PP-031

ACUTE MYOCARDIAL INFARCTION DURING THE EARLY POSTPARTUM PERIOD SUCCESSFULLY TREATED WITH TIROFIBAN

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Objective: Acute myocardial infarction (AMI) during the early postpartum period is rare but may be associated with poor maternal outcome. We report an inferior AMI in 30-year-old woman with mitral valve replacement (MVR) during early postpartum period successfully treated with tirofiban.
Case: A 30-year-old woman with MVR was admitted to our emergency department because of sudden onset chest pain on the third day after delivery. She did not have dyspnea, syncope, haemoptysis, or fever. She gave no history of cardiovascular risk factors. Her medical history included an operation of MVR approximately ten months ago. She had used warfarin for four months then began to take enoxaparine (2*1 SC) during pregnancy. Electrocardiography showed ST-segment elevation of 2 mm in leads DII, DIII, aVF and reciprocal ST depression in DI, aVL, V1-3. Echocardiography revealed hypokinesis of the inferior wall, with an overall ejection fraction estimated at 45%. Emergency coronary angiography demonstrated extensive thrombus load in the left circumflex coronary artery (LCx) and first obtus margin brunch (OM1). Because of significant amount of thrombus load and TIMI III flow in LCx and OM1, angioplasty did not performed. Additionally thrombolytic therapy was not administrated due to presence of vaginal hemorrhage. She was treated with aspirin, clopidogrel, metoprolol, enapril, rosuvastatin, nitroglycerin, unfractionated heparin and tirofiban infusion. Four hours after starting the therapy ST-segment normalization in inferior and V1-3 lead on electrocardiography was observed. The patient received tirofiban infusion for 48 hours. Total resolution of thrombus in LCx and OM1 was observed in control coronary angiography three days after medical therapy. Patient did not have any problems during follow-up period and she was discharged ten days after the admission.
Discussion/Conclusion: AMI due to extensive intracoronary thrombus load without evidence of atherosclerotic disease in early postpartum period is a rare condition. For a patient that has got AMI due to massive thrombus and that is not suitable for percutaneous coronary intervention and has got contraindication to thrombolytic therapy, tirofiban infusion must be kept in mind. However, further studies are required to determine the efficacy and safety of tirofiban therapy (alone or adjunctive) use for AMI.

PP-032

THE RATES OF MORTALITY AND MORBIDITY ACCORDING TO PATIENTS' STRATEGIES OF TREATMENT, WHO HAVE SEVERE CORONARY ARTERY DISEASE

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Objective: Short and long term morbidity and mortality conditions of patients, who had severe coronary artery disease, were evaluated according to strategies of CABG, PCI or medical therapy. For this purpose, the records of patients who underwent coronary angiography at Ege University Medical Department of Cardiolog, were analysed.
Methods: The coronary angiography records which dated between Jan 1, 2007-March 31, 2009 were scanned. The patients (at least >75% stenosis) who had severe coronary artery disease were identified. All patients were evaluated in terms of unstable engina, MI, arrhytmia, revascularization, rehospitalisation, mortality, SVO AND renal failure.
Results: The average age was 62 and most of the patients were male. In the 6th month, the rate of mortality was 5% in patients who were observed with medical therapy, rehospitalisation was 15%, the need of revascularization was 11% and arrhytmia was 25%. In the 6th month, the total rate of events was 28%. The rate of all adverse events was significantly high in the group which were medically treated but did not undergo PCI and CABG.
Conclusions: The mortality and morbidity rates of patients; who were observed with medial therapy but were not revascularized because of some reasons, were higher than the ones who underwent PCI and CABG. The CABG group was the population of the patients who had the lowest rates in terms of having adverse events.

PP-033

EFFICIACY AND OUTCOME OF PRIMARY PERCUTANEOUS CORONARY INTERVENTION IN PATIENTS WITH ST ELEVATION MYOCARDIAL INFARCTION DUE TO SAPHENOUS VEIN GRAFT OCCLUSION

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Objective: We investigated efficacy and outcome of primary percutaneous coronary intervention (PCI) in patients with ST segment elevation myocardial infarction (STEMI) due to saphenous vein graft occlusion.
Methods: We reviewed 2646 consecutive patients (mean age 56.6±11.8 years, 2189 male, 457 female) treated primary PCI for STEMI between 2003 to 2009. All clinical, angiographic data and in-hospital and longterm outcome were retrospectively collected. Study patients were classified into two groups as patients who underwent PCI to native vessels (n=2625) and to saphenous vein graft (n=21).
Results: The rate of successful primary PCI in saphenous vein grafts was lower compared to native vessels (61.9%.vs 84.7%, p=0.01). When comparing saphenous vein graft and native vessels occlusion patients, we found no statistically significant difference between the two groups in terms of in-hospital and long term mortality (9.5% vs 5.6%, p=0.43; 5.2% vs 5.4%, p=0.92, respectively). Besides, application of PCI to saphenous vein graft was found to be an independent predictor for unsuccessful procedure (odds ratio 6.76, 95% confidence interval 2.05-22.21; p=0.002).
Conclusions: Procedural success of primary PCI in occluded saphenous vein grafts is less than that of native vessels. Moreover, STEMI developing patients due to saphenous vein graft and native vessel occlusion, despite low procedural success, have similar cardiovascular mortality rates.

PP-034

ACUTE ST ELEVATION MYOCARDIAL INFARCTION DURING INTRAVENOUS IMMUNOGLOBULIN INFUSION

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Objective: Intravenous immunoglobulin (IVIG) is used widely for the treatment of various autoimmune disorders including autoimmune neuromuscular disorders. It is generally considered a safe medication and most adverse effects associated with IVIG administration are mild and transient. Acute myocardial infarction (MI), mainly non-ST elevation MI, during or after treatment with IVIG has been reported. We describe here a patient who developed acute ST elevation MI during infusion of the first course of IVIG.
Methods: A 51-year-old male with squamous cell lung cancer was admitted to the neurology department because of weakness in his extremities. The patient was hospitalized because of the paraneoplastic chronic polyneuropathy. Additional past medical history included hypertension and hypercholesterolemia. Medications prior to admission included aspirin 300 mg, atorvastatin 20 mg and metoprolol 50 mg. On the day following his admission, intravenous immunoglobulin (IVIG) 0.4 g/kg per day for 5 days was prescribed (a dose of 28 g per day based on actual body weight of 70 kg). Four hours following the start of infusion, when he had received 16 g of IVIG, the patient developed crushing retrosternal pain. ECG revealed ST elevation of 3 mm in leads V1–3.
Results: Anterior wall ST elevation MI was diagnosed, IVIG infusion was stopped and the patient was transferred to the intensive coronary care unit. The patient was treated with aspirin, clopidogrel, unfractionated heparin and streptokinase; his chest pain resolved and ST segment returned to isoelectric line. Coronary angiography which was performed two days later revealed thrombotic occlusion of distal LAD and luminal irregularities in circumflex and right coronary artery. No intervention was performed and medical therapy was given with proper anticoagulation.
Conclusions: Acute MI may occur during or after infusion of IVIG, especially in older, high-risk cardiovascular patients. Before beginning IVIG treatment, the treating physician should evaluate the patient's cardiovascular risk profile and weigh the potential benefits against the risks involved. If IVIG treatment is chosen, we recommend close monitoring and a slow infusion rate.