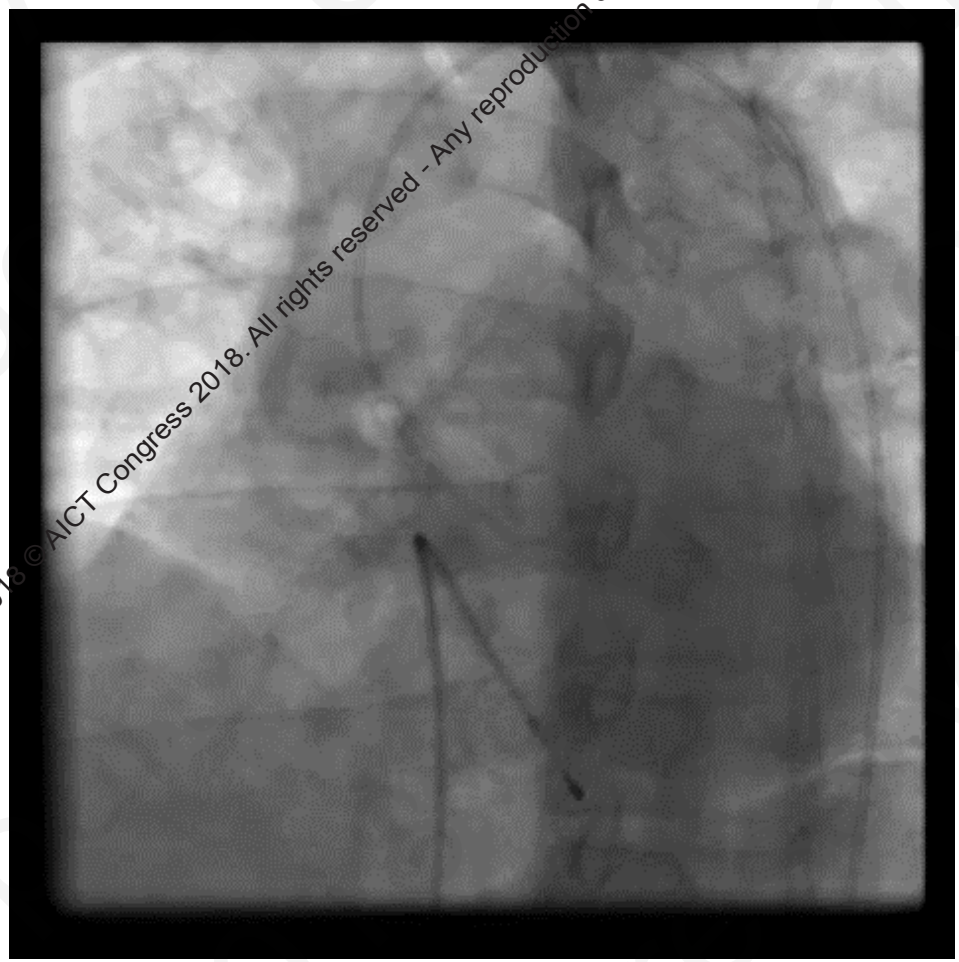


CAG: LMCA, LAD and LCx were normal



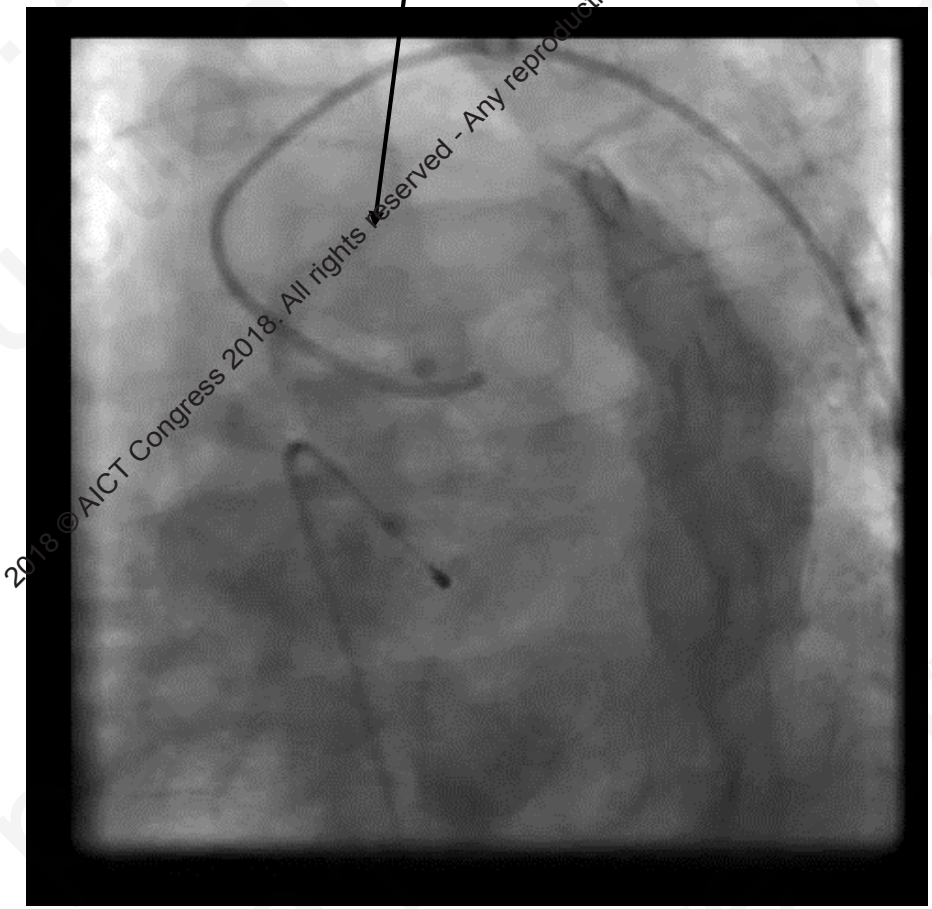


- Meanwhile, patient developed complete heart block;
- so temporary pacemaker inserted
- But, RCA was not cannulated in both right and left coronary cusps

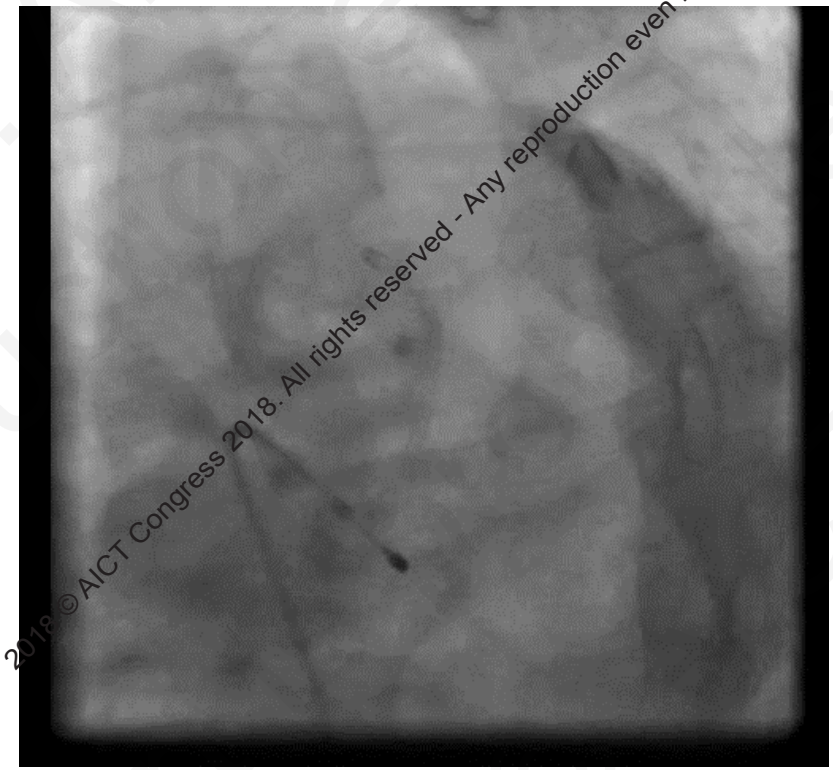


- RCA could not visualised even in aortogram with pigtail catheter
- Patient had ongoing chest pain with complete heart block
- So, a decision of thrombolysis was taken
- **Tenecteplase 40 mg** was given **in aortic root** with pigtail catheter

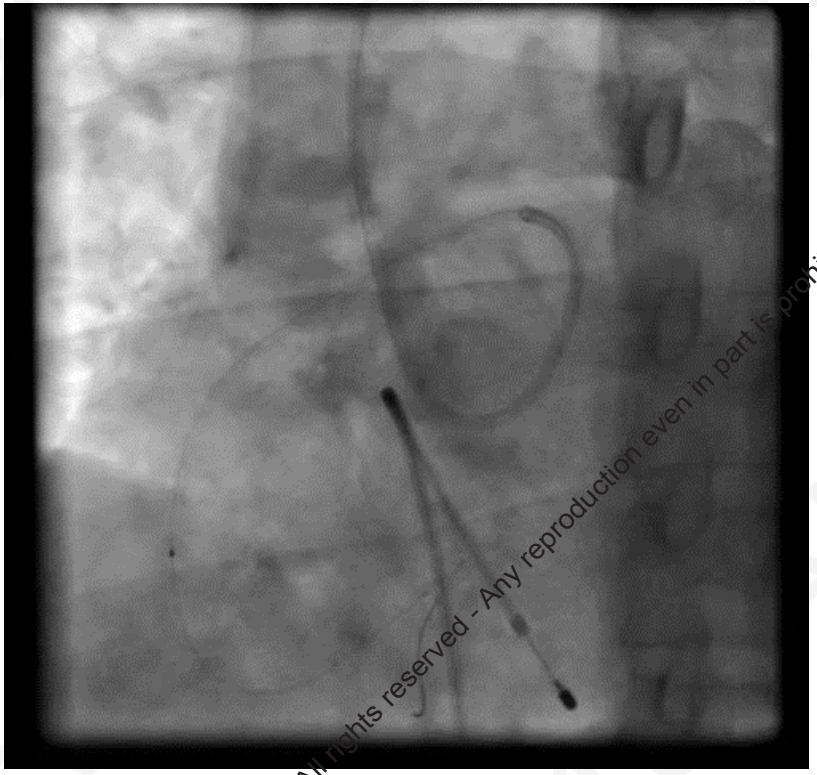
RCA contrast seen



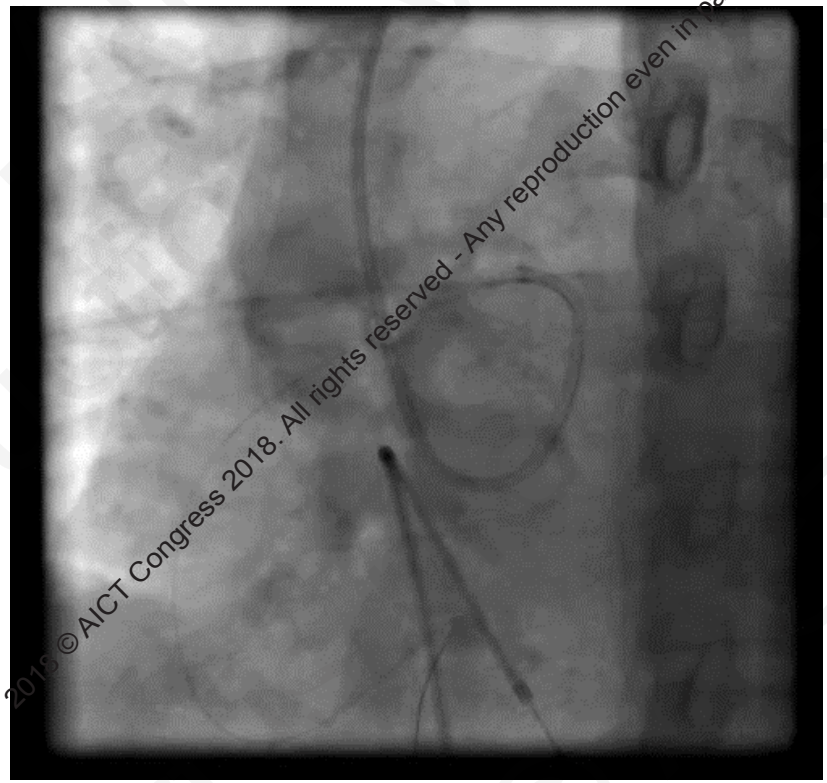
- After 15 minutes, an aortogram was taken again
- A faint flow was seen in left coronary cusp

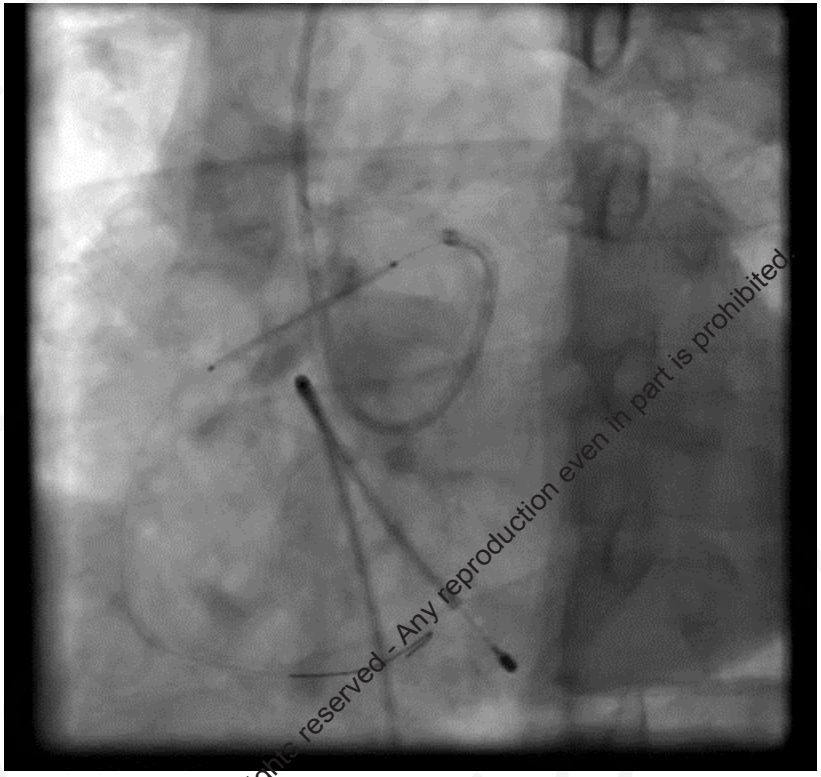


- So, a JL 4.0 was taken
- And RCA was engaged

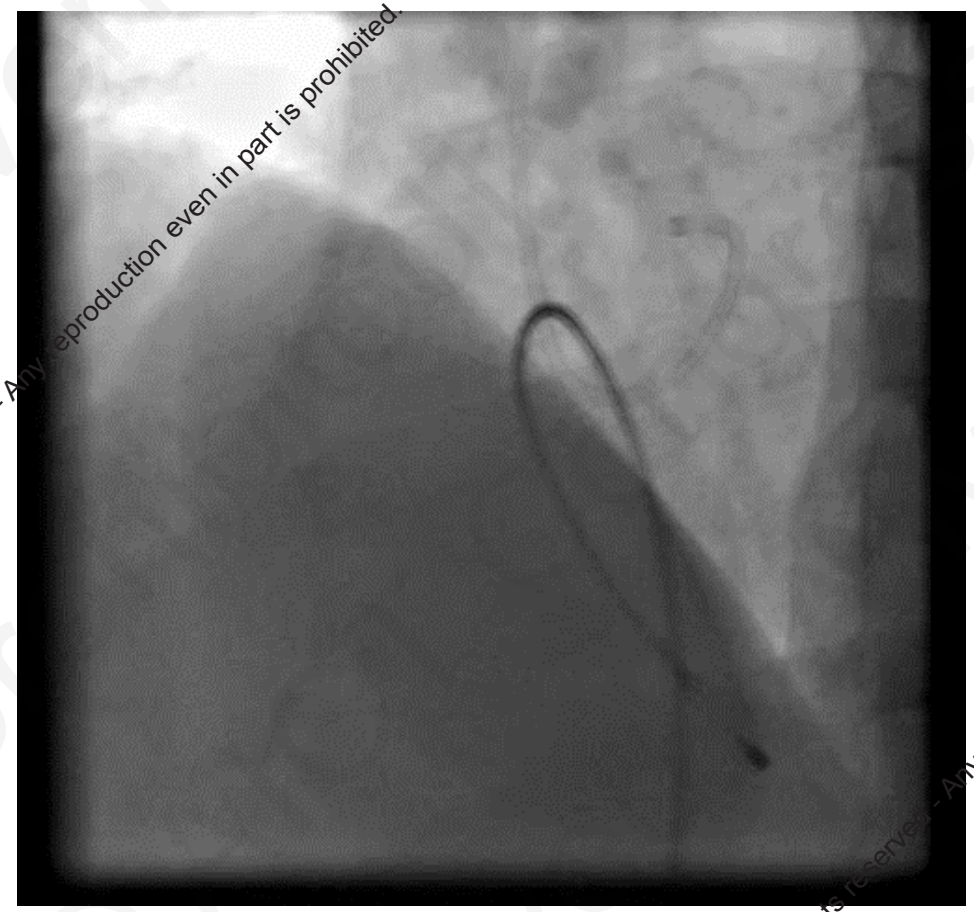


- A thrombosuction run was taken,
- But, no thrombus could be aspirated





2 DES were implanted to cover the mid and proximal stenotic area in RCA





- Final result was TIMI III flow in RCA
- CHB was resolved
- Patient was discharged after 3 days

# Learning points

- Anomalous RCA occasionally arises from left coronary cusp
- Its origin in left coronary cusp is usually superior and backwards
- JL 4.0 or 5.0 takes curve in left cusp and engages in RCA ostium
- The anomalous RCA has occlusion and thrombus formation usually in the mid part where it takes acute bend
- This RCA probably had thrombus migration proximally and was occluded from the ostia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- When we were not able to engage this RCA, we had this nasty thought of giving thrombolysis in aortic root
- This helped in slight dissolution of thrombus
- Ultimately, RCA was seen and we were able to complete the procedure
- This was a unique example of **on-table pharmaco-invasive** approach


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# Thank You



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