Acute ST-elevation Myocardial Infarction

Acute Myocardiac Infarction/Acute Coronary Syndrome I

Wednesday, April 24, 2013

2:00 PM ~ 3:00 PM

(Abstract nos. AS-007, AS-008, AS-021)

Acute Myocardiac Infarction/Acute Coronary Syndrome II

Wednesday, April 24, 2013

3:00 PM ~ 4:00 PM

(Abstract nos. AS-009, AS-013, AS-014, AS-015, AS-022)

Acute Myocardiac Infarction/Acute Coronary Syndrome III

Wednesday, April 24, 2013

4:00 PM ~ 5:00 PM

(Abstract nos. AS-010, AS-011, AS-016, AS-017, AS-018)

Acute Myocardiac Infarction/Acute Coronary Syndrome IV

Wednesday, April 24, 2013

5:00 PM ~ 6:00 PM

(Abstract nos. AS-020, AS-023, AS-129)

AS-007

Direct Culprit Vessel PCI Followed by Contra Lateral Angiography by Transradial Route in Acute Myocardial Infarction - Direct Prospective Pilot Study. <u>Tapan Ghose</u>, Ranjan Kachru, Abid Hussain, Upendra Kaul. Fortis Flt Lt Rajan Dhall Hospital, New Delhi, India.

Background: Percutaneous coronary intervention (PCI) of the infarct related artery during primary PCI for ST elevation myocardial infarction (STEMI) is appropriate. Two retrospective analyses suggested that, direct PCI to the IRA without knowledge of the anatomy of the contralateral artery is feasible .This approach would shorten the door to balloon time which is a validated surrogate for mortality in AMI. To the best of our knowledge no prospective study looked into the feasibility of such an approach. In this pilot study we tested the hypothesis that in anterior STEMI, direct PCI to left anterior descending (LAD) artery before right coronary artery angiogram is feasible and this would shorten the door to balloon (d2b) time.

Methods: Anterior wall STEMI was diagnosed by standard ECG criteria. All consequtive stable patients of anterior MI admitted between March 2012 to May 2012 were studied prospectively. Patients were pretreated as per standard protocol after the ECG and shifted to cath lab. Radial access was obtained by anterior wall puncture of the right radial artery. LMCA was hooked with 6F XB guiding catheter and primary PCI of LAD was done as per modified INFUSE-AMI protocol. After successful PCI to LAD, the RCA angiogram was performed. All the intervals were recorded.

S. No.	Door to ECG	ECG to Cath Lab arrival	Cath arrival to first device activation	D2B time	RCA Angiogram Time
1	7.5	11.38	12.37	31.03	2.3
2	8.3	15.29	15.3	38.89	10.45
3	9.24	12.3	13	34.54	2.45
4	10.36	13	14.36	37.72	1.3
5	11.42	14.28	16.38	42.08	0.3
6	8	10.38	17.45	35.83	2.2
7	12.32	14.45	15.48	42.25	0.45
8	8.34	13.46	12.39	34.19	14.3
9	7.36	11.29	13.34	31.99	2.45
10	9.44	12.32	14.38	36.14	1

* All time intervals in min:sec.

Results: The median d2b time was 35.98 minutes and the mean d2b time was 36.46 min. In two cases SL (2) and (8), the RCA angiogram required multiple attempts with different catheters. Prior RCA angiogram would have prolonged the median d2b time by 2.45 minutes (p=0.05 sec) and mean d2b time by 4.76 minutes (p=<0.05 sec).

Conclusion: From this pilot study, we conclude that in anterior wall STEMI, it is feasible to perform PCI to LAD directly without knowing the RCA anatomy which significantly shortens the d2b time. Randomized controlled trial is warranted.

AS-008

Using a Single Transradial MAC Guiding Catheter for Both Coronary Angiography and Intervention in Patients with ST Elevation Myocardial Infarction (STEMI-Rapid trial).

<u>Jincheng Guo</u>, Zhenghai Zhang, Lixin Zhang, Guozhong Wang, Guowang Gao, Shunjin Gan. Luhe Hospital, Tongzhou District, Beijing, China.

Background: It is unknown whether using a single guiding catheter for both nonculprit and culprit vessel angiography and intervention during transradial primary percutaneous coronary intervention (PCI) is

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