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Intracoronary Tenecteplase : A treatment option in STEMI, failed aspiration thrombectomy

Department of Internal Medicine, Eulji University Hospital, Daejeon, Korea

*Jong Woo Kim

A 57-year-old female presented with chest pain of 4 hours duration associated with posterior ST segment elevation. Troponin T was elevated. Echocardiography showed a decreased LVEF of 42% with regional wall motion abnormalities of the lateral, posterior and anterior wall. She was treated with aspirin, clopidogrel, atorvastatin before intervention. Coronary angiography revealed a total occlusion of the P-LCX with TIMI 0 flow as infarction-related artery with massive thrombus burden. A weight adjusted bolus of unfractionated heparin was administered and a 0.014-inch guide wire passed across the occlusion. First, we injected a weight-adjusted abciximab of 8.25mg at the site of the thrombus through an aspiration catheter followed by manual aspiration thrombectomy. However, no particles including thrombus could be aspirated and the proximal LCX with ectatic change remained occluded. Second, we performed ballooning several times using a balloon with 2.5mm diameter in order to break the huge thrombus. However, the thrombus was not broken. Third, we tried thrombus removal with another catheter with larger luminal tip. However, despite of repeated aspiration and LCX still remained occluded. Fourth, ballooning was performed a couple of times with larger balloon, but this did not improve the angiographic thrombus burden. Finally, a 35mg bolus of intracoronary tenecteplase was administered at the site of the thrombus through the aspiration catheter. Ten minutes later coronary angiography revealed nearly complete removal of the thrombus and TIMI 3 flow in a large ectatic artery. And we could identified the true culprit lesion which was located in the just proximal site of the bifurcation (between distal LCX and obtus marginal branch). IVUS (iLab, Boston Scientific, USA) showed large plaque burden, plaque rupture, and residual thrombus at the culprit lesion. IVUS-guided drug eluting stent implantation (Promus PREMIRE stent 4.0mmx12mm, Boston Scientific, USA) was performed. IVUS did not show mal-apposition or under-expansion of the stent. Her inpatient stay was uncomplicated and she was discharged home four days after her initial presentation

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Spontaneous isolated dissection of Celiac artery

Sanbon Hospital, Wonkwang University College of Medicine, Gunpo, Republic of Korea

*Byoung-Su Oh¹, Dong-Sik Yun², Young-Woo Son³

Introduction: Celiac artery dissection including other visceral artery dissection such as superior mesenteric artery (SMA), inferior mesenteric artery (IMA) has been reported frequently, but spontaneous isolated celiac artery dissection itself is very rare and the least reported. Therefore, we report a case of symptomatic spontaneous isolated celiac artery dissection. **Case:** A 39 year-old woman had been admitted with epigastric pain radiated to back. A contrast-enhanced computed tomography (CT) of abdomen had preceded to evaluate unexplained abdominal pain. In CT images, celiac artery dissection extended to the common hepatic artery with intimal flap had shown. After she had a conservative treatment with anticoagulation for 8 days, she had discharged to home. **Discussions:** If we could not find out visceral artery dissection progressed to emergency such as ischemia or rupture, we may have been in catastrophe. Therefore in our daily practice including emergency room, especially if the patients complain of acute abdominal pain radiated to back which is not explained by physical examination, simple x-ray images, and blood test. we need to be considered visceral artery dissection including the superior mesenteric artery (SMA), inferior mesenteric artery (IMA) and the celiac artery without aortic dissection.

