Deferred stenting in primary PCI: individualistic approach leads to less ‘slow flow’ or ‘no reflow’

Dr Deepak Ameta

MD, DM(Cardiology), MAPSIC

Consultant, Interventional Cardiology,

Fortis JK Hospital,

Udaipur, India

Speaker's name : Deepak AMETA, Udaipur

☑ I do not have any potential conflict of interest

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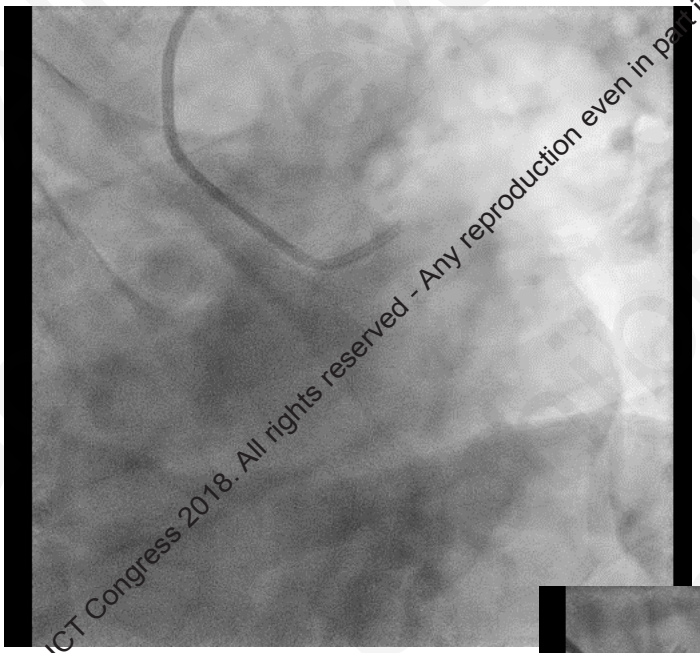
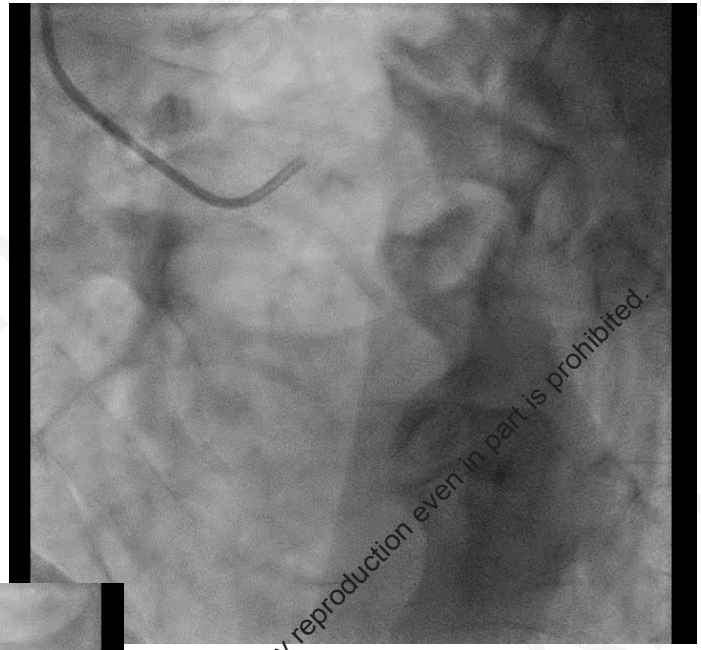
Prologue

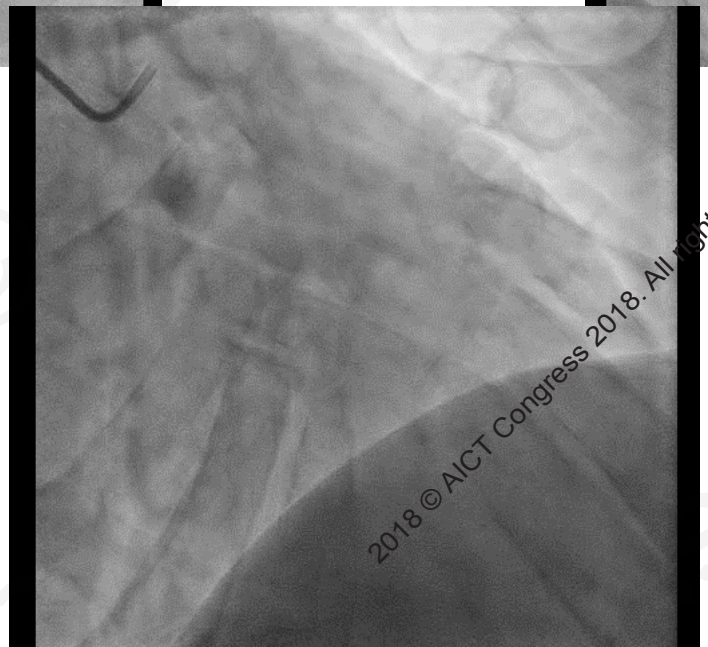
- Acute STEMI has got lot of thrombus in its pathogenesis; moreover in younger individuals
- Various interventional technique have been described to treat such lesions
- But, thrombus needs medical treatment and such lesions should be “cool down” with drugs
- The best treatment of thrombus remain medical treatment, in our practice
- Here, we share many of our such cases

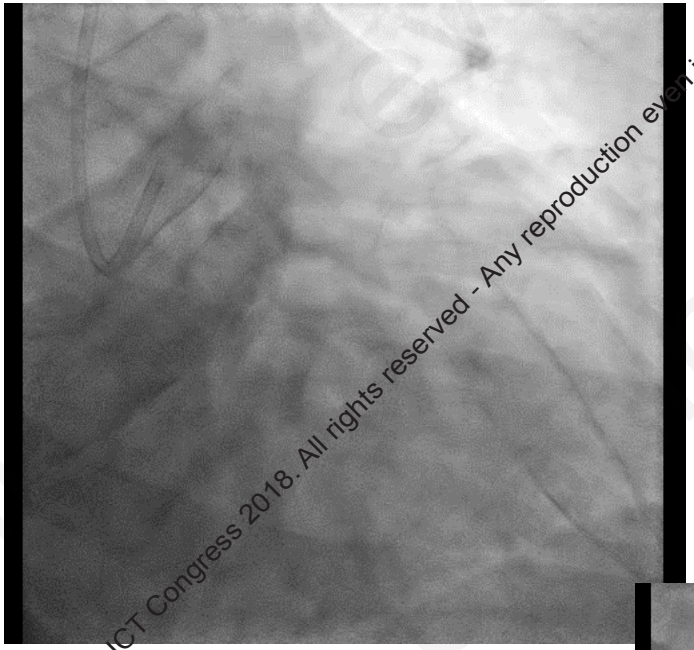
Case 1



Thrombotic
critical lesion
in dominant px
LCx

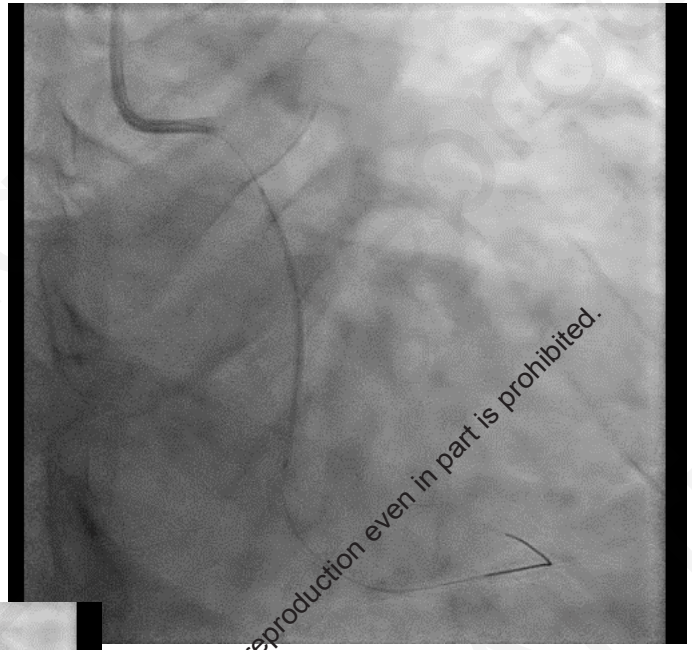


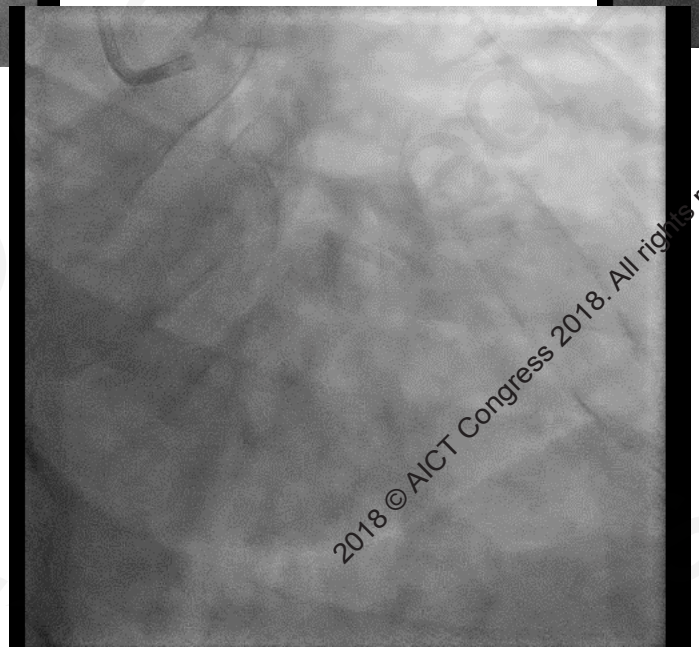




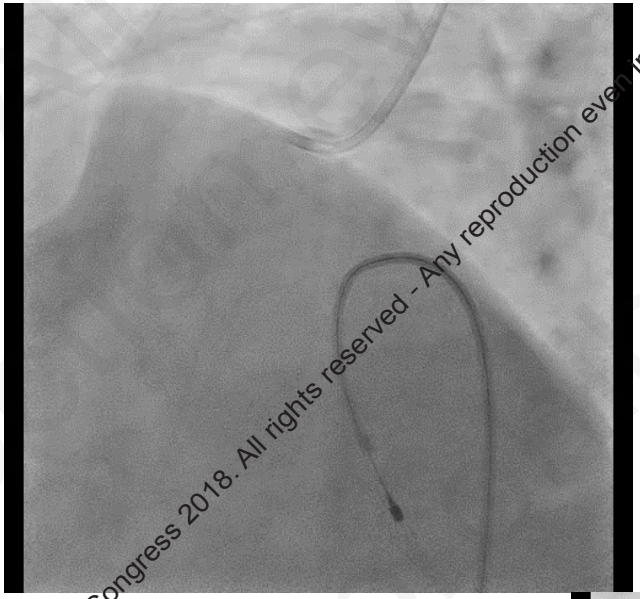
DES implanted

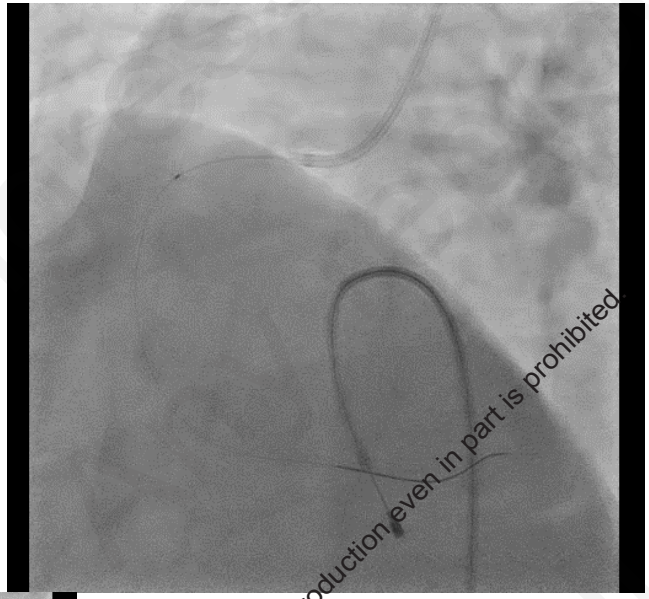
After 24 hours of heparin and GP IIb/IIIa inhibitor infusion

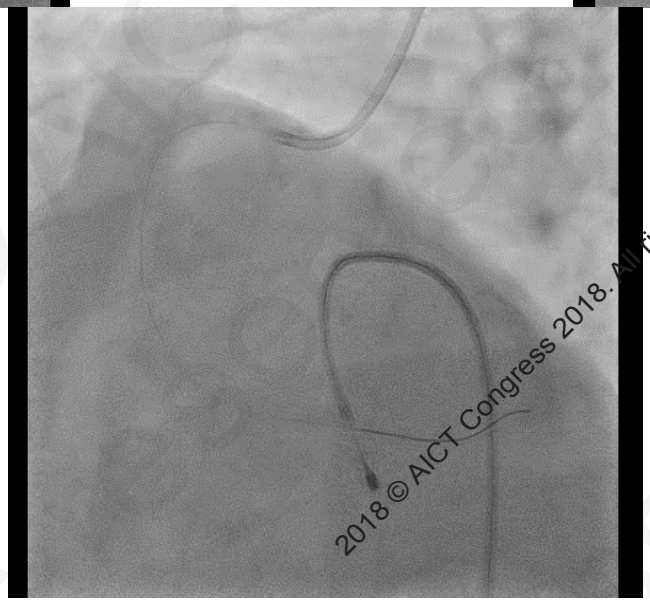


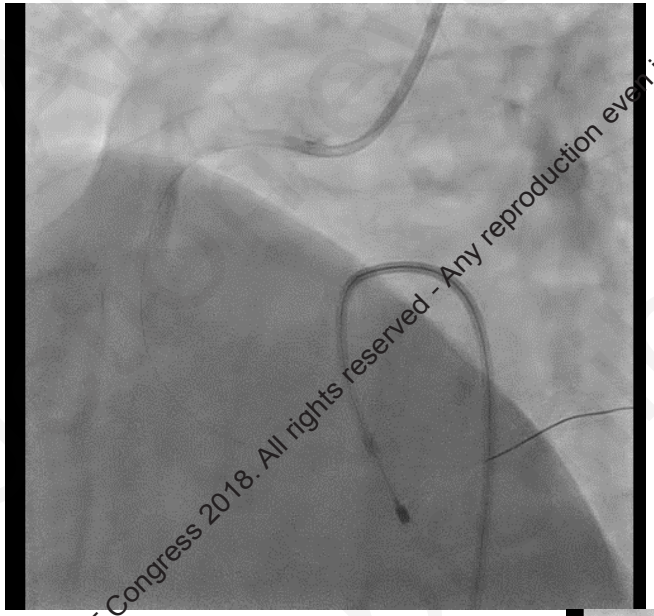


Case 2: Ac IWMI with CHB

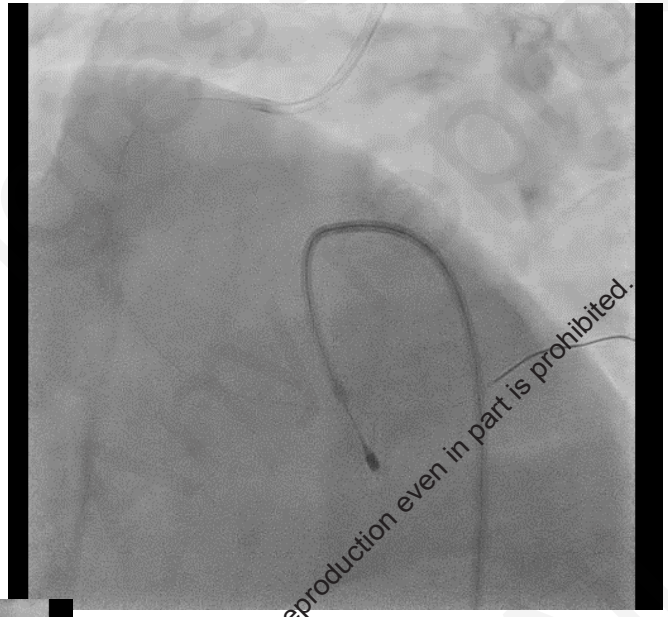


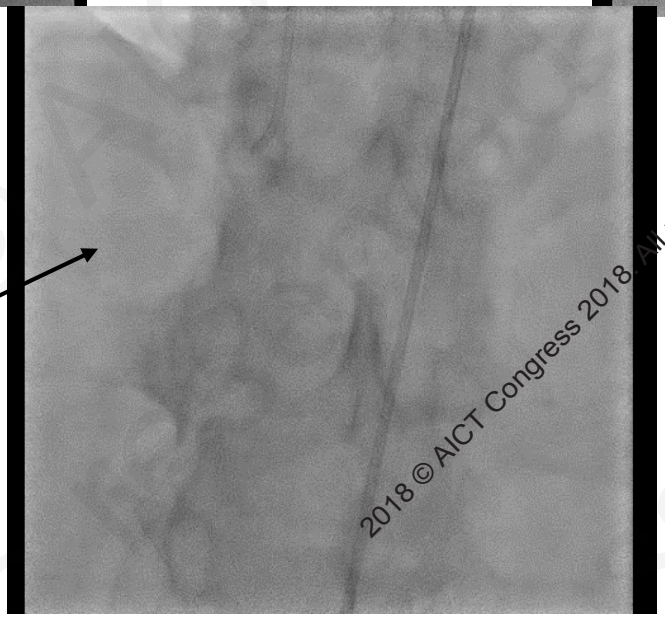






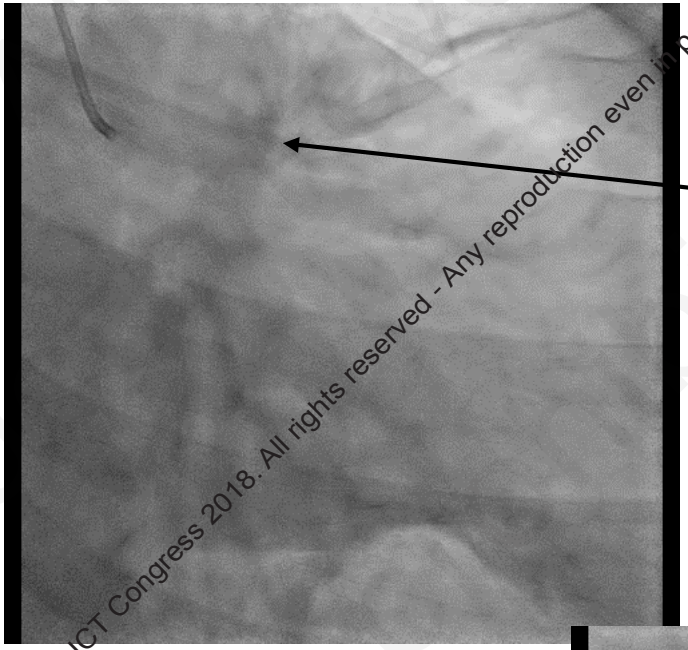
TIMI II flow after thrombosuction and intra-coronary pharmacological agents



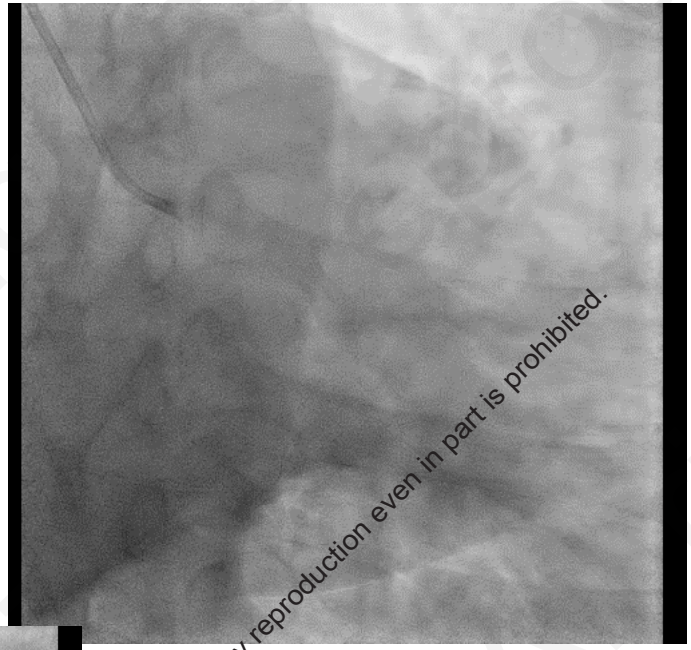


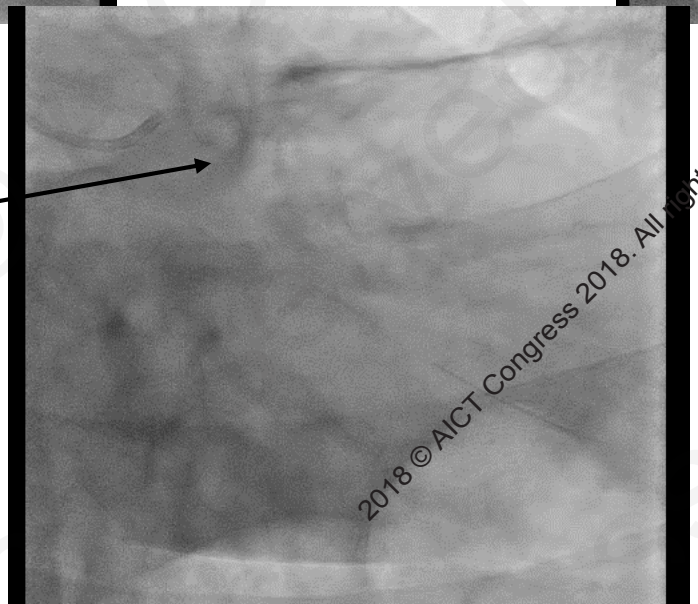
- No stent placed
- CAG on next day showing TIMI II/III flow

Case 3: Ac AWMI



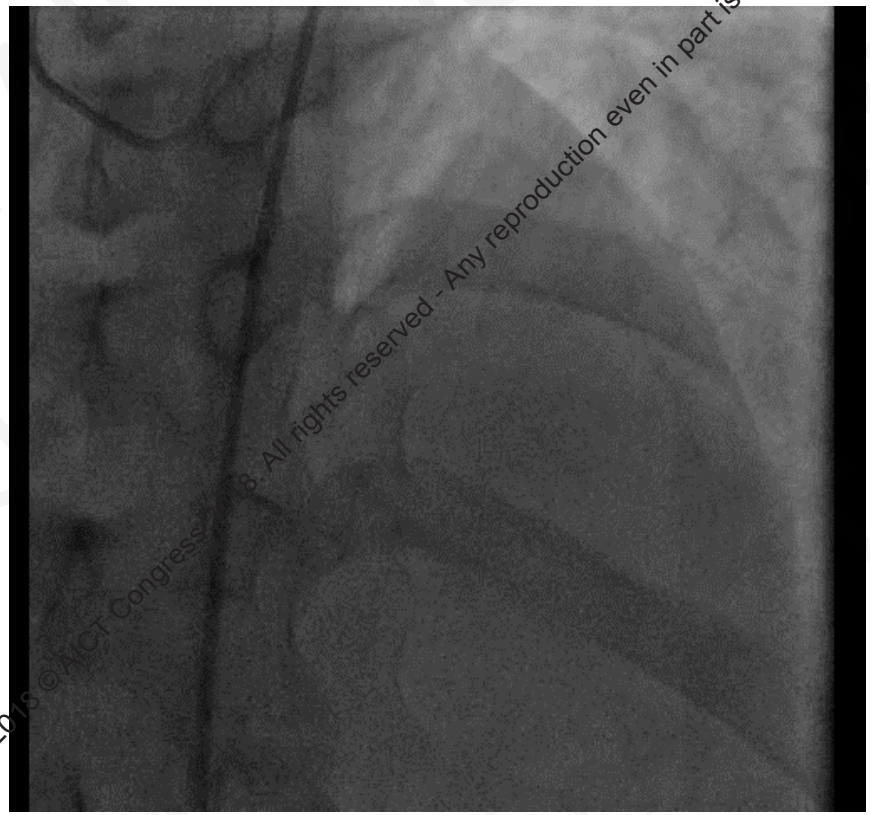
Large chunk of thrombus in px LAD



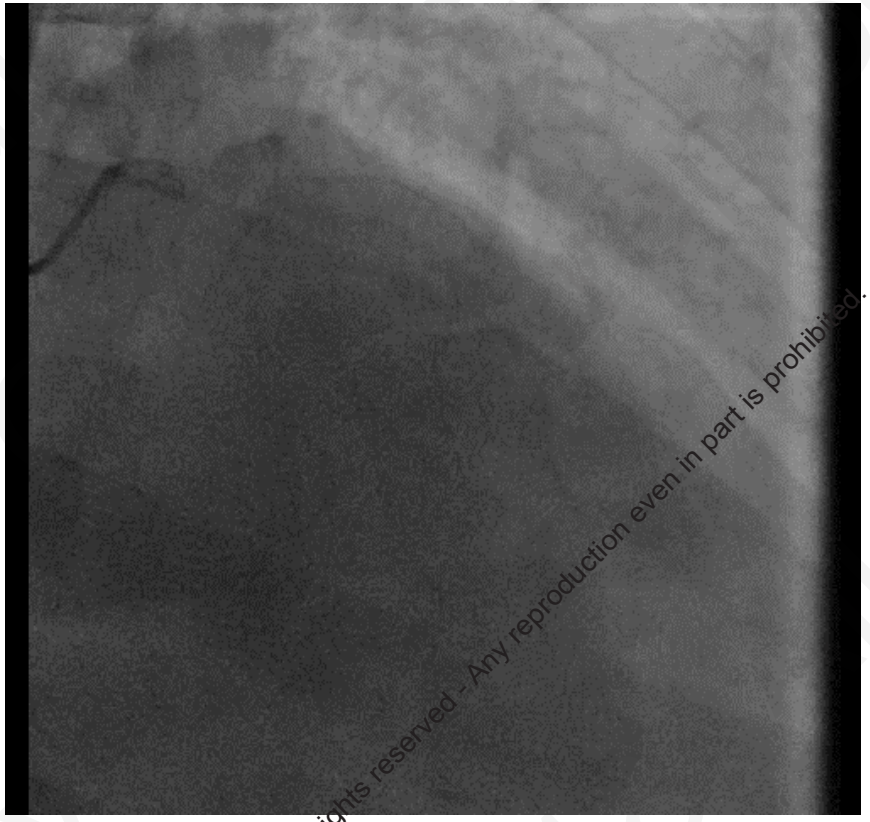


CAG after 24 hours of heparin and GP IIb/IIIa inhibitor

Case 4: Ac AWMI late presentation

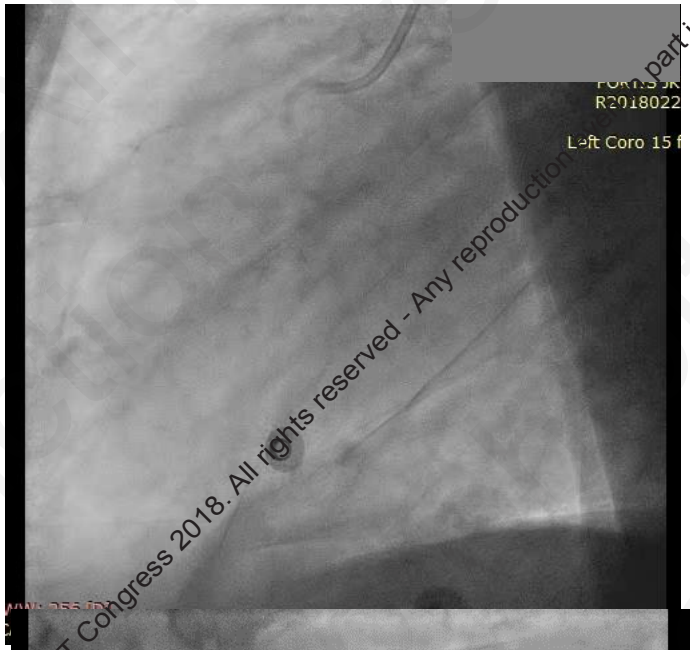


Initial CAG

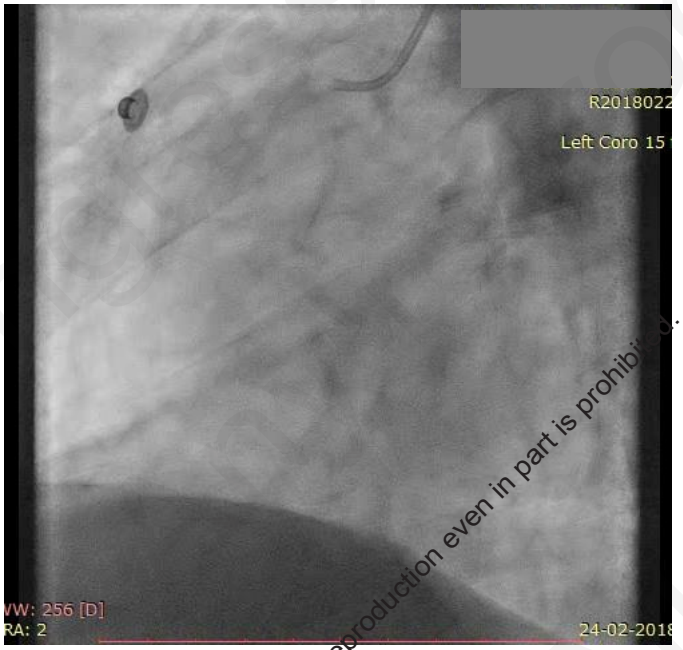


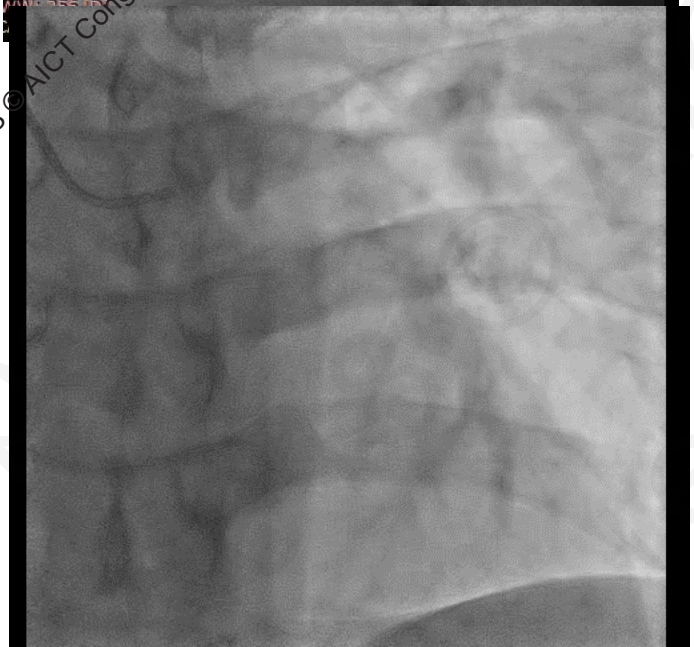
CAG after 7 days of LMWH

Other cases

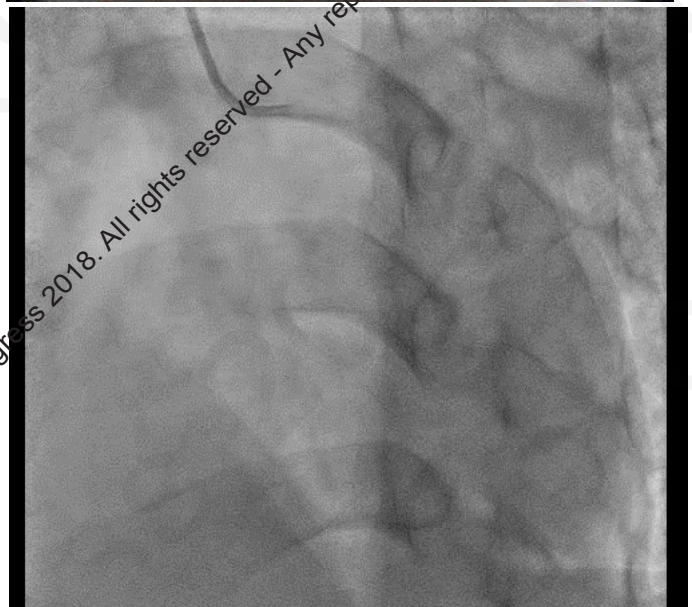


Huge thrombus load





Heavy thrombus burden in Px LAD and D1



Learning points

- Cases of acute MI with thrombus load needs individualistic approach
- Intervention in such cases usually result in “slow flow” or “no reflow”
- If infarct related artery is occluded, pass the wire, thrombo-aspirate and give intra coronary agents like sodium nitroprusside, adenosine or GPIIb/IIIa inhibitors
- If infarct related artery is open with TIMI I or above flow, give time for thrombus dissolution with these intra coronary agents
- The optimal treatment of thrombus is only appropriate medications and not any intervention

Thank You

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