

### Surgery in acute coronary syndrome and their sequelae

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61

**Background:** Acute coronary syndromes are commonly classified as unstable angina, Non Q wave MI and Q wave MI. All of these have common pathophysiology of atherosclerotic plaque rupture and coronary thrombosis. This paper discusses the Army Hospital (R&R) experience of surgery in cases of unstable angina and in case of life threatening complication of acute MI i.e. post infarction VSD and LV wall rupture.

**Methods:** From January 2001 to September 2002 there were 24 cases of unstable angina out of 190 cases of CABG opted (12.6%). 15 cases could be stabilized on medical management with Heparin and NTG and were taken up for surgery electively during the same hospitalization. However 9 cases did not respond to treatment and were taken up for emergency CABG.

**Results:** 2 patients needed on line haemofiltration due to pre existing renal impairment. 7 out of 24 patients needed IABP support. 8 patients required 4-12 hrs of post op ventilation. There was one mortality in this series. This 70 yrs old lady died of septicaemia and renal failure on 6th post op day. All patients have been under follow-up. One patient was readmitted with LVF after 15 days of discharge but improved with optimization of medical management.

Complication following acute MI is usually life threatening and needs urgent surgical management. In this series there were 6 such cases apart from 24 cases of unstable angina discussed above. They were as follows :-

Post infarct VSD :-2 cases, they underwent VSD closure and CABG, Post MI ischaemic MR:- 2 cases they underwent MVR and CABG, Post infarct LV Pseudoaneurysm (LV wall rupture). They underwent repair of the LV wall defect.

All the these cases underwent emergency surgery. There was one mortality. This 76 years old lady a case of post infarct VSD who already had a cardiac arrest before operation and was on ventilation and IABP. She remained in low c.o. after operation and died 6 hrs post op.

### Coronary artery bypass surgery in ischemic cardiomyopathy

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62

**Objective:** In the current scenario Ischemic Cardiomyopathy represents the commonest cause of congestive heart failure, with figures ranging from 40-70%.

Ischemic Cardiomyopathy represents the cumulative effects of myocardial ischemia [stunning and hibernation] and infarction, followed subsequently by ventricular remodeling.

In patients with ICM, all these states coexist and have tremendous importance in the prediction of prognosis after CABG.

The aim of this presentation was to analyze the factors that are responsible for morbidity and mortality of patients with ICM and the effect of surgical revascularisation in improving the quality of life and survival in such patients.

**Methods:** In our institution 242 patients underwent CABG since May 2001. Of these patients 29 preented with Ischemic Cardiomyopathy. Twenty-one of them were males and eight females. Average age of the group was 65 years. [The oldest patient operated was 79 years of age]. Sixteen patients were diabetics, 20 were hypertensive and eight had associated COPD.

All had severe triple vessel disease with ejection fraction ranging

from 20-30%. Mean ejection fraction 25%. Stress thallium study was done to assess myocardial viability in 15 patients. All the patients were in CHF and were aggressively treated with medications for periods ranging from 10-14 days before being taken up for surgery. Pre-operative insertion of IABP was necessary in 4 patients and in 10 patients it was inserted postoperatively.

**Results:** All patients were operated using the conventional method of cardiopulmonary bypass and intermittent cross clamping of aorta. LV was vented via the right superior pulmonary vein. IABP was used in 14 patients. In one of these IABP was inserted via a conduit into the ascending aorta, as there was peripheral vascular disease involving both common iliac arteries.

Postoperative recovery of all patients was good. There was an improvement in the ejection fraction to 35-40%. Three patients required prolonged inotropes support [ranging from 3-5 days]. There were no postoperative infections. There were two deaths, one on the 14th day and the other on the 28th day after surgery due to respiratory infections [due to poor respiratory effort].

**Conclusion:** Thus coronary artery bypass surgery remains an important method of treatment for patients with Ischemic Cardiomyopathy with congestive heart failure. Coronary artery bypass surgery has acceptably low morbidity and mortality in this subset of patients.

### Left ventricular free wall rupture – A case report

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63

**Introduction:** Left Ventricular free wall ruptures occur more frequently than ventricular septal ruptures after Myocardial Infarction. Acute ruptures are usually fatal. Subacute and chronic ruptures present with cardiac tamponade or pseudo aneurysm. Surgical repair is inevitable for survival.

**Case Report:** A 70-year old man was referred as a case of Congestive cardiac failure. He was admitted in shock, with features of cardiac tamponade. Echo revealed pericardial effusion with multiple strands in the pericardium. Emergency surgical decompression of tamponade was performed through a subxiphoid incision under local anesthesia. Patient stabilized haemodynamically and discharged after a week. Postoperative echo revealed pseudoaneurysm of LV. He had no history or evidence of coronary artery disease or myocardial infarction.

Coronary angiography after 8 weeks revealed solitary lesion in Marginal circumflex and LV angio showed a faint filling of the cavity through a narrow outlet from the LV free wall. Surgical repair of the pseudoaneurysm was done by closing the narrow fibrotic opening with interrupted pledgetted mattress suture. The patient had an uneventful stay in the hospital and was discharged on the 8th Postoperative day.

This case is being presented for the uniqueness of its clinical presentation, especially with no history or clinical features suggestive of preceding myocardial infarction.

### Re-do CABG where LAD was not grafted during first CABG

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64

**Objective:** Review of Re-do CABG where LAD was not grafted in the first operation.