

Spontaneous forearm Laceration after Transradial Coronary Intervention

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An 86-year-old woman was admitted to hospital with effort-related angina. Transradial coronary angiography was performed via left radial artery. It revealed severe stenosis at the left anterior descending coronary artery, and we successfully implanted drug-eluting stent. The puncture site was compressed by using a hemostasis device (TR-band, Terumo, Japan). Immediate after hemostasis, patient suddenly complained of pain and swelling at left forearm, so we removed initial hemostasis device, and compressed the radial puncture site manually. Despite the proper manual compression, she complained of worsening swelling, pain, and paresthesia, and suddenly spontaneous laceration was occurred at the dorsal side of the forearm due to compartment syndrome (Panel A and B). Some trapped blood was emitted through the spontaneous laceration wound. In emergency operation room, skin incision was performed on the volar side of the forearm, and there was noted a left radial artery dissection and perforation. Hematoma was evacuated, and radial artery repair was accomplished as the manner of end to end anastomosis (Panel C). At the dorsum side of the forearm, there was a spontaneous laceration of skin and fascia which could be called as automatic 'self-fasciotomy', therefore, surgeon did not need to perform additional fasciotomy, and the dorsal wound was simply sutured immediately (Panel D). The volar side incision was sutured two days later, after forearm edema resolved. She has not presented any other complication including any neurologic and muscular deficit.



Urgent TAVR, another treatment option for severe aortic stenosis with decompensated heart failure

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An 82-year-old man was transferred to our hospital for TAVR. He was diagnosed with severe aortic stenosis(AS) two years ago and recommended for surgery, but he refused for personal reason. He admitted to the intensive care unit(ICU) at another medical center for 4 days, but clinical course was deteriorated. The electrocardiogram(ECG) showed atrial fibrillation with bifascicular block and pneumonia with pulmonary edema was observed on chest X-ray. Transthoracic echocardiography showed decreased left ventricular ejection fraction(34%). The aortic valve area(AVA) was 0.69 cm² with mean systolic pressure gradient of 16.3mmHg, compatible with low pressure low gradient severe AS. Patient's STS score was 21.153%, so urgent TAVR was determined because of the high risk of surgery and the progression of hear failue. The procedure was performed under general anesthesia. We confirmed that the annulus size corresponded to the Core-Valve 26mm by transesophageal echocardiography. Core-Valve deployed at the aortic annulus under angiographic guidance without pre-balloonng. Procedure was done successfully. There was no evidence of further heart failure, and the subsequent echocardiographic function was improved in 50%. He was discharged one week later without any other complications. The patients with symptomatic severe AS should be treated, but for high risk patients surgical treatment may increase mortality risk. In conclusion, TAVR can be considered one of the treatment options for the high risk patients with severe AS who present decompensated heart failure.

