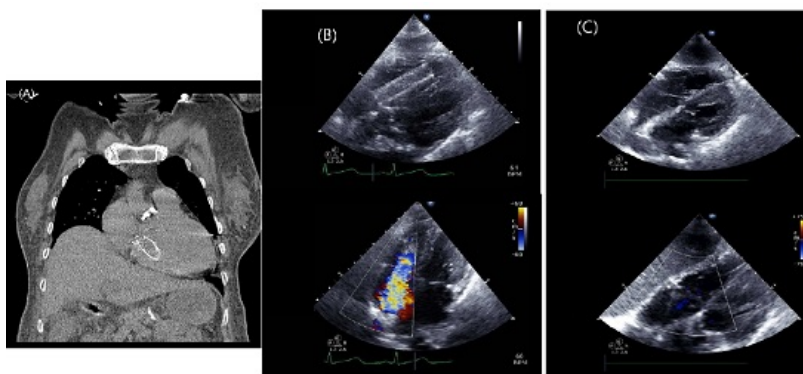


Percutaneous retrieval of a migrated stent in ventricle in a patient with infective endocarditis

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Introduction: Infective endocarditis (IE) of native tricuspid valve owing to a venous stent migration is extremely rare, but its morbidity and mortality are very high if undiagnosed and treated lately. **Case:** An 84-year-old female patient presented to emergency department with fever (39.2 °C) and dyspnea. She had hypertension, diabetes, stroke, end-stage renal disease maintained on hemodialysis. Chest x-ray and chest CT scan (Figure 1A) revealed a migrated 6 cm-sized stent in right ventricle. Echocardiogram showed the stent was entrapped within the tricuspid valve causing severe tricuspid regurgitation (Figure 1B). Under the fluoroscopic and echocardiographic guidance, we successfully performed percutaneous retrieval of the stent with 15mm multi snare through 16-Fr ultimum sheath without any complication. After stent retrieval, the echocardiogram showed only mild tricuspid regurgitation without pericardial effusion or free wall rupture (Figure 1C). Blood and retrieved stent culture all yielded methicillin-susceptible *Staphylococcus Aureus* and IE caused by a migrated stent was confirmed. **Discussion:** In the treatment of IE due to the migrated venous stent, along with proper antibiotics therapy, sterilization of tricuspid valve is utmost important. We suggest that percutaneous stent removal could be safe and feasible approach even in patients with high surgical risk and surgical removal may be reserved in case of the percutaneous approach failed.



Cardiac arrest due to coronary artery disease in a 20-year old man

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A 20-year-old man was transferred because of sudden cardiac arrest. The patient was an enlisted soldier, and had no remarkable previous medical history. He had dyspnea on exertion during the last 2 months, and developed sudden cardiac arrest while running. By-stander cardiopulmonary resuscitation with automated external defibrillator was successful, but the patient showed unstable vital sign. Emergent coronary angiography revealed total occlusion in the left main coronary artery with collateral flows. Coronary intervention was unsuccessful, because the stump of the left coronary artery was obscure and retrograde wiring resulted in false lumen wiring. Fortunately, he recovered after the intensive care unit care, and was discharged alive after coronary artery bypass graft surgery. Laboratory tests to rule out coagulopathy and vasculitis were all negative. This is a rare case of sudden cardiac arrest because of coronary artery disease in a young male patient with no obvious cardiovascular risk factors.