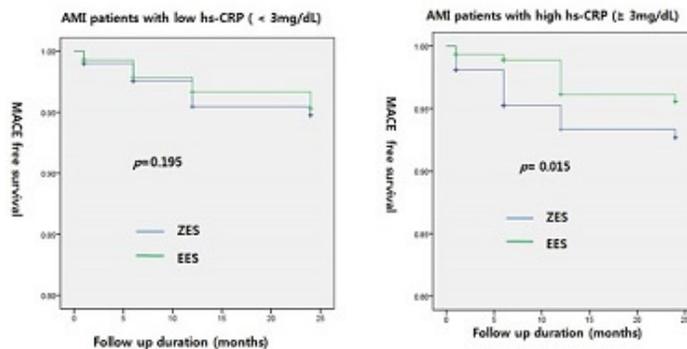


Everolimus-stent is superior to zotarolimus-stent in MI patients with periprocedural inflammation

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Background: There were several studies that compared the efficacy of second-generation DES; Everolimus versus Zotarolimus. However, the impact of peri-procedural inflammation on efficacy of these DES was not evaluated. **Method:** From KAMIR data, 8401 MI patients were enrolled and 5050 patients with hs-CRP under 3 mg/dL and 1646 patients with hs-CRP over 3 mg/dL were analyzed after propensity score matching. The primary end point was defined as MACEs. The secondary end points were cardiac death, recurrence of MI, and target lesion revascularization respectively. For AMI patients with low hs-CRP and high hs-CRP, the clinical outcome were compared between EES group and ZES group respectively. **Results:** For AMI patients with low hs-CRP level (< 3 mg/dL), the cumulative incidence of MACE was similar between two 2nd-generation stent ($p=0.195$). However, when the level of hs-CRP over 3 mg/dL, EES revealed better outcome than ZES ($p=0.015$). To adjust compounding variables, Cox-regression multivariate analysis was performed and the use of EES rather than ZES had significant impact on improving clinical outcome ($p=0.029$). However, the difference of cumulative incidence of respective cardiac outcome such as cardiac death ($p=0.053$), non-fatal MI ($p=0.781$) and target-lesion revascularization ($p=0.155$) was not significant. **Conclusions:** EES was superior to ZES, when the peri-procedural inflammation was severe in AMI patients. The level of hs-CRP can be a guidance to select appropriate drug-eluting stent in AMI patients.



Pulmonary embolism caused by huge popliteal venous saccular aneurysm: A case report

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A 67-year-old woman presented with atypical chest pain with shortness of breath on walking. The patient was brought to the emergency room for evaluation. Her physical examination did not reveal any pathology. The coronary angiogram and Echocardiogram revealed no significant finding except mild septal bouncing of LV wall. At the night of admission day, multiple syncopal episode with transient shock were observed. A CT angiogram revealed multiple bilateral filling defects diagnostic of multiple bilateral pulmonary emboli (Fig. 1A) and enlargement of right popliteal vein. A lower extremity ascending venogram revealed a right saccular popliteal vein aneurysm (PVA) that measured 3.5 cm in diameter and filled with floating thrombus (Fig. 1B). Laboratory test revealed no evidence of hypercoagulable state. A preoperative inferior vena cava (IVC) filter was inserted into infrarenal IVC and the patient was anticoagulated with heparin and warfarin for preoperative period. 2 months later, a lateral tangential aneurysmectomy was performed to prevent a recurrence of pulmonary embolism on posterior approach via an S-shaped incision to the popliteal fossa (Fig. 1C). The lateral venorrhaphy was primarily repaired. The opened aneurysm sac was filled with organizing thrombi and observed intima necrosis with medial hypertrophy. The patient was anticoagulated for 1 year. The patient has been asymptomatic for 1 year with no sign of deep venous insufficiency. A CT angiogram revealed patent repair with no evidence of deep venous thrombosis.

