ENDER SEMİZ
Acıbadem Maslak Hastanesi
ACIBADEM

Figure 2

The spectrum of clinical presentations, electrocardiographic findings, and high-sensitivity cardiac troponin levels in patients with acute coronary syndrome

The ACS spectrum

Clinical presentation: Oligo/ asymptomatic · Increasing chest pain/symptoms · Persistent chest pain/symptoms · Cardiogenic shock/ acute heart failure · Cardiac arrest

ECG findings: Normal · ST segment depression · ST segment elevation · Malignant arrhythmia

Working diagnosis: NSTE-ACS · STEMI

hs-cTn levels: Non-elevated · Rise and fall

Final diagnosis: Unstable angina · NSTEMI · STEMI

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(European Heart Journal; 2023 – doi:10.1093/eurheartj/ehad191)

Recommendations for clinical and diagnostic tools for patients with suspected acute coronary syndrome (3)

Recommendations	Class	Level
Triage for emergency reperfusion strategy		
It is recommended that patients with suspected STEMI are immediately triaged for an emergency reperfusion strategy.	I	A

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Recommendations for non-invasive imaging in the initial assessment of patients with suspected acute coronary syndrome

Recommendations	Class	Level	2017	2020
Emergency TTE is recommended in patients with suspected ACS presenting with cardiogenic shock or suspected mechanical complications.	I	C		
In patients with suspected ACS, non-elevated (or uncertain) hs-cTn levels, no ECG changes and no recurrence of pain, incorporating CCTA or a non-invasive stress imaging test as part of the initial workup should be considered.	IIa	A	I	B
Emergency TTE should be considered at triage in cases of diagnostic uncertainty but this should not result in delays in transfer to the cardiac catheterization laboratory if there is suspicion of an acute coronary artery occlusion.	IIa	C		
Routine, early CCTA in patients with suspected ACS is not recommended.	III	B		

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Recommendations for reperfusion therapy and timing of invasive strategy (1)

Recommendations	Class	Level
Recommendations for reperfusion therapy for patients with STEMI		
Reperfusion therapy is recommended in all patients with a working diagnosis of STEMI (persistent ST-segment elevation or equivalents) and symptoms of ischaemia of ≤12 h duration.	I	A
A PPCI strategy is recommended over fibrinolysis if the anticipated time from diagnosis to PCI is <120 min.	I	A
If timely PPCI (<120 min) cannot be performed in patients with a working diagnosis of STEMI, fibrinolytic therapy is recommended within 12 h of symptom onset in patients without contraindications.	I	A
Rescue PCI is recommended for failed fibrinolysis (i.e. ST-segment resolution <50% within 60–90 min of fibrinolytic administration) or in the presence of haemodynamic or electrical instability, worsening ischaemia, or persistent chest pain.	I	A

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Recommendations for reperfusion therapy and timing of invasive strategy (2)

Recommendations	Class	Level
Recommendations for reperfusion therapy for patients with STEMI (continued)		
In patients with a working diagnosis of STEMI and a time from symptom onset >12 h, a PPCI strategy is recommended in the presence of ongoing symptoms suggestive of ischaemia, haemodynamic instability, or life-threatening arrhythmias.	I	C
A routine PPCI strategy should be considered in STEMI patients presenting late (12–48 h) after symptom onset.	IIa	B
Routine PCI of an occluded IRA is not recommended in STEMI patients presenting >48 h after symptom onset and without persistent symptoms.	III	A

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Recommendations for reperfusion therapy and timing of invasive strategy (3)

Recommendations	Class	Level
Transfer/interventions after fibrinolysis		
Transfer to a PCI-capable centre is recommended in all patients immediately after fibrinolysis.	I	A
Emergency angiography and PCI of the IRA, if indicated is recommended in patients with new-onset or persistent heart failure/shock after fibrinolysis.	I	A
Angiography and PCI of the IRA, if indicated, is recommended between 2 and 24 h after successful fibrinolysis.	I	A
Invasive strategy in NSTE-ACS		
An invasive strategy during hospital admission is recommended in NSTE-ACS patients with high-risk criteria or a high index of suspicion for unstable angina.	I	A
A selective invasive approach is recommended in patients without very high- or high-risk NSTE-ACS criteria and with a low index of suspicion for NSTE-ACS.	I	A

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Recommendations for reperfusion therapy and timing of invasive strategy (4)

Recommendations	Class	Level
Invasive strategy in NSTE-ACS (continued)		
An immediate invasive strategy is recommended in patients with a working diagnosis of NSTE-ACS and with at least one of the following very high-risk criteria: • Haemodynamic instability or cardiogenic shock • Recurrent or refractory chest pain despite medical treatment • In-hospital life-threatening arrhythmias • Mechanical complications of MI • Acute heart failure presumed secondary to ongoing myocardial ischaemia • *Recurrent* dynamic ST-segment or T wave changes, particularly intermittent ST-segment elevation.	I	C

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Recommendations for reperfusion therapy and timing of invasive strategy (5)

Recommendations	Class	Level	2017 2020
Invasive strategy in NSTE-ACS (continued)			
An early invasive strategy within 24 h should be considered in patients with at least one of the following high-risk criteria: • Confirmed diagnosis of NSTEMI based on current recommended ESC hs-cTn algorithms • Dynamic ST-segment or T wave changes • Transient ST-segment elevation • GRACE risk score >140	**IIa**	**A**	**I A**

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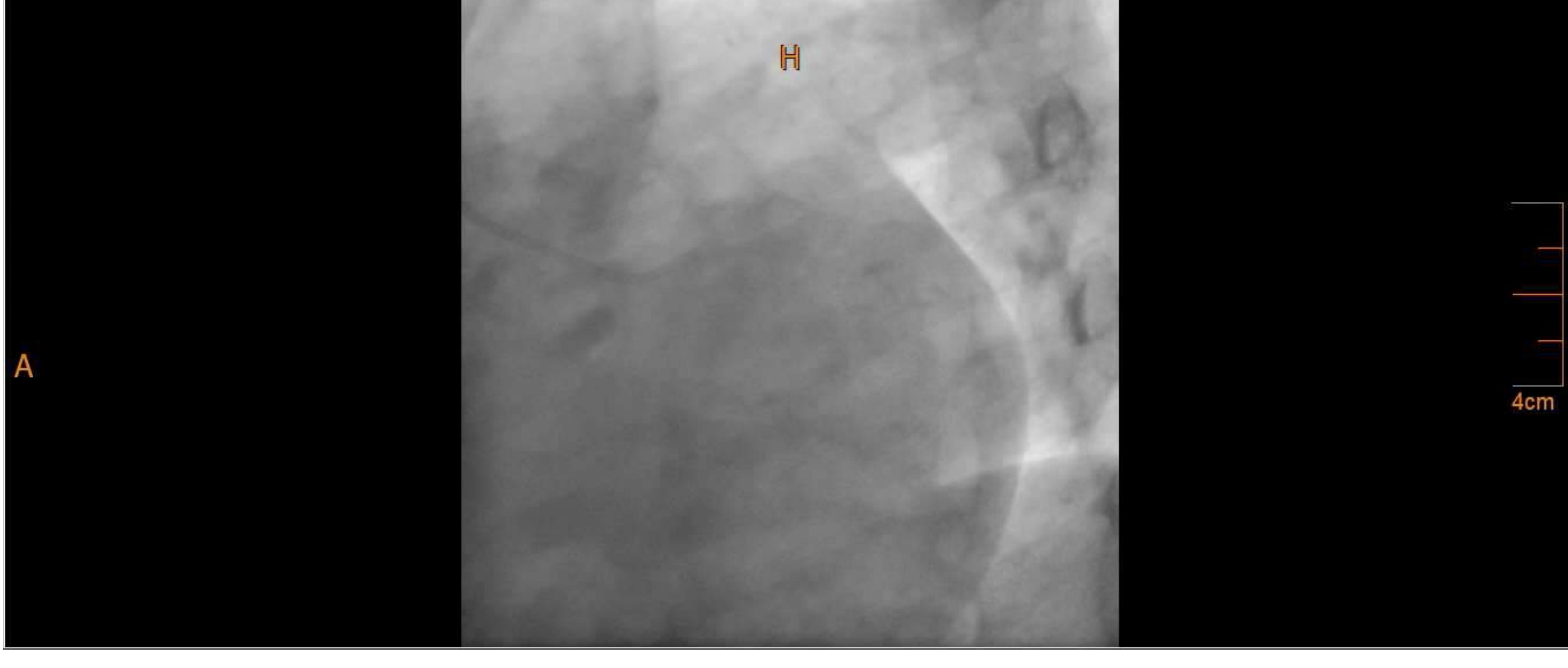
- OLGU 1 - Ü.S. 55 yaşında erkek hasta
- 25.05. 2022 …… 2 saattir süren göğüs ağrısıyla acil servise ayaktan başvurdu.
- HT ve DM (+)
  - EKG: Normal
  - Troponin: 2.7 ng/ml (ref. < 0,057 ng/ml)
- NSTE-MI ön tanısı ile koroner yoğun bakım ünitemize yatırıldı.
  - EKO: Sol ventrikül EF'si: % 50, hafif konsantrik hipertrofi ve evre 1 diyastolik disfonksiyon, apex ve septum apikali hafif hipokinetik, eser MR, normal sağ kalp boşlukları şeklinde raporlandı.
- Antiagregan ve S.C. enoxaparine başlandı.
- Yatış sonrası göğüs ağrısı yok.
- Ertesi gün koroner anjiyografi yapıldı.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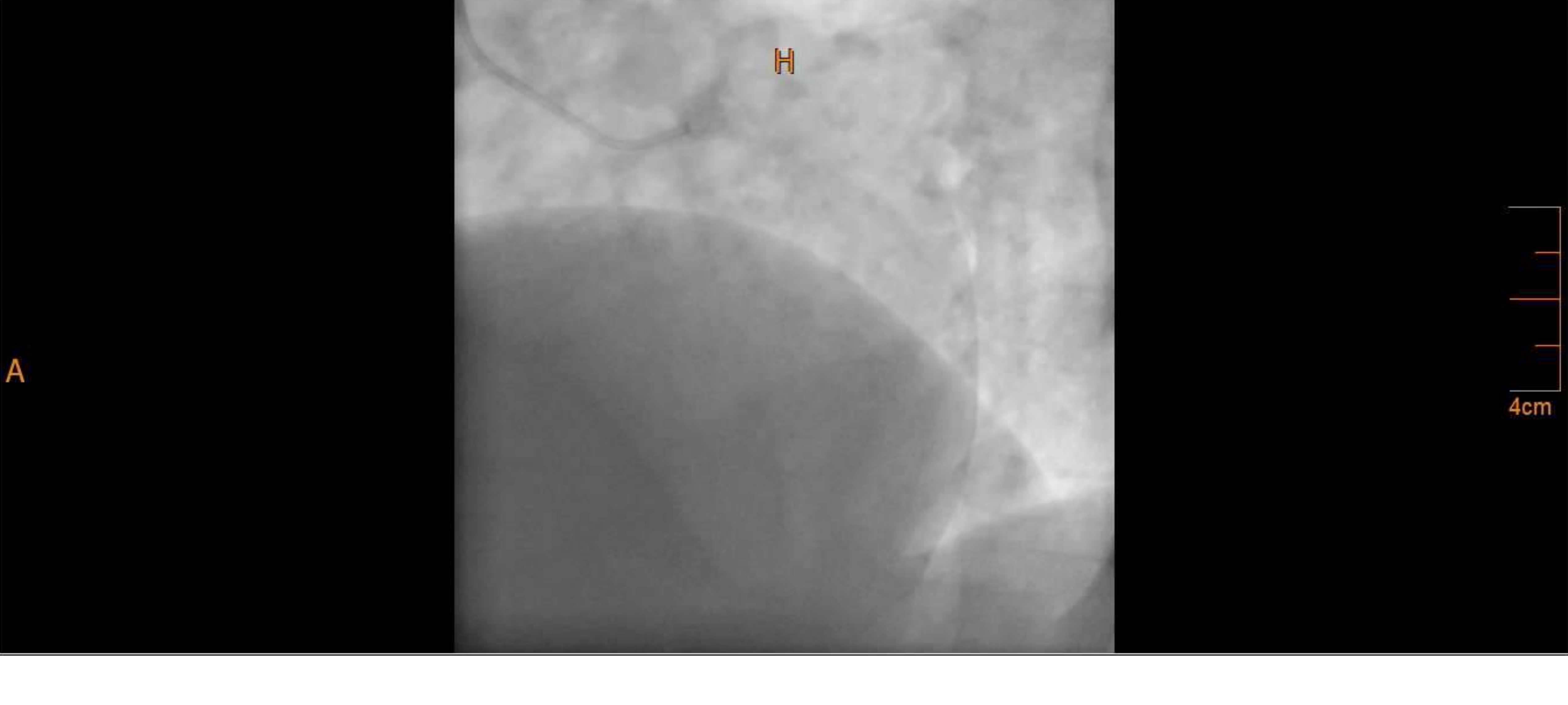
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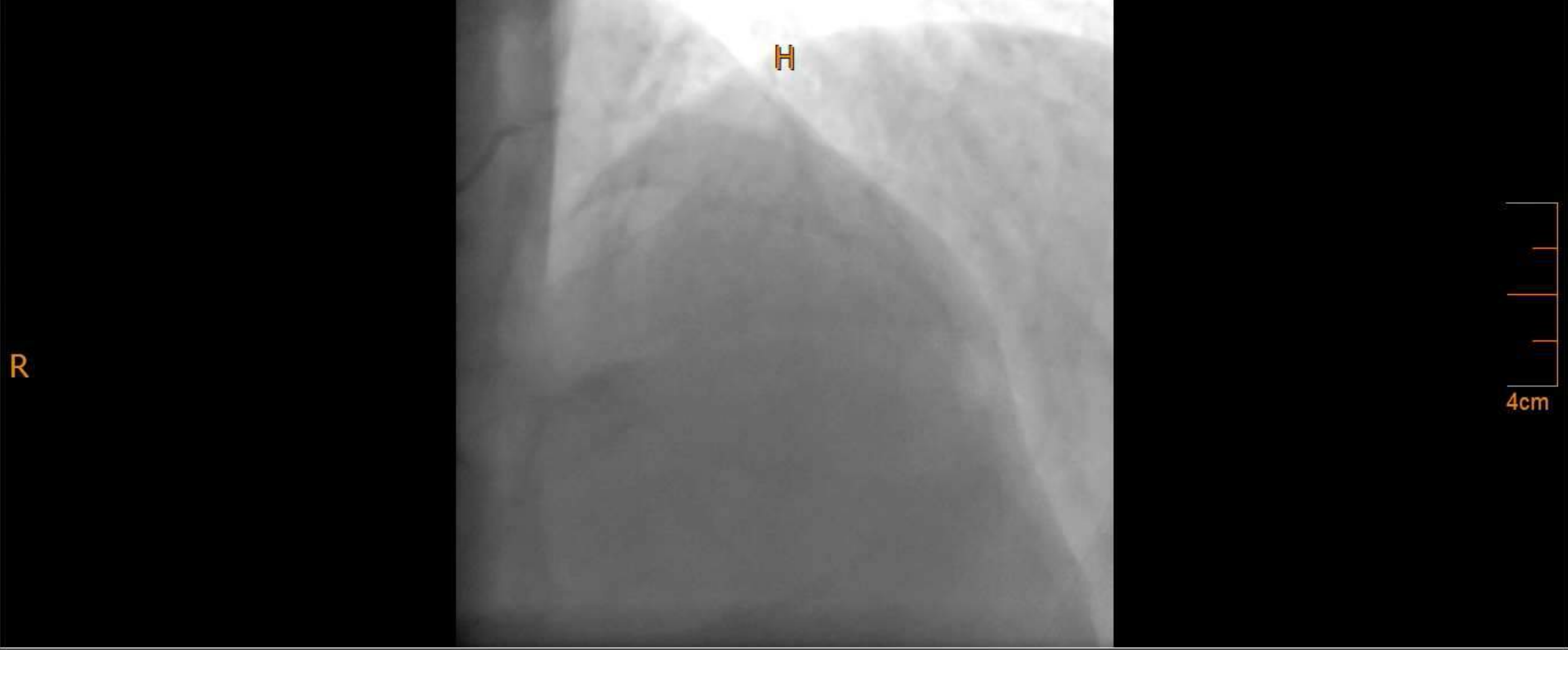
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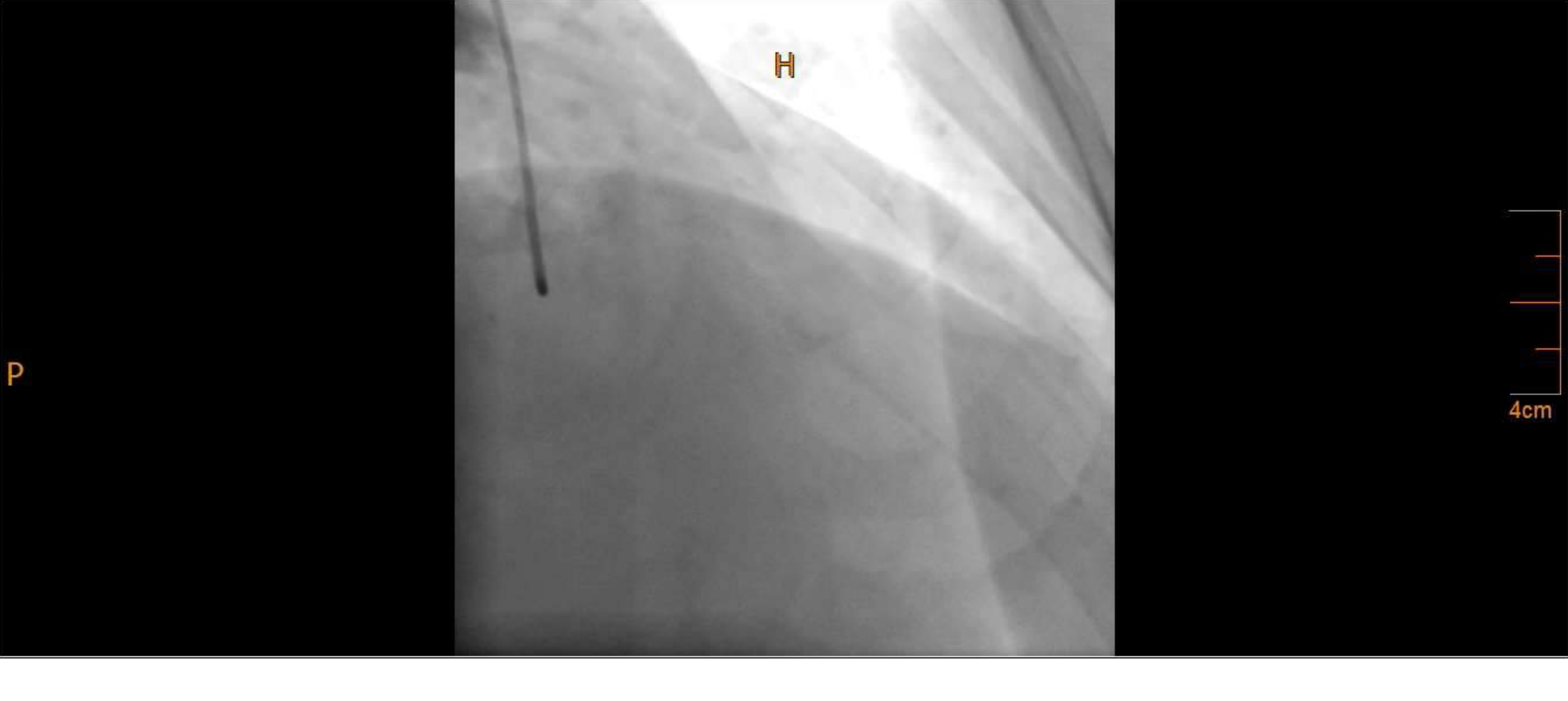
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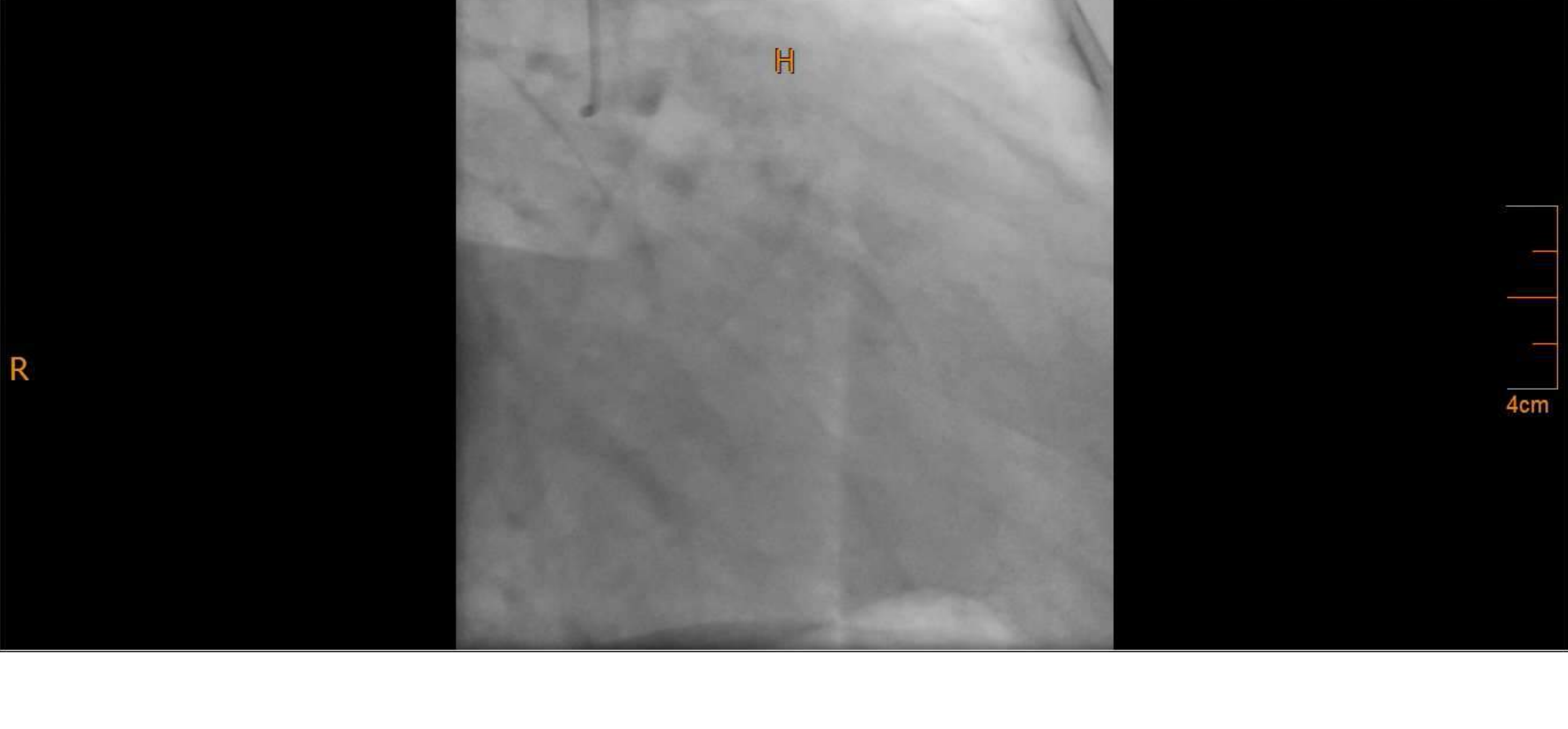
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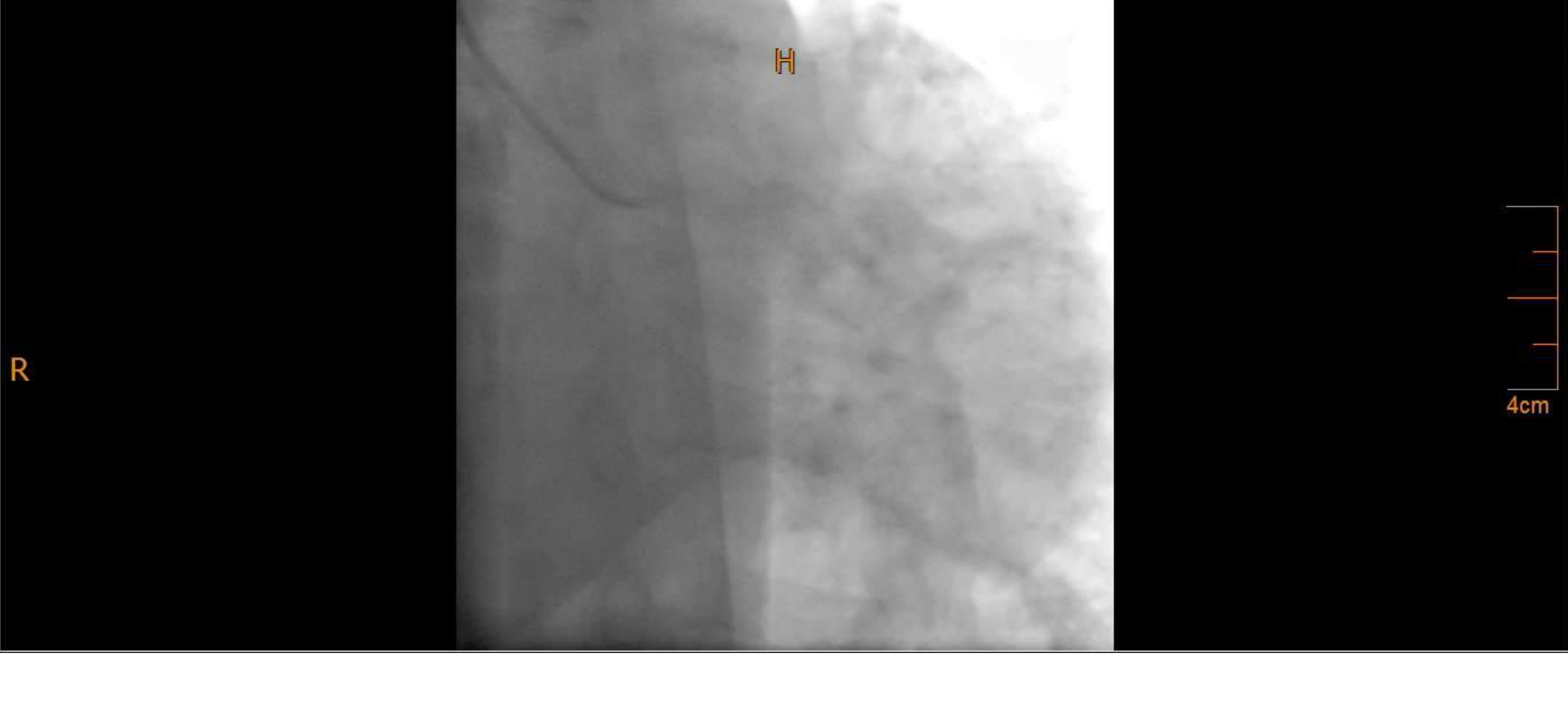
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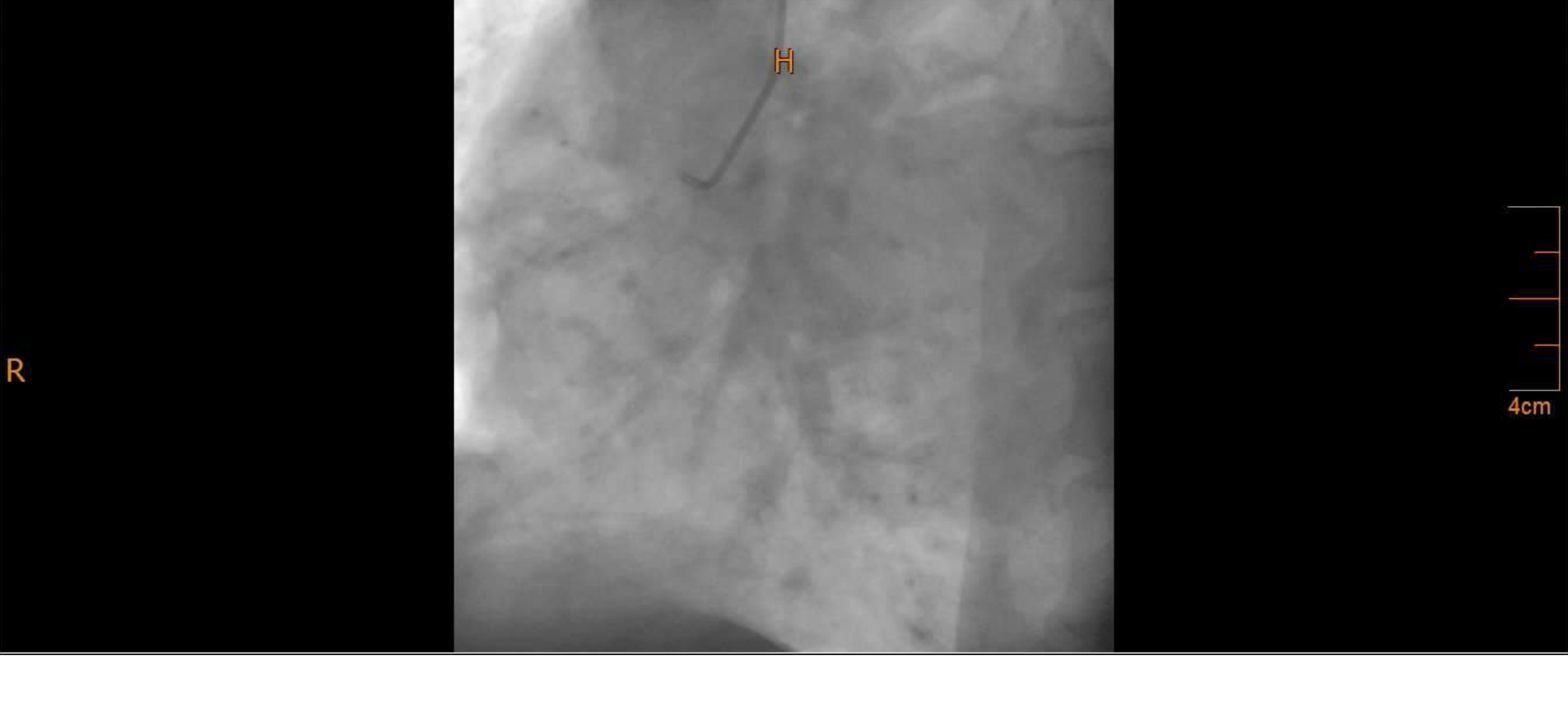
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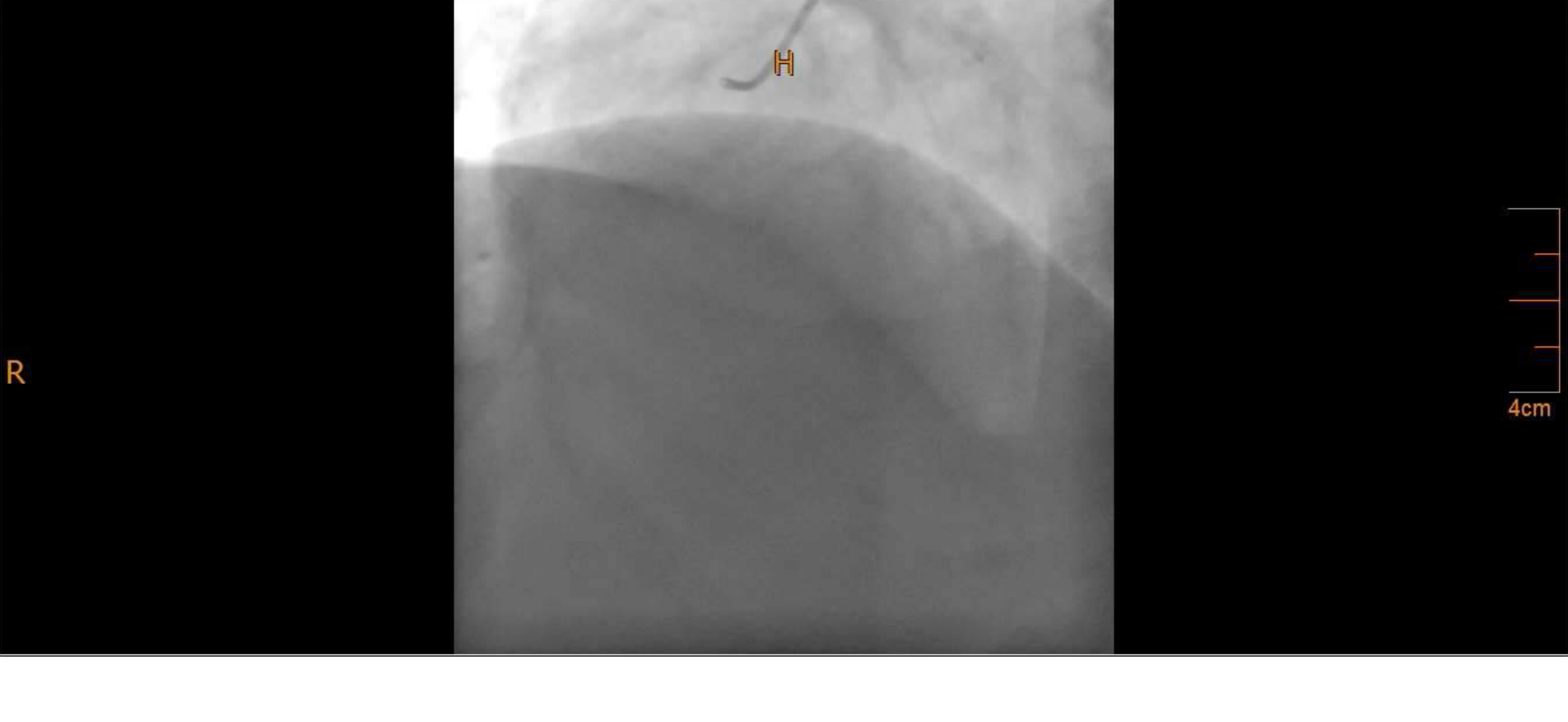
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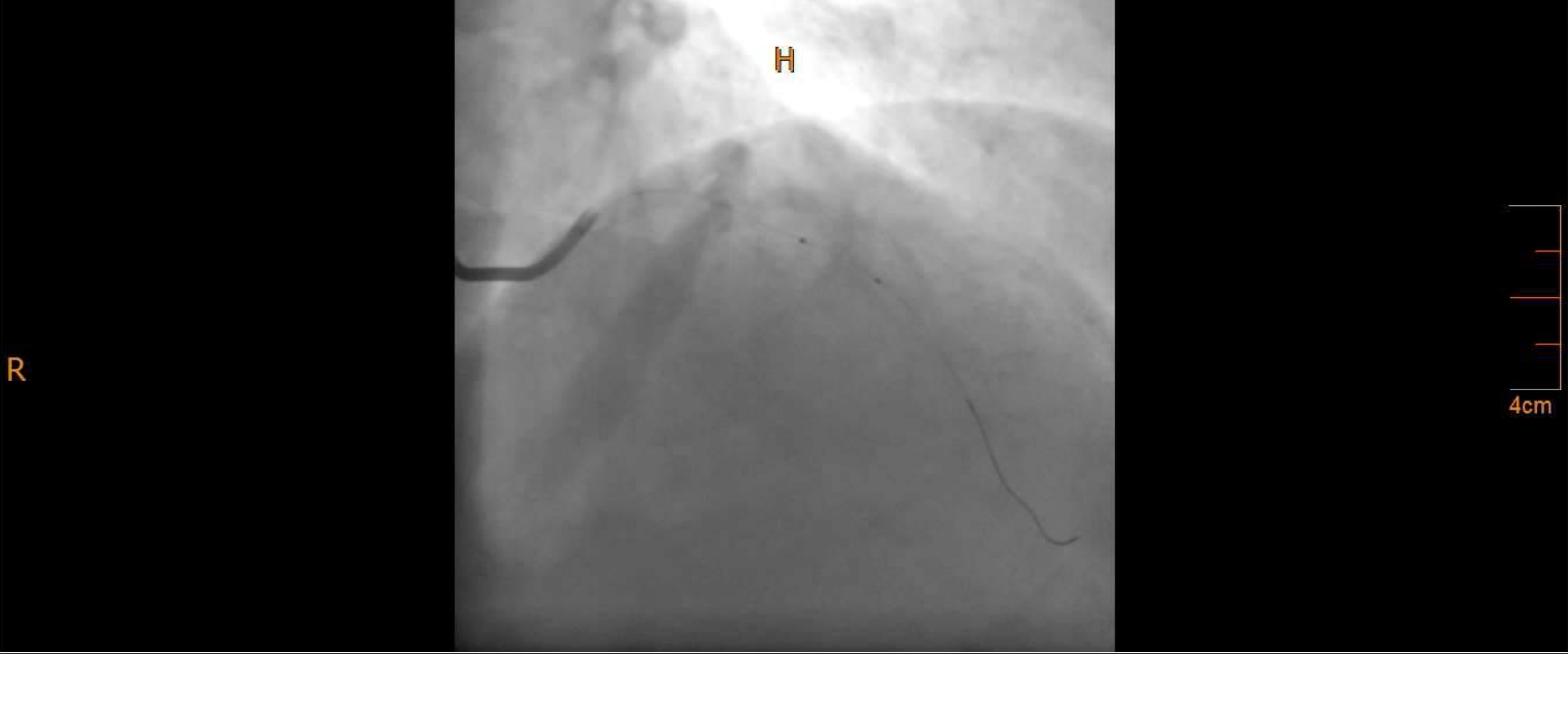
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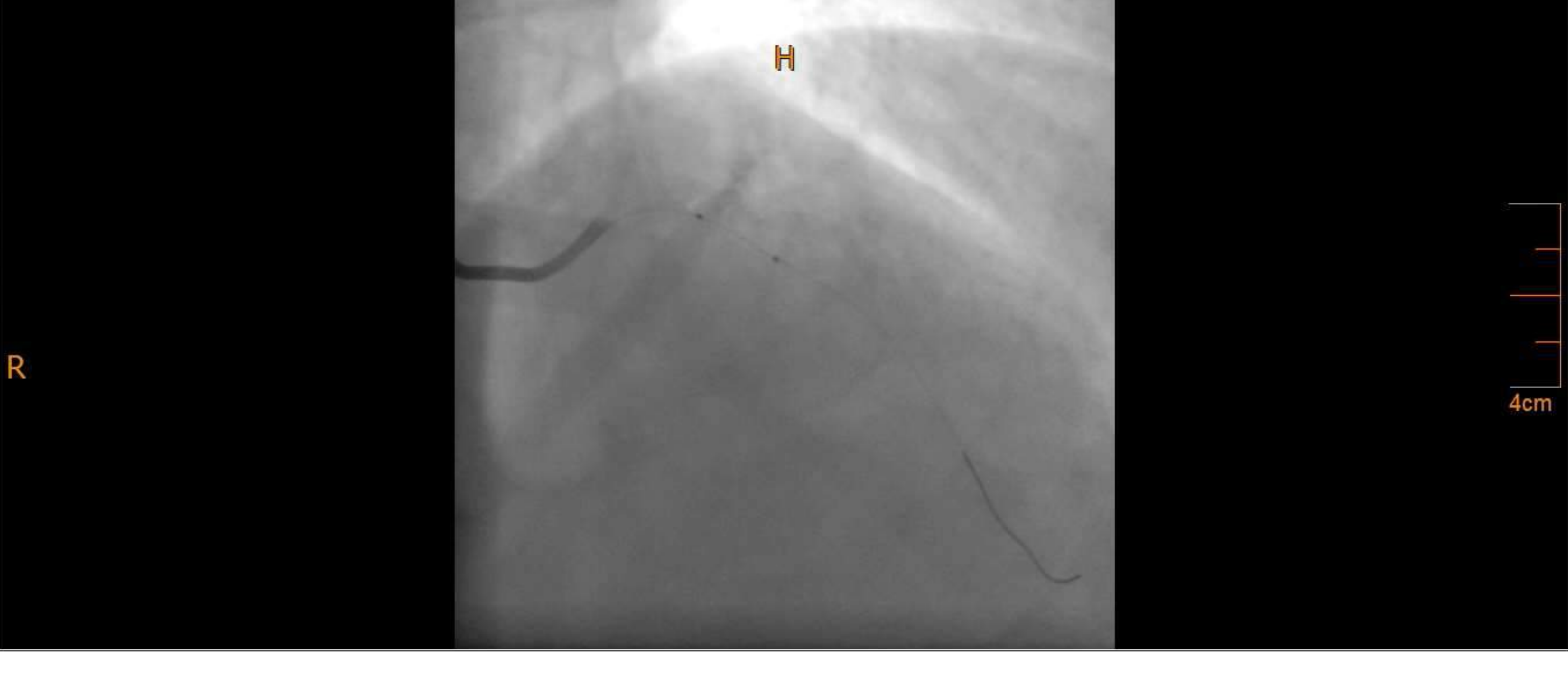

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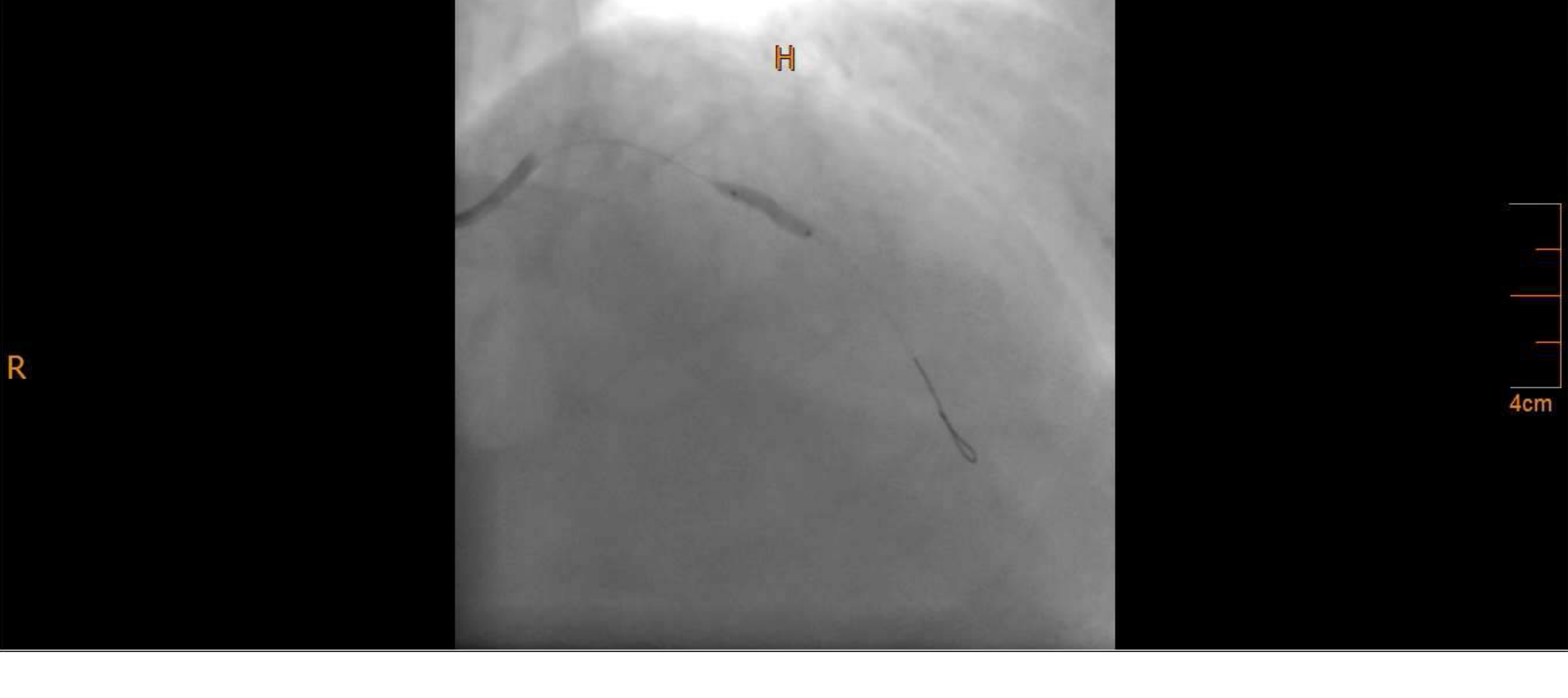
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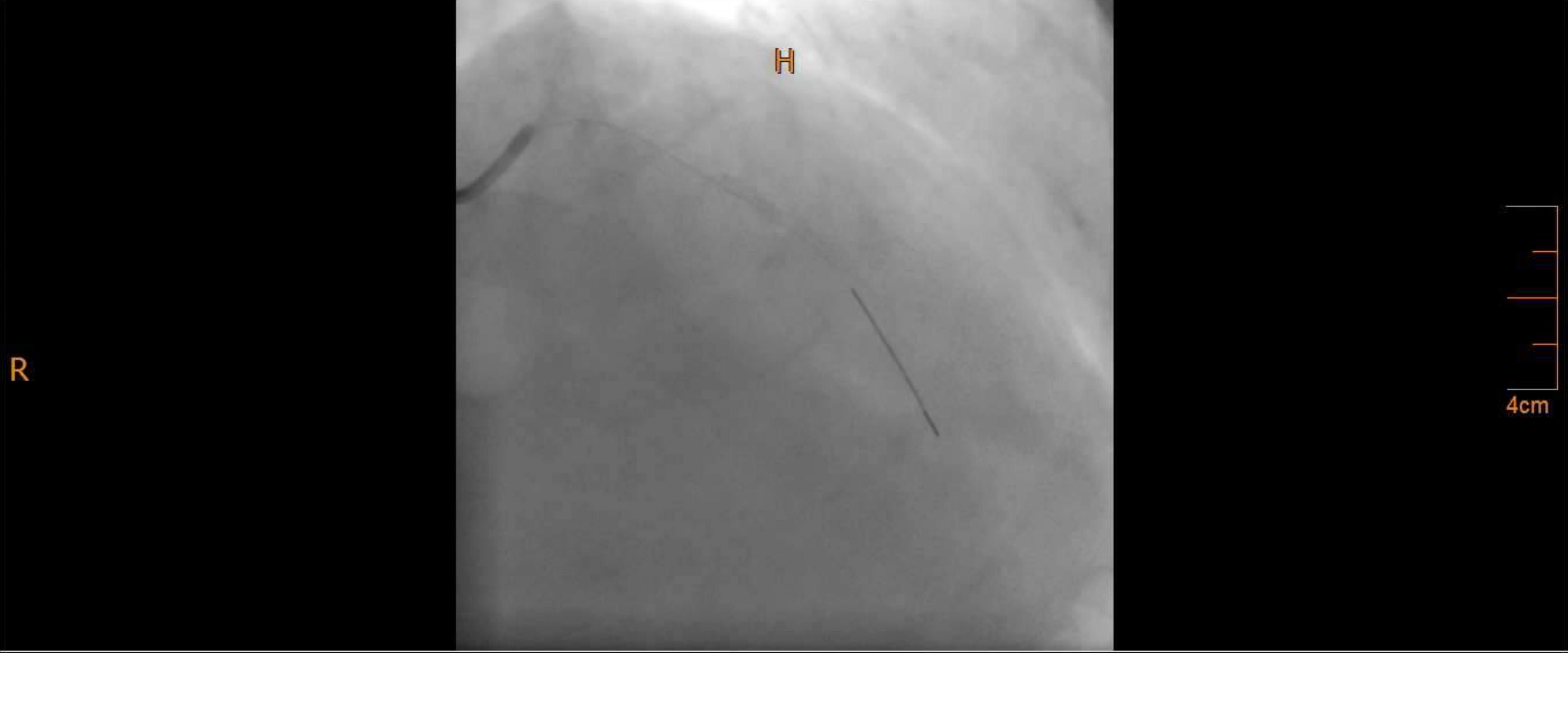
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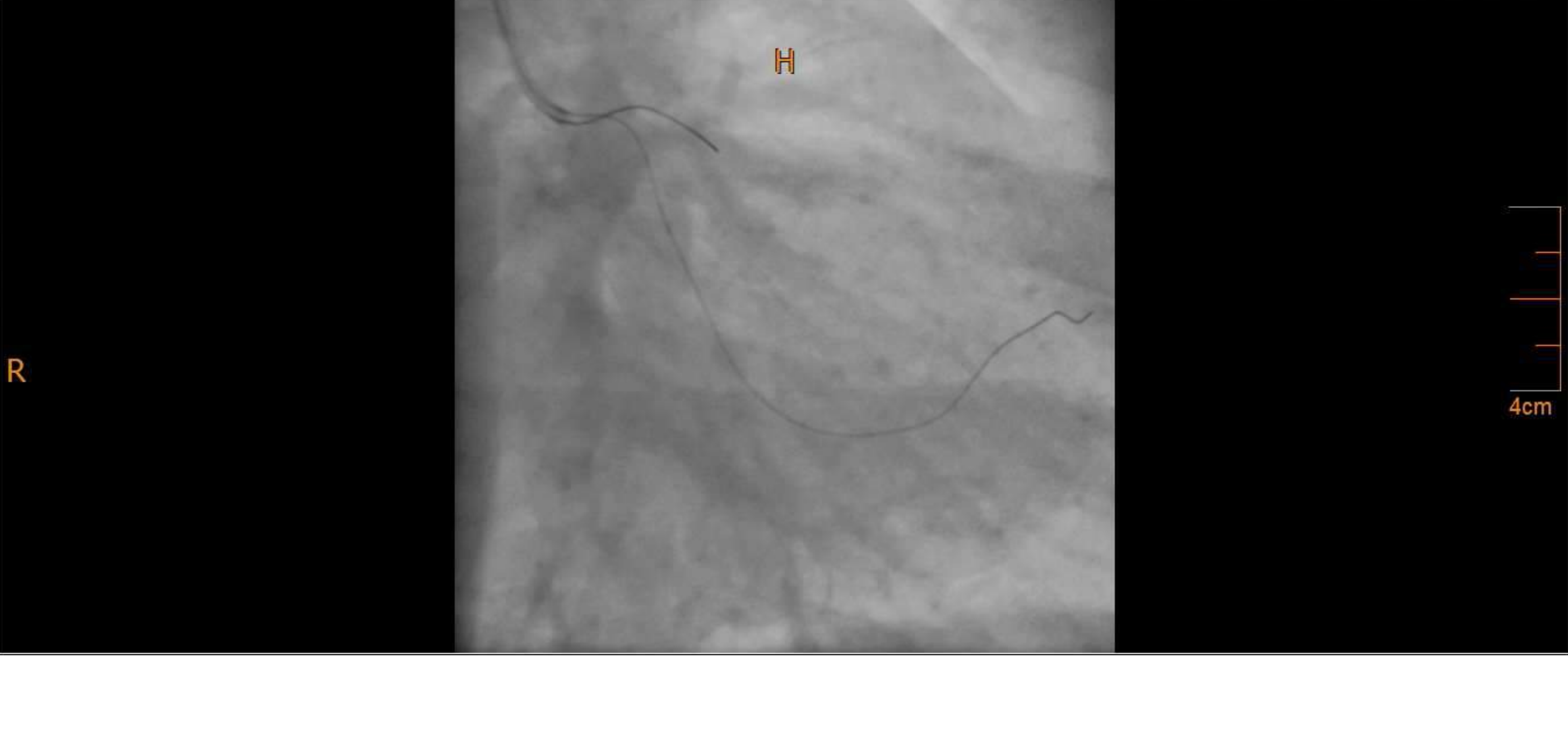
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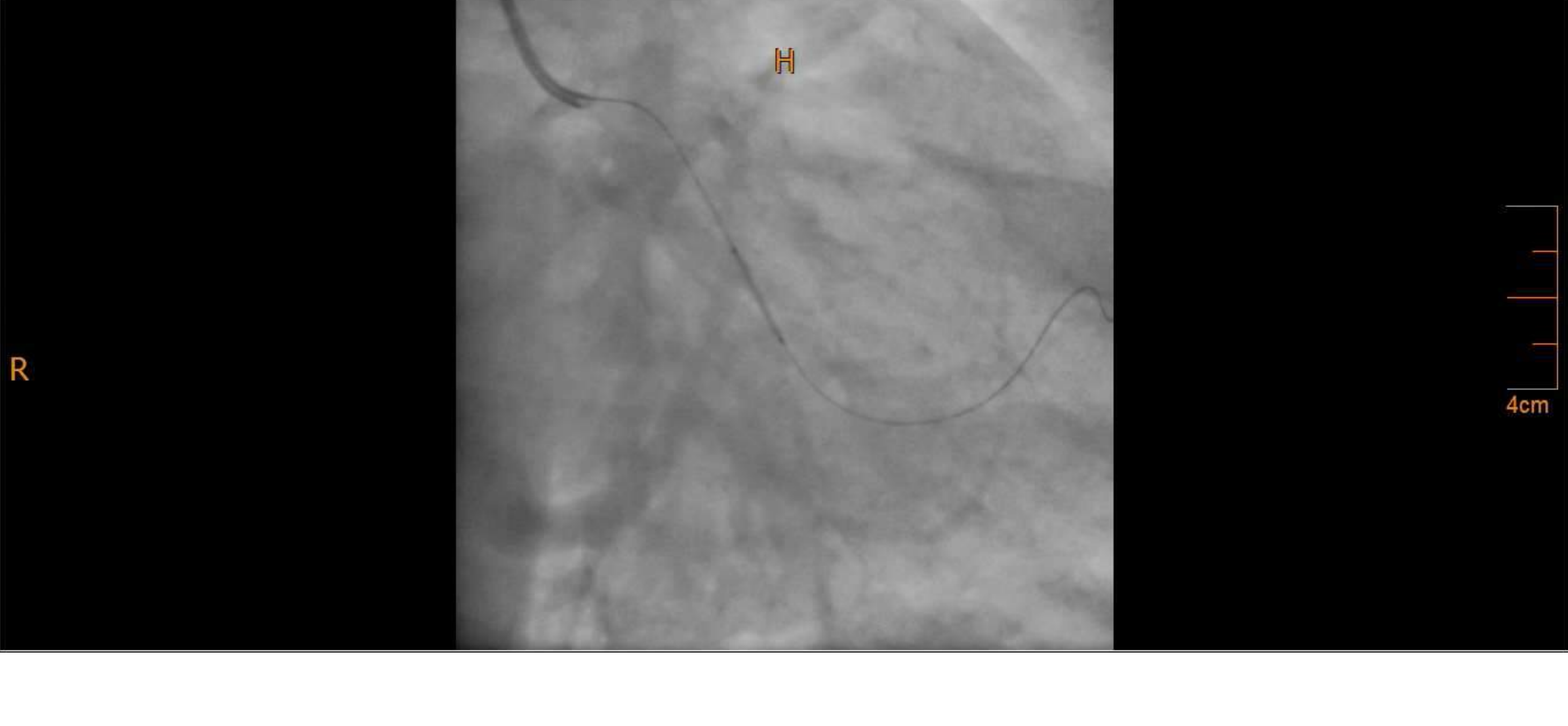
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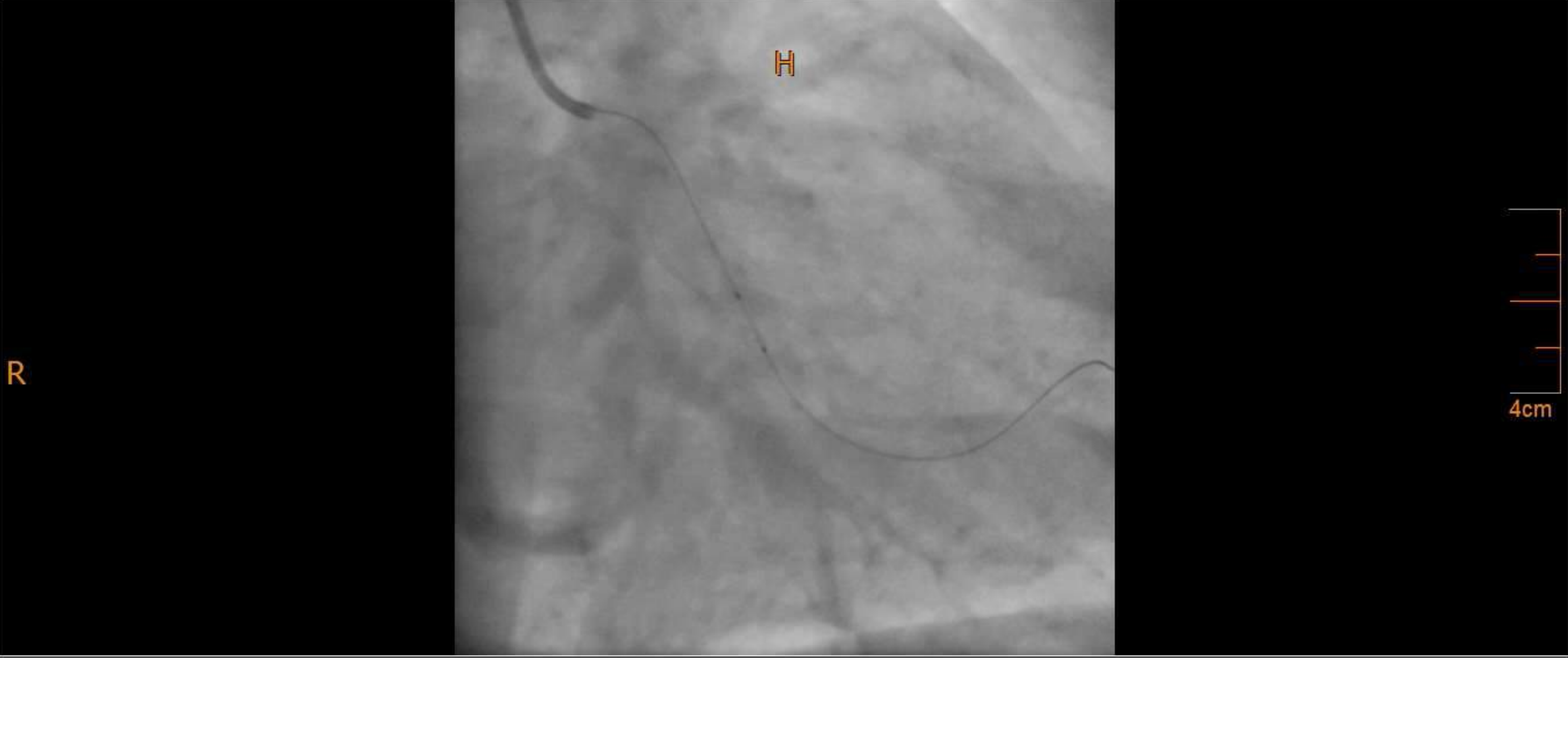
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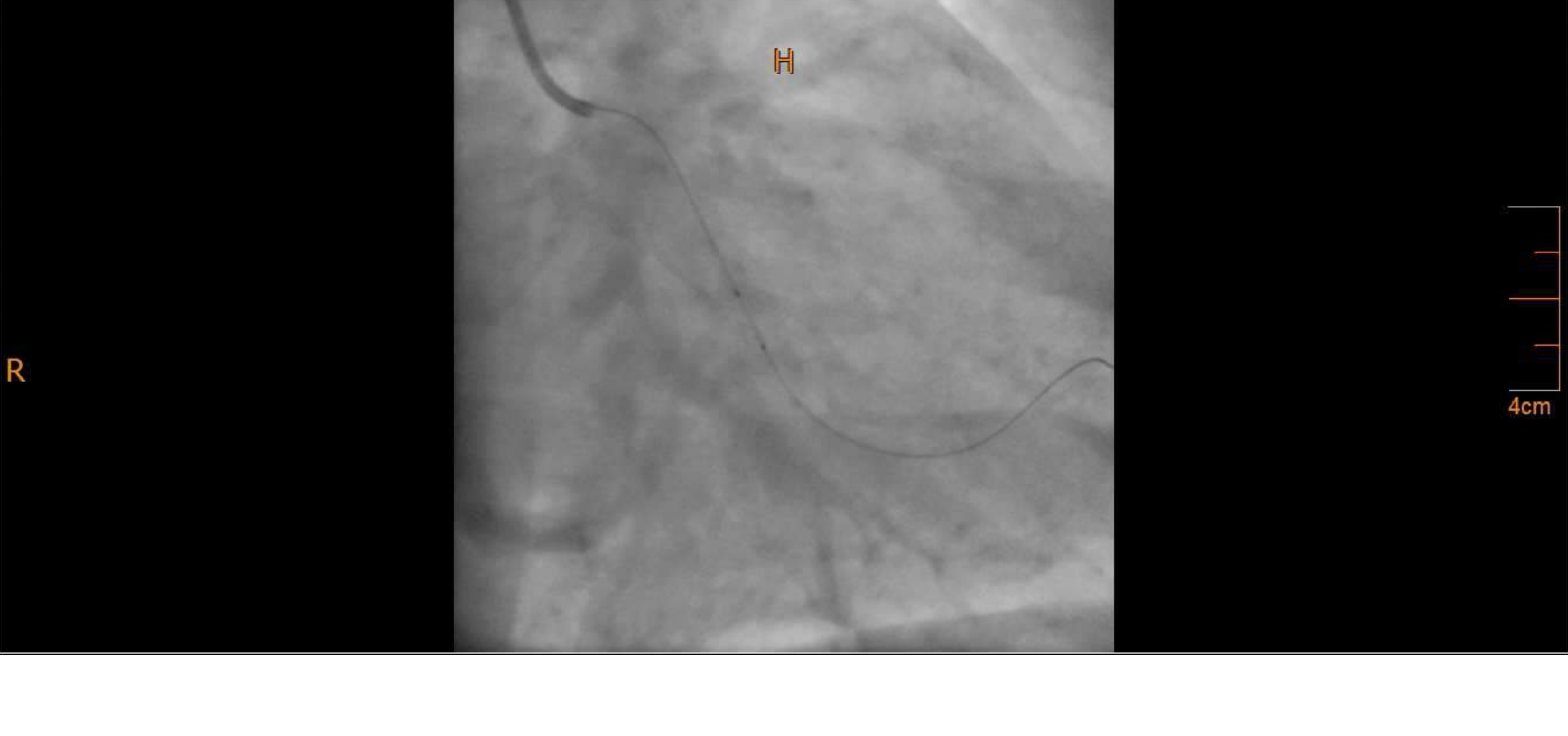
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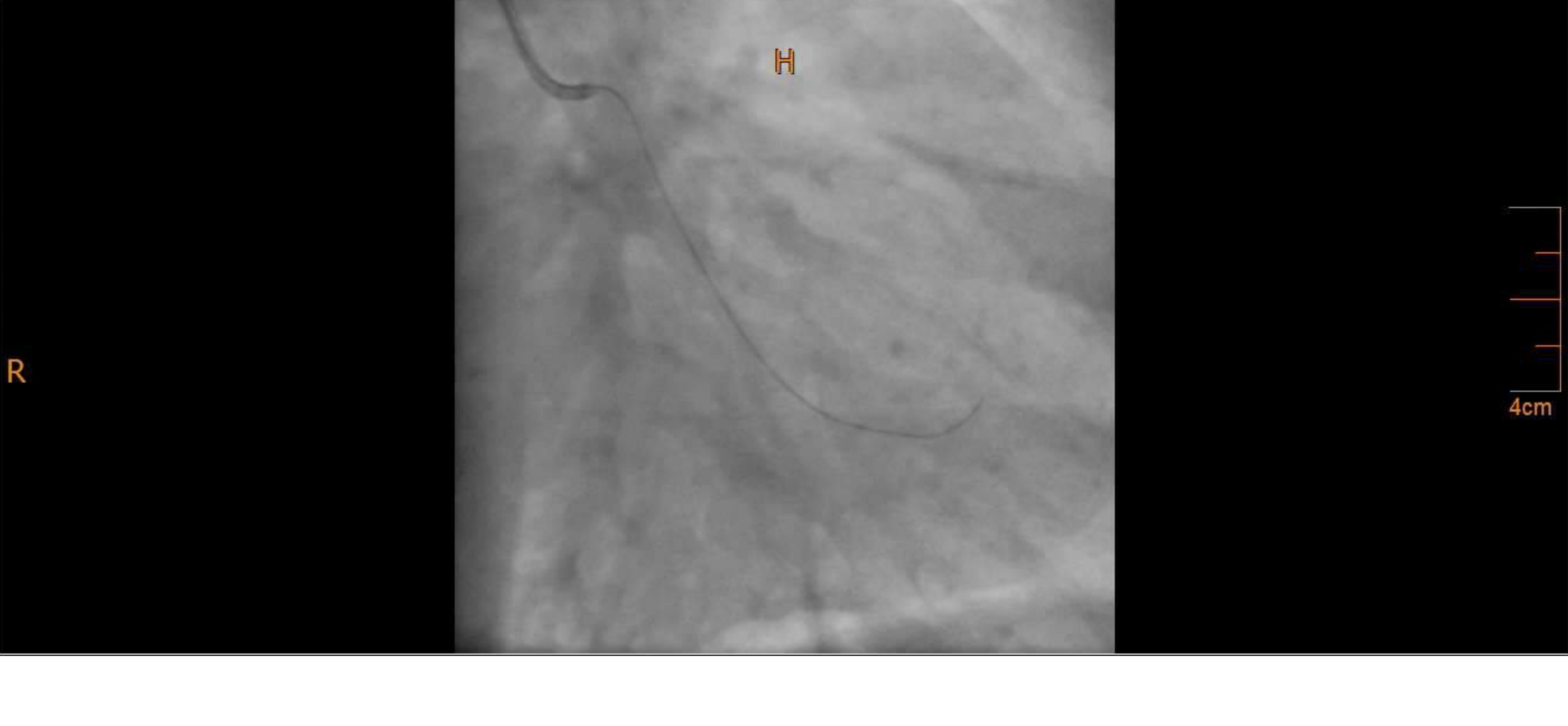
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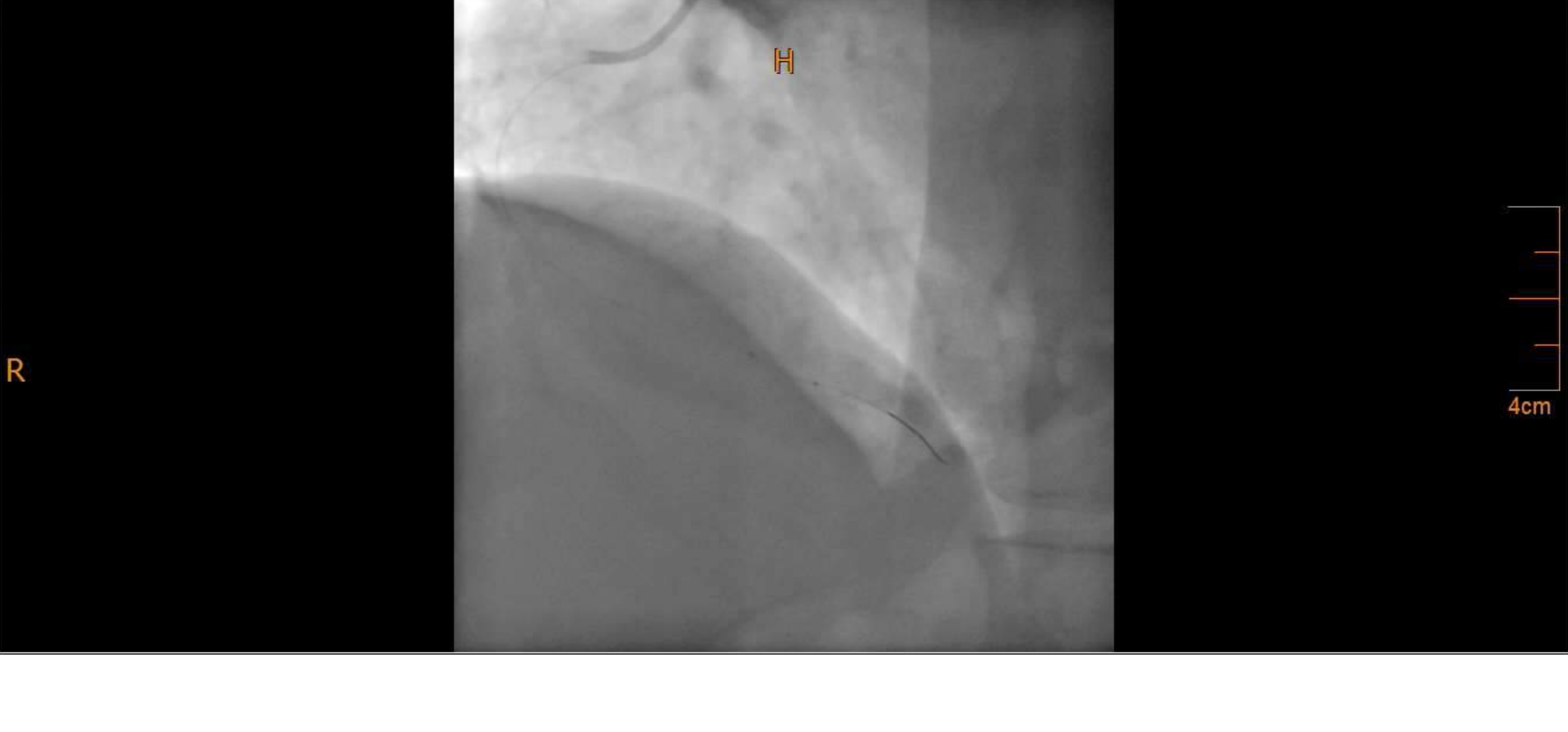

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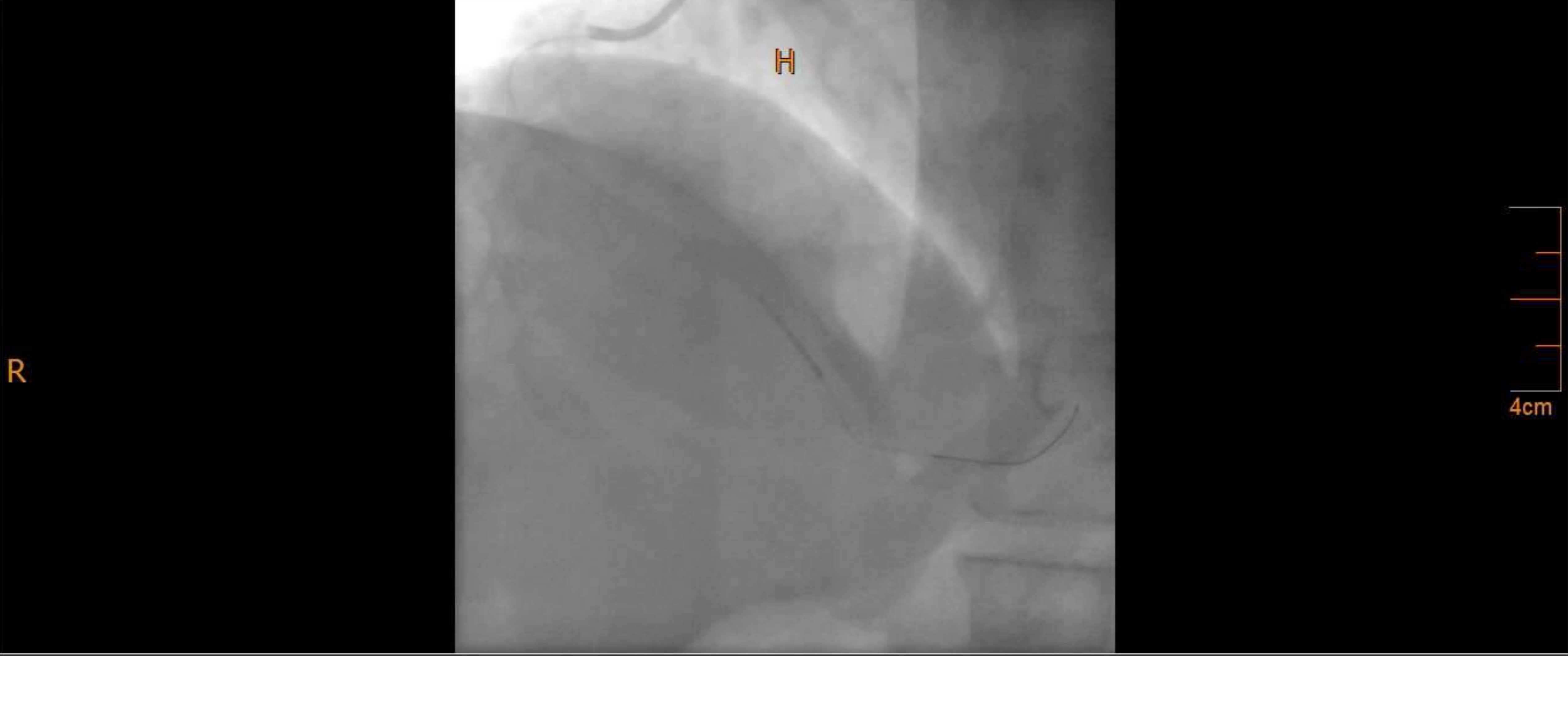
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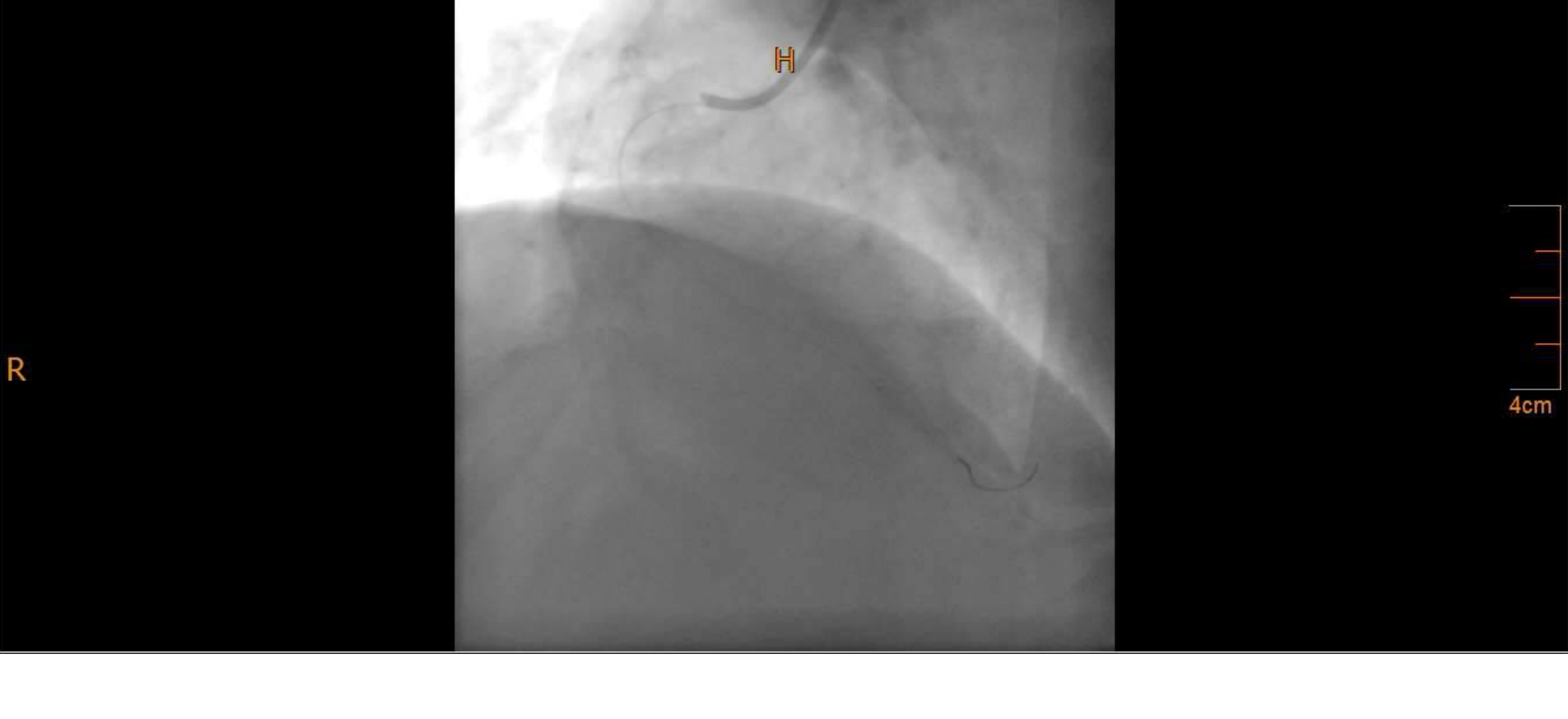
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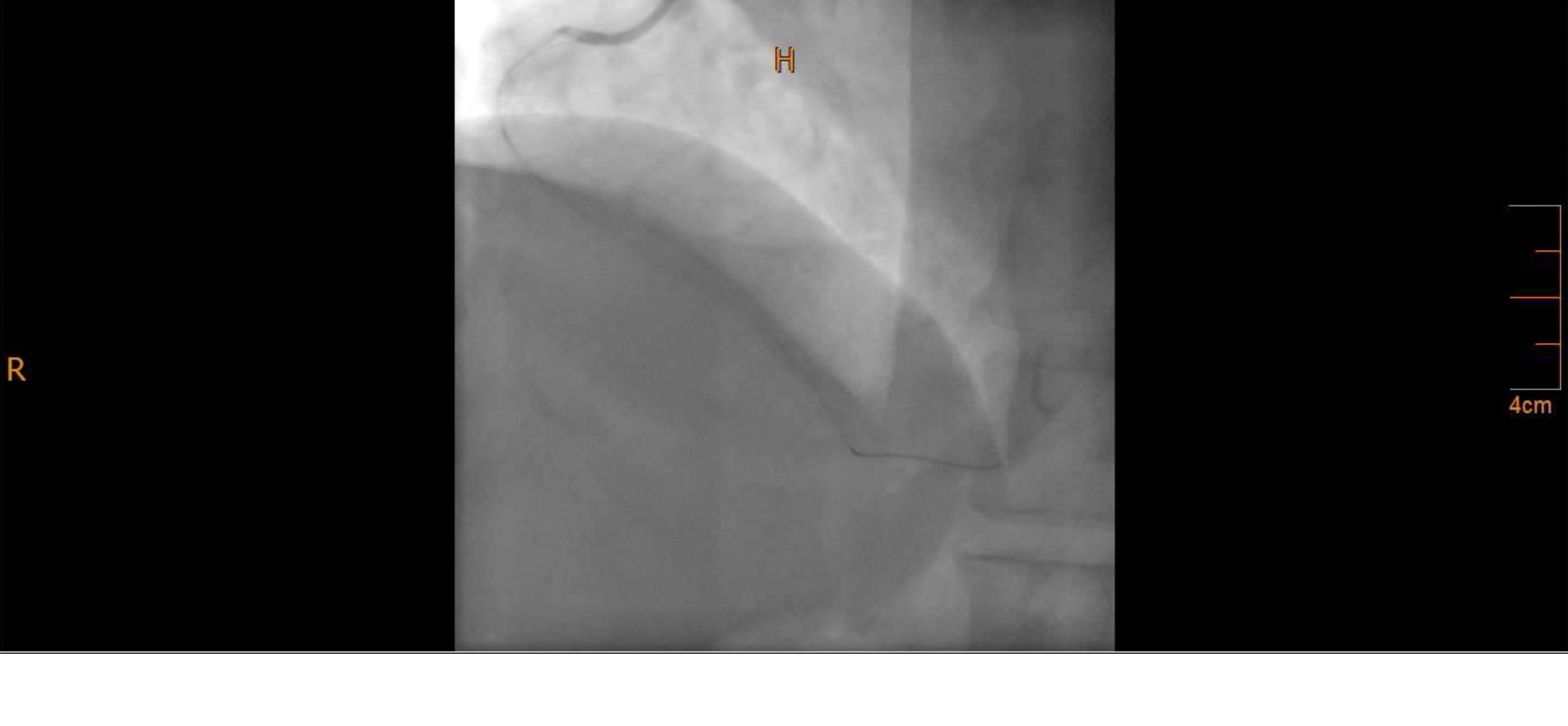

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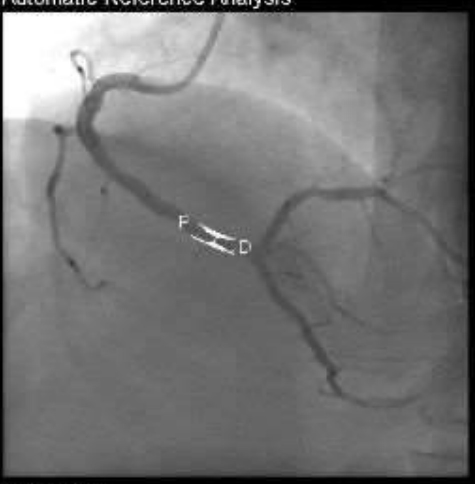
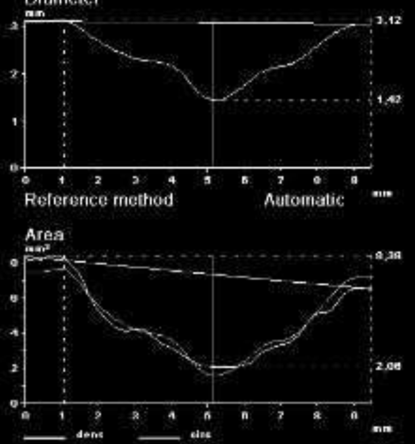
Automatic Reference Analysis





SOFTA UMIT	
ID	75030579
Sex	Male
Birth Date	29-3-1968
Accession Number	
Study ID	1
Physician	Prof.Dr. Ender SEMIZ
Hospital	ACIBADEM MASLAK
Acquisition Date	23-5-2022
Series Descr	Coro 3040
Frame Number	37
Rot / Ang	34,20 ; 14,30 °
Segmentname	
Trial Name	
Intervention	
Cal Factor	0,1354 mm/pix
Cal Object	6,00 French Catheter (Curv...

Stenosis	(%)
%Diameter	54
%Area Circ	79
%Area Dens	72

Obstruction Segment

	Diameter (mm)	Area Circ (mm²)	Area Dens (mm²)
Lesion	1,42	1,58	2,06
Ref	3,07	7,38	7,38
Mean	2,29	4,33	4,15

Prox D	3,10	mm
Dist D	3,04	mm
Pos Prox	1,10	mm
Obstruction Length	8,38	mm
Obstruction Volume	36,71	mm³
Plaque Area	6,52	mm²
Plaque Volume	24,75	mm³
Plaque Symmetry	0,68	

Recommendations for antiplatelet and anticoagulant therapy in acute coronary syndrome (2)

Recommendations	Class	Level
Antiplatelet therapy (continued)		
Clopidogrel (300–600 mg LD, 75 mg o.d. MD) is recommended when prasugrel or ticagrelor are not available, cannot be tolerated, or are contraindicated.	I	C
If patients presenting with ACS stop DAPT to undergo CABG, it is recommended they resume DAPT after surgery for at least 12 months.	I	C
Prasugrel should be considered in preference to ticagrelor for ACS patients who proceed to PCI.	IIa	B
GP IIb/IIIa receptor antagonists should be considered if there is evidence of no-reflow or a thrombotic complication during PCI.	IIa	C
In $P2Y_{12}$ receptor inhibitor-naïve patients undergoing PCI, cangrelor may be considered.	IIb	A
In older ACS patients, especially if HBR, clopidogrel as the $P2Y_{12}$ receptor inhibitor may be considered.	IIb	B

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Recommendations for antiplatelet and anticoagulant therapy in acute coronary syndrome (3)

Recommendations	Class	Level	2017 2020
Antiplatelet therapy (continued)			
Pretreatment with a $P2Y_{12}$ receptor inhibitor may be considered in patients undergoing a primary PCI strategy.	IIb	B	I A
Pretreatment with a $P2Y_{12}$ receptor inhibitor may be considered in NSTE-ACS patients who are not expected to undergo an early invasive strategy (<24 h) and do not have HBR.	IIb	C	
Pretreatment with a GP IIb/IIIa receptor antagonist is not recommended.	III	A	
Routine pretreatment with a $P2Y_{12}$ receptor inhibitor in NSTE-ACS patients in whom coronary anatomy is not known and early invasive management (<24 h) is planned is not recommended.	III	A	

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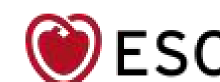
Recommendations for alternative antithrombotic therapy regimens (1)



Recommendations	Class	Level	2017 2020
Shortening/de-escalation of antithrombotic therapy			
In patients who are event-free after 3–6 months of DAPT and who are not high ischaemic risk, single antiplatelet therapy (preferably with a $P2Y_{12}$ receptor inhibitor) should be considered.	**IIa**	**A**	IIa A
De-escalation of $P2Y_{12}$ receptor inhibitor treatment (e.g. with a switch from prasugrel/ticagrelor to clopidogrel) may be considered as an alternative DAPT strategy to reduce bleeding risk.	**IIb**	**A**	
In HBR patients, aspirin or $P2Y_{12}$ receptor inhibitor monotherapy after 1 month of DAPT may be considered.	**IIb**	**B**	
De-escalation of antiplatelet therapy in the first 30 days after an ACS event is not recommended.	**III**	**B**	

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Recommendations for alternative antithrombotic therapy regimens (2)

Recommendations	Class	Level
Prolonging antithrombotic therapy		
Discontinuation of antiplatelet treatment in patients treated with an OAC is recommended after 12 months.	I	B
Adding a second antithrombotic agent to aspirin for extended long-term secondary prevention should be considered in patients with high ischaemic risk and without HBR.	IIa	A
Adding a second antithrombotic agent to aspirin for extended long-term secondary prevention may be considered in patients with moderate ischaemic risk and without HBR.	IIb	A
$P2Y_{12}$ inhibitor monotherapy may be considered as an alternative to aspirin monotherapy for long-term treatment.	IIb	A

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Recommendations for cardiac arrest and out-of-hospital cardiac arrest (1)

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Recommendations	Class	Level	2017 2020
Cardiac arrest and OHCA			
A PPCI strategy is recommended in patients with resuscitated cardiac arrest and an ECG with persistent ST-segment elevation (or equivalents).	I	B	
Routine immediate angiography after resuscitated cardiac arrest is not recommended in haemodynamically stable patients without persistent ST-segment elevation (or equivalents).	III	A	IIa B
Temperature control			
Temperature control (i.e. continuous monitoring of core temperature and active prevention of fever [i.e. >37.7ºC]) is recommended after either out-of-hospital or in-hospital cardiac arrest for adults who remain unresponsive after return of spontaneous circulation.	I	B	I B

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Recommendations for cardiac arrest and out-of-hospital cardiac arrest (2)

Recommendations	Class	Level
Systems of care		
It is recommended that healthcare systems implement strategies to facilitate transfer of all patients in whom ACS is suspected after resuscitated cardiac arrest directly to a hospital offering 24/7 PPCI via one specialized EMS.	I	C
Transport of patients with OHCA to a cardiac arrest centre according to local protocols should be considered.	IIa	C
Evaluation of neurological prognosis		
Evaluation of neurological prognosis (no earlier than 72 h after admission) is recommended in all comatose survivors after cardiac arrest.	I	C

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Recommendations for in-hospital management (2)

Recommendations	Class	Level	2017 2020
Logistical issues for hospital stay (continued)			
Same-day transfer in selected stable patients after successful and uneventful PCI should be considered.	IIa	C	
Imaging			
Routine echocardiography is recommended during hospitalization to assess regional and global LV function, detect mechanical complications, and exclude LV thrombus.	I	C	
When echocardiography is suboptimal/inconclusive, CMR imaging may be considered.	IIb	C	IIa C

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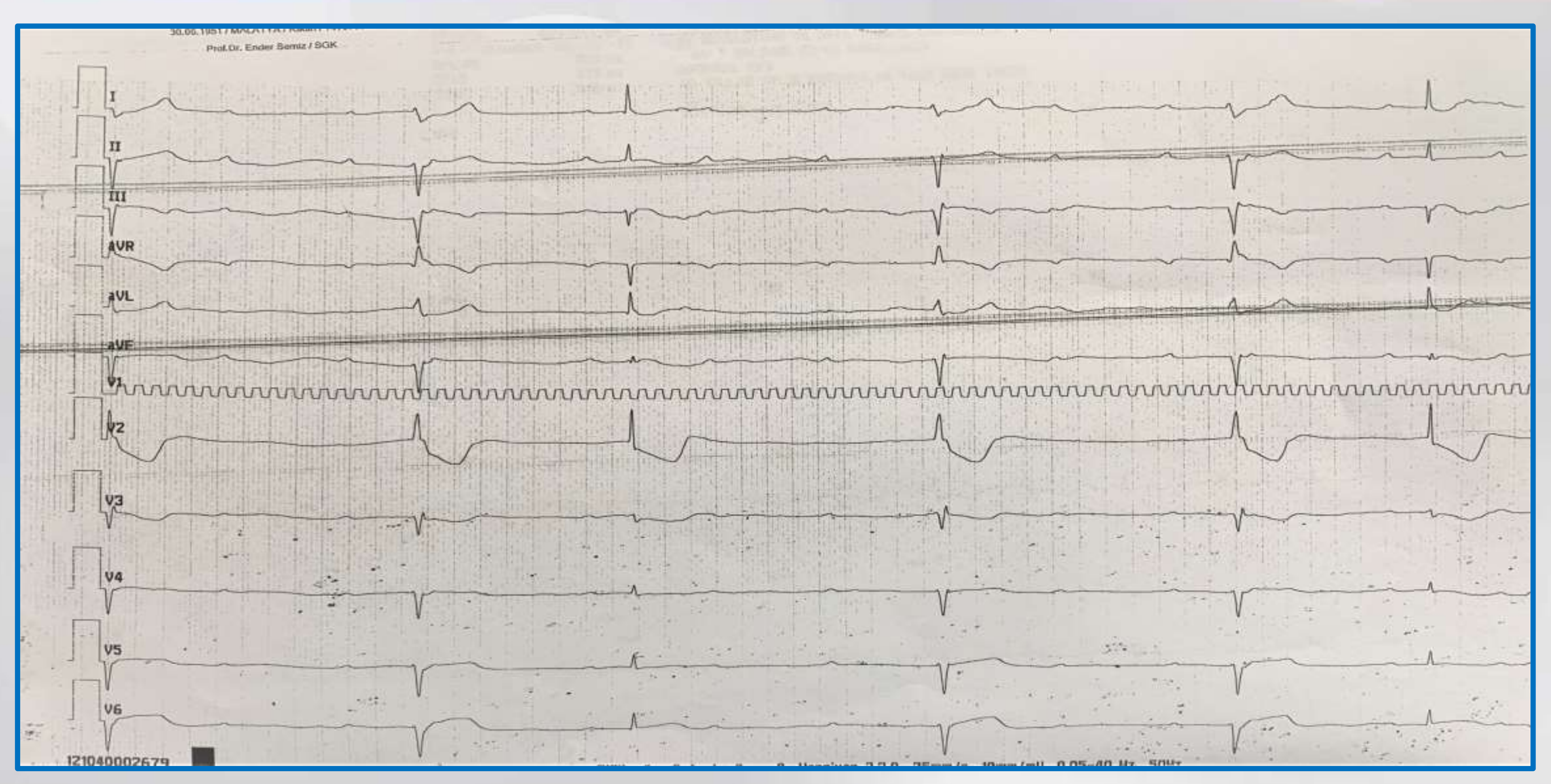
- OLGU 2 - Ö.O. 72 yaşında kadın hasta
- 23.03.2023 …… göğüs ağrısı yakınmalı bir hasta, 112 ambulans tarafından acil servisimize getirildi (300 mg aspirin, IV hidrasyon uygulanmış).
- Özgeçmişte yıllar önce geçirilmiş 2 damar KABG, HT ve kolesterol yüksekliği (+)
- Acil serviste CP arrest
  - KPR sırasında 2 kez 100 mcg IV adrenalin ve çekilen EKG'de tam AV blok saptanması üzerine 1 mg atropin verilmiş.
- Hasta agoni durumunda iken, anestezi hekimi eşliğinde geçici pacemaker uygulanmak üzere koroner anjiyografi laboratuvarına alındı.
- Geçici pacemaker işlemi sonrası koroner anjiyografi yapıldı.
- İşlemler sırasında çok fazla sıvı replasmanı yapıldığı halde hastanın hemodinamik durumu hiç düzelmedi; bilinç bulanıklığı sürüyordu.



Prof.Dr. Ender Semiz / SGK
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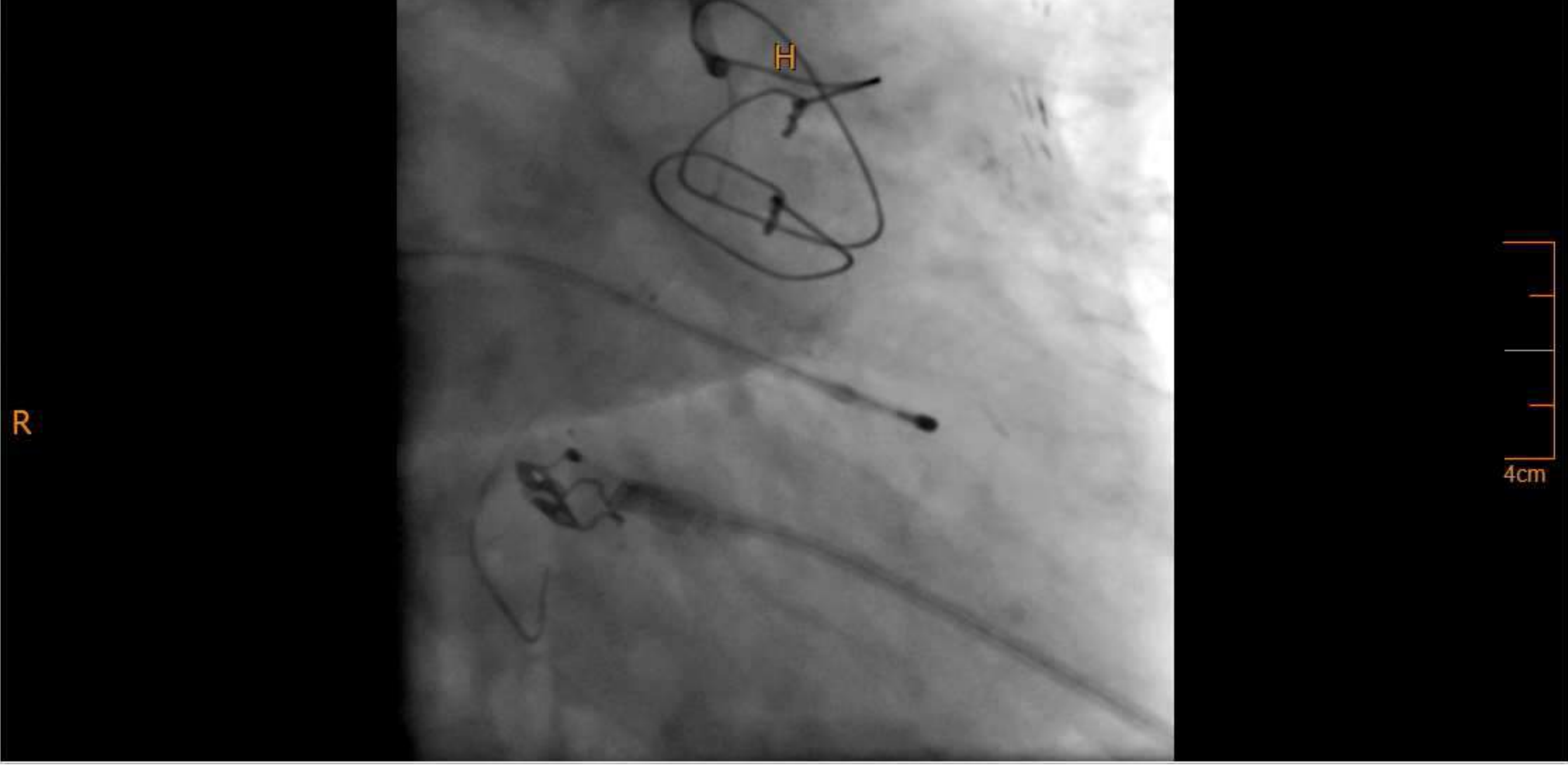
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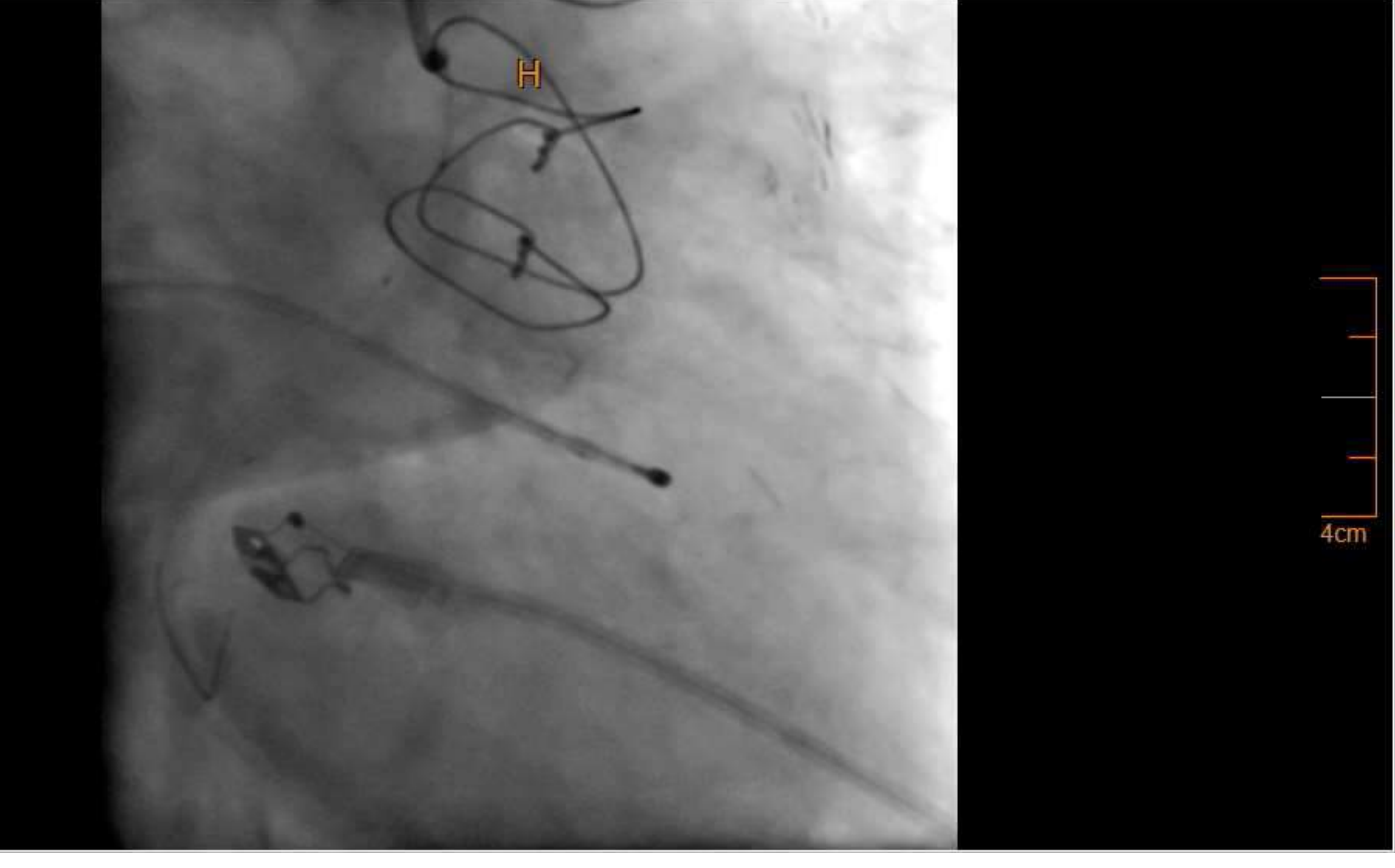

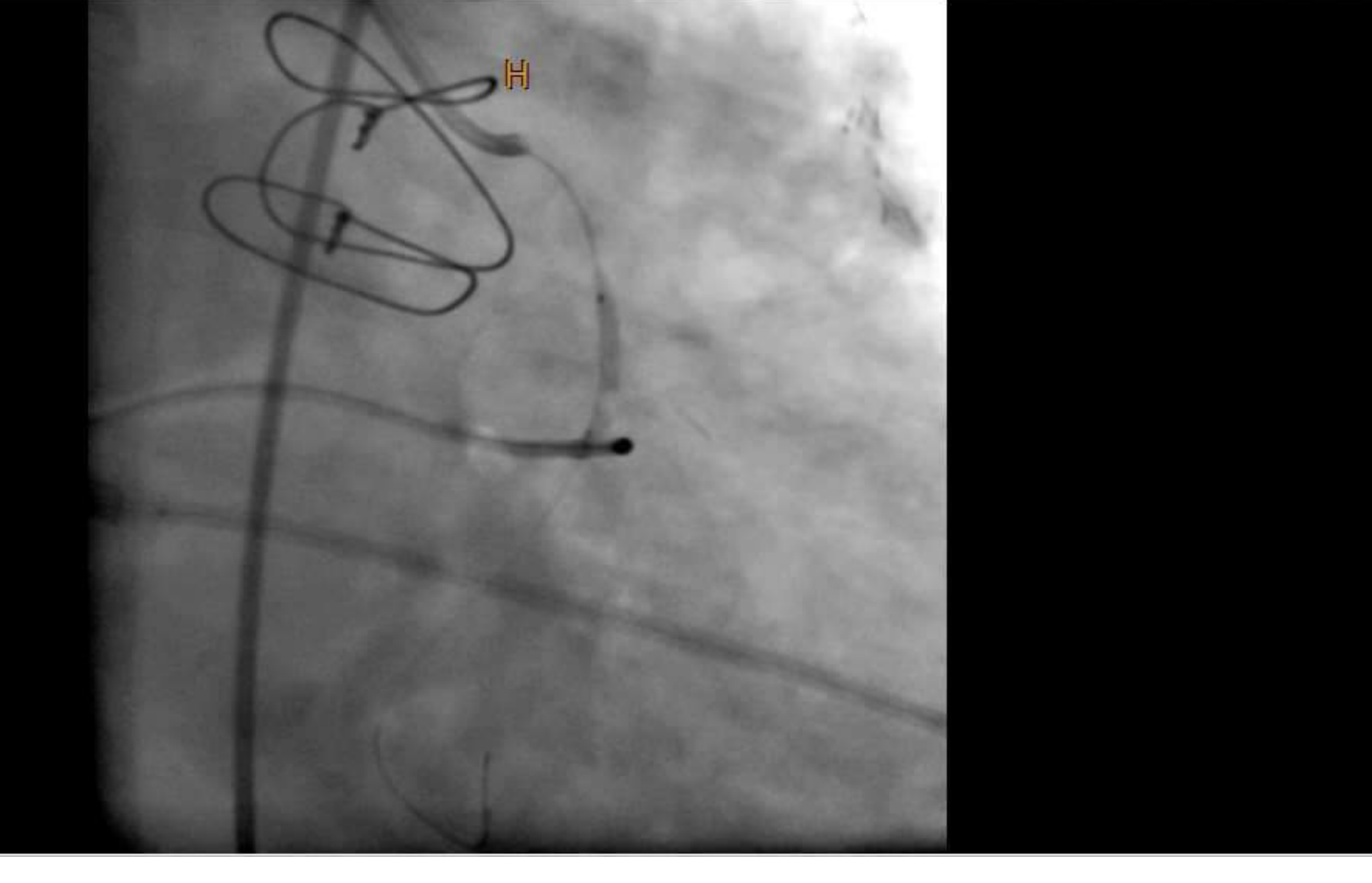
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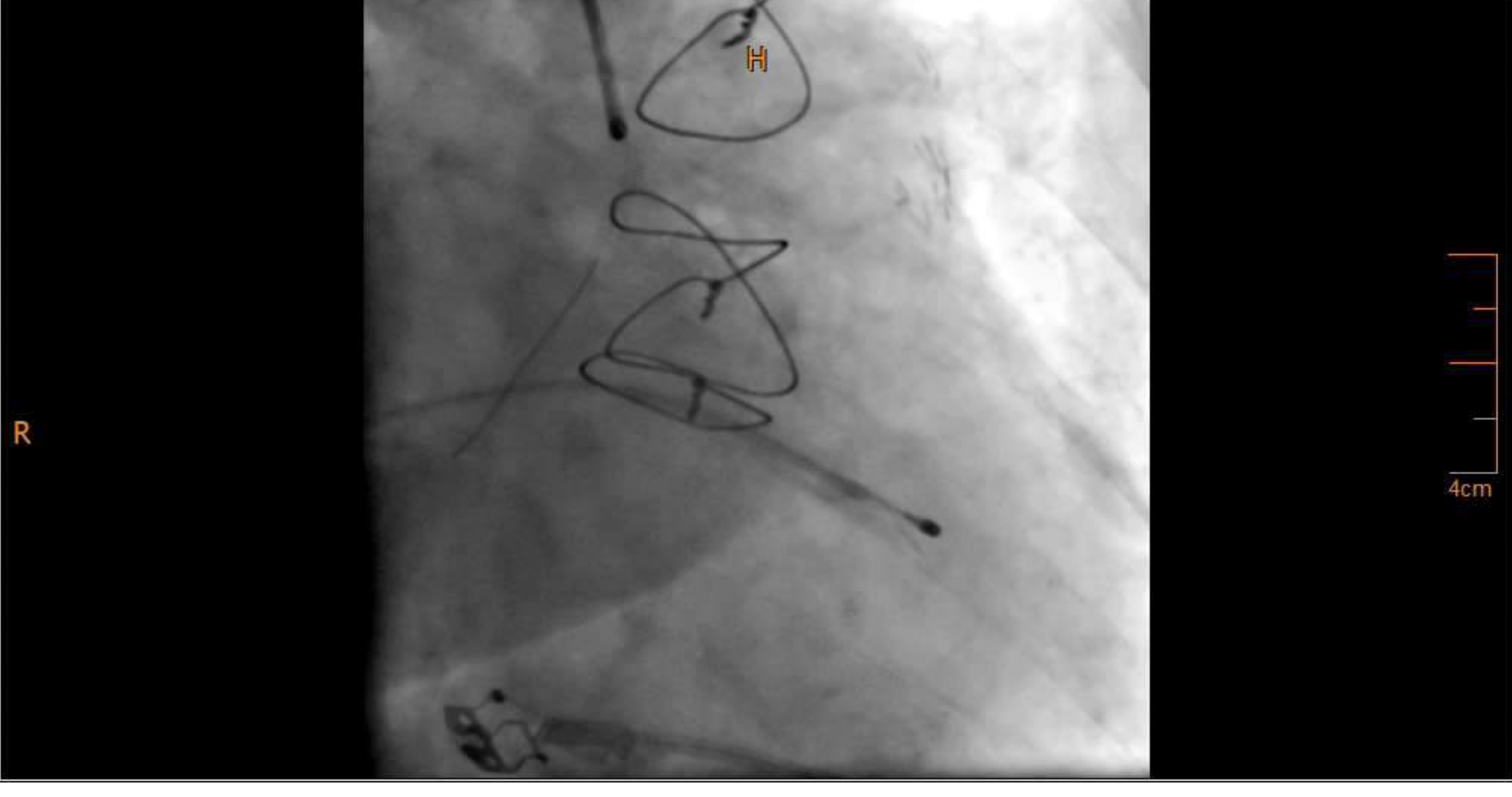

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- PKG sonrası koroner yoğun bakıma alınan hastada işlem sonrası
  - EKG: Sağ ventrikül katılımlı, infero-postero-lateral MI örneği saptandi.
  - EKO: Sol ventrikül sistolik disfonksiyonu (EF %40), sol ventrikül infero-lateral duvar hareketleri ileri hipokinetik, sağ ventrikül hipokinetik, 1. derece MR ve TR (+)
- Sıvı tedavisine noradrenalin infüzyonu eklendi.
- Geçici pace-maker ara-ara devrede
- Bulantı-kusması ve takikardisi gelişen hastanın nor-adrenalin infüzyonu sonlandırıldı.
- Oligüri gelişen hastada nefroloji hekiminin önerisiyle renal dozda dopamin infüzyonuna geçildi.

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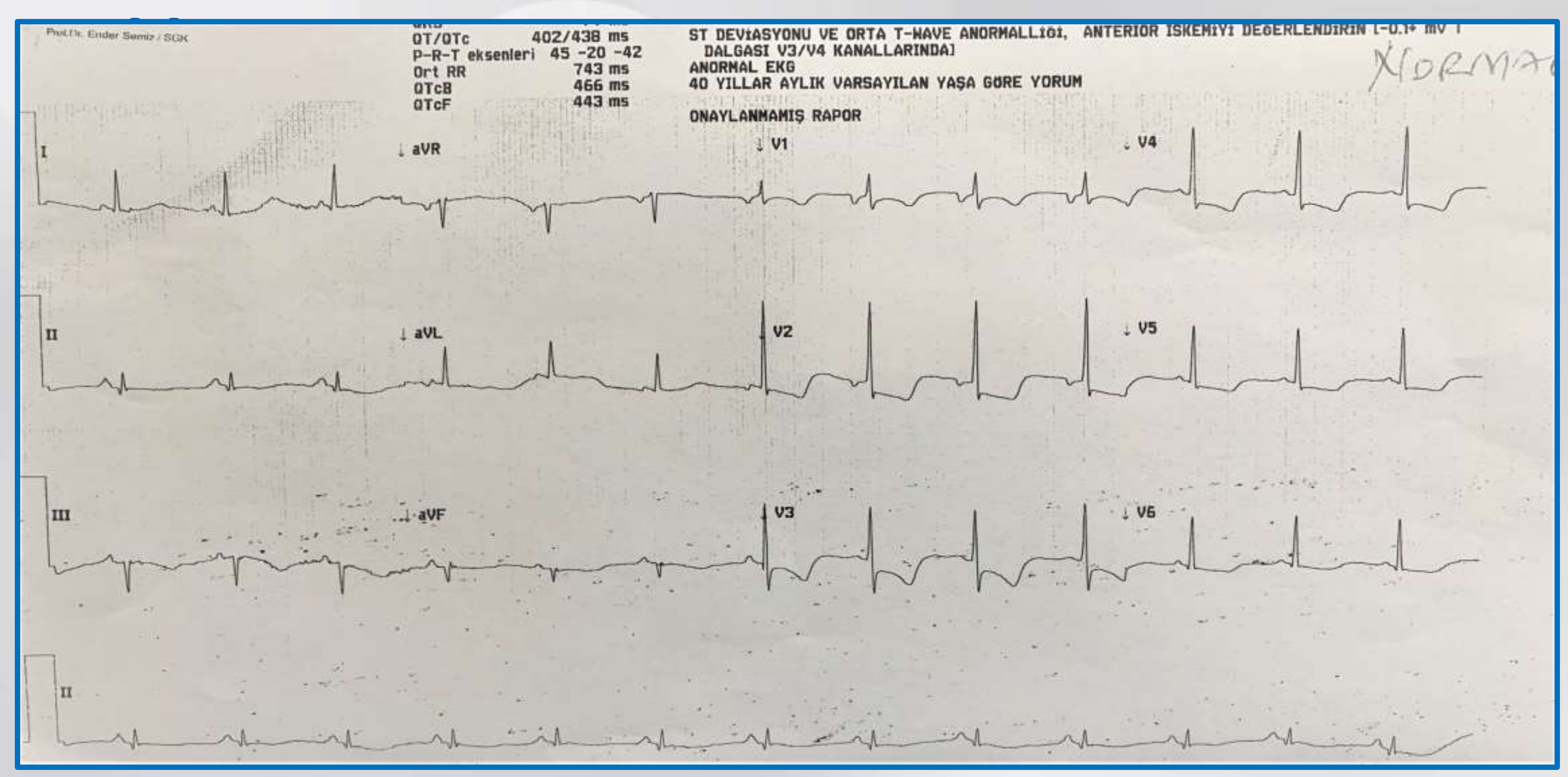

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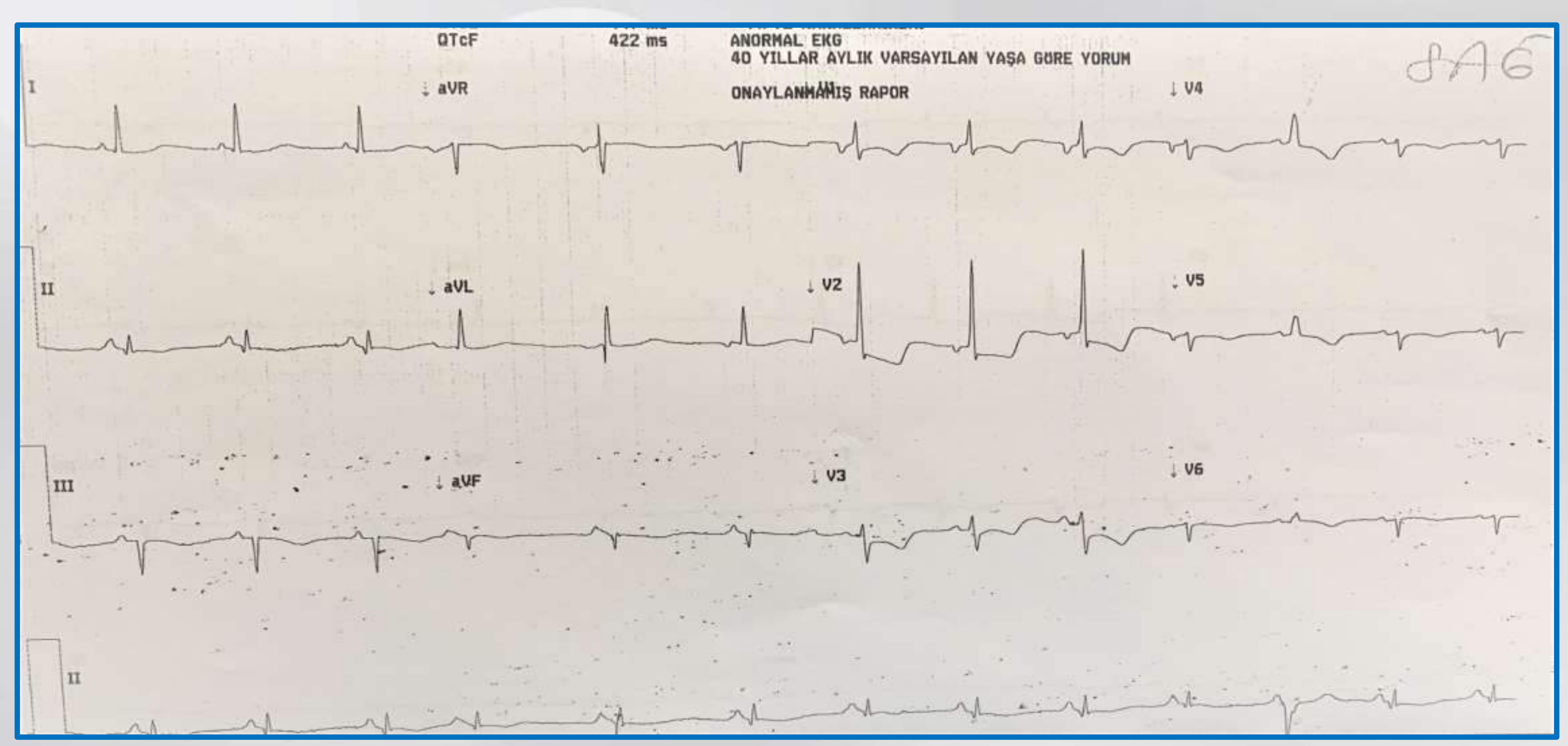

- Ertesi gün enfeksiyon bulguları gelişti.
  - Göğüs hastalıkları …….. Pnömoni tanısıyla seftriakson başladı.
  - Nefroloji …… Hipopotasemi ve hipoalbuminemi sorunları nedeniyle tedaviye potasyum replasmanı ekledi.
  - Enfeksiyon hastalıkları……Kan kültürleri sonucunda gram (+) kok ürediğini belirterek, ikili IV antibiyotik tedavisi başlattı (meropenem ve linezolid).
- AV blok sorunu düzeldi, pacemaker elektrodu çekildi.
- 6 gün antibiyotik tedavisi alan hastanın hemodinamisi ve genel durumu düzeldi.
  - Kan kültüründe enterokok ve MSKNS, idrar kültüründe enterokok ürediği belirtildi.
  - Amoksisilin/klavulonat önerilerek taburcu edildi.
- İşlem sonrası 6. ay kontrolünde hasta asemptomatik, efor testi negatif
- Takipte sorun yok

Recommendations for technical aspects of invasive strategies (1)

Recommendations	Class	Level
Radial access is recommended as the standard approach, unless there are overriding procedural considerations.	I	A
PCI with stent deployment in the IRA during the index procedure is recommended in patients undergoing PPCI.	I	A
Drug-eluting stents are recommended in preference to bare metal stents in all cases.	I	A
In patients with spontaneous coronary artery dissection, PCI is recommended only for patients with symptoms and signs of ongoing myocardial ischaemia, a large area of myocardium in jeopardy, and reduced antegrade flow.	I	C
Intravascular imaging should be considered to guide PCI.	IIa	A
Coronary artery bypass grafting should be considered in patients with an occluded IRA when PPCI is not feasible/unsuccessful and there is a large area of myocardium in jeopardy.	IIa	C

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(European Heart Journal; 2023 – doi:10.1093/eurheartj/ehad191)

Recommendations for technical aspects of invasive strategies (2)

Recommendations (continued)	Class	Level
Intravascular imaging (preferably optical coherence tomography) may be considered in patients with ambiguous culprit lesions.	IIb	C
The routine use of thrombus aspiration is not recommended.	III	A

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Recommendations for management of patients with multivessel disease (1)

Recommendations	Class	Level
It is recommended to base the revascularization strategy (IRA PCI, multivessel PCI/CABG) on the patient's clinical status and comorbidities, as well as their disease complexity, according to the principles of management of myocardial revascularization.	I	B
Multivessel disease in ACS patients presenting in cardiogenic shock		
IRA-only PCI during the index procedure is recommended.	I	B
Staged PCI of non-IRA should be considered.	IIa	C

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Recommendations for management of patients with multivessel disease (2)

Recommendations	Class	Level
Multivessel disease in haemodynamically stable STEMI patients undergoing PPCI		
Complete revascularization is recommended either during the index PCI procedure or within 45 days.	I	A
It is recommended that PCI of the non-IRA is based on angiographic severity.	I	B
Invasive epicardial functional assessment of non-culprit segments of the IRA is not recommended during the index procedure.	III	C
Multivessel disease in haemodynamically stable NSTE-ACS patients undergoing PCI		
In patients presenting with NSTE-ACS and MVD, complete revascularization should be considered, preferably during the index procedure.	IIa	C
Functional invasive evaluation of non-IRA severity during the index procedure may be considered.	IIb	B

2017
2020

IIa A

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Recommendations for acute coronary syndrome complications (6)

Recommendations	Class	Level
Bradyarrhythmias (continued)		
• urgent angiography with a view to revascularization is recommended if the patient has not received previous reperfusion therapy.	I	C
Implantation of a permanent pacemaker is recommended when high-degree AV block does not resolve within a waiting period of at least 5 days after MI.	I	C
In selected patients with high-degree AV block in the context of an anterior wall MI and acute HF, early device implantation (CRT-D/CRT-P) may be considered.	IIb	C
Pacing is not recommended if high-degree AV block resolves after revascularization or spontaneously.	III	B

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Recommendations for acute coronary syndrome comorbid conditions (4)

Recommendations	Class	Level
Patients with cancer		
An invasive strategy is recommended in cancer patients presenting with high-risk ACS with expected survival ≥6 months.	I	B
A temporary interruption of cancer therapy is recommended in patients in whom the cancer therapy is suspected to be a contributing cause of ACS.	I	C
A conservative non-invasive strategy should be considered in ACS patients with poor cancer prognosis (i.e. with expected survival <6 months) and/or very high bleeding risk.	IIa	C
Aspirin is not recommended in cancer patients with a platelet count <10 000/µL.	III	C
Clopidogrel is not recommended in cancer patients with a platelet count <30 000/µL.	III	C
In ACS patients with cancer and <50 000/µL platelet count, prasugrel or ticagrelor are not recommended.	III	C

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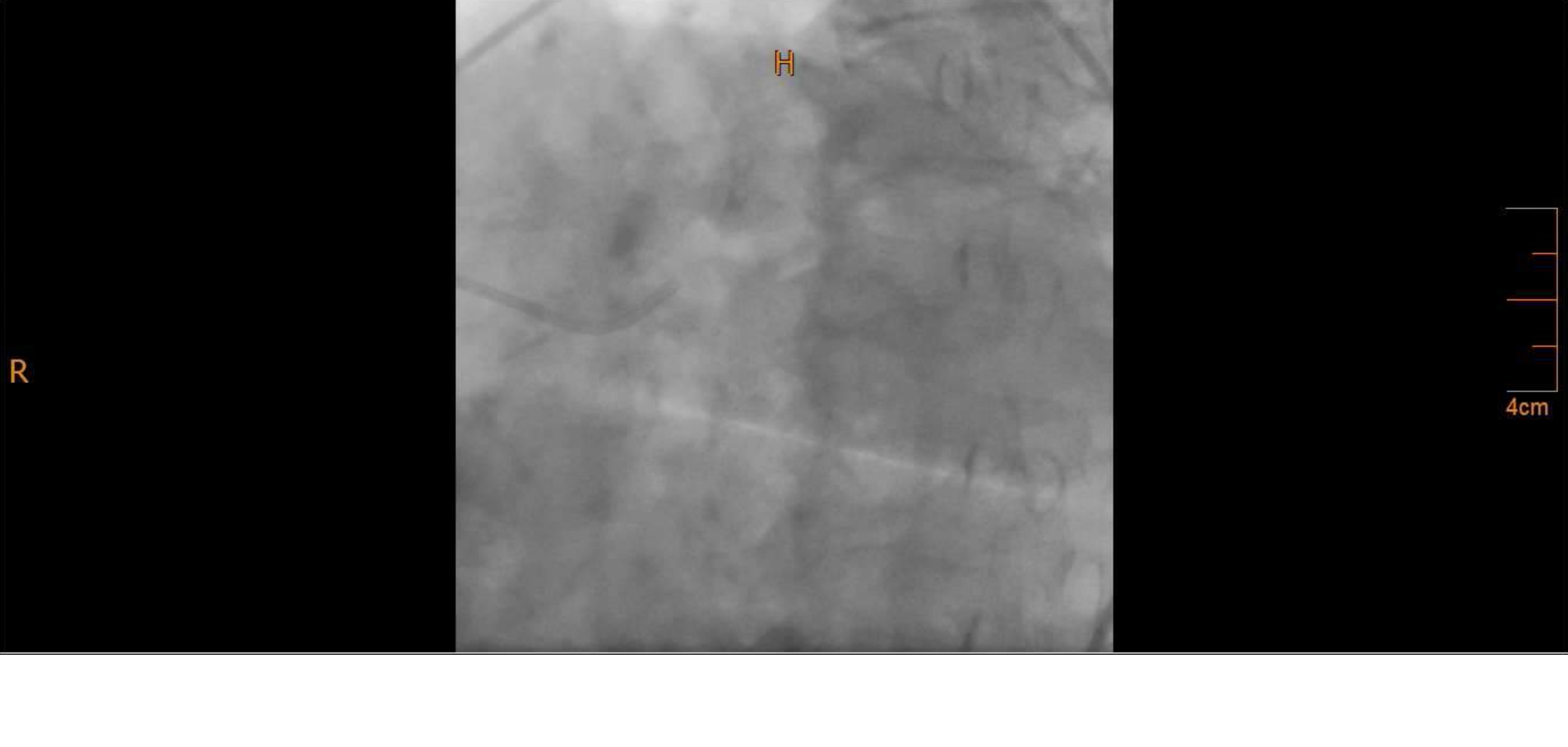
- OLGU 3 - Z.B. 78 yaşında kadın hasta
- 06.12.2021 …… göğüs ağrısıyla gittiği başka bir sağlık merkezinden ST elevasyonlu inferior MI tanısıyla primer PKG için sevk edildi.
- HT, kolestrol yüksekliği, ID (+)
- 3 yıl önce sol pleural ve perikardiyal efüzyon nedeniyle çok kısa tüberküloz tedavisi
- Başvuru
  - FM: KB: 13/7 cmHg; kalp-akciğer muayenesi normal
  - EKG: Bradikardik; II, III, aVF’de ST elevasyonu; V1-V2’de ST depresyonu
  - Troponin: 0,022 ng/ml (N <0,037 ng/ml)
- Koroner anjiyografi
  - Primer PKG amacıyla trombotik RCA'da PTKA ile TIMI-III akım sağlandı.
  - Diffüz, kısmen kalsifik ve yüksek dereceli stenotik-ardışık lezyonlar içeren LAD damarının da olduğu 3 damar hastası olması nedeniyle işleme ara verilerek tedavi kararı için kardiyoloji-KVC konseyi yapıldı.
- Konsey kararı: Yüksek riskli KABG ? PKG ? …… Hasta ve yakınları KABG operasyonunu kabul etmediler …… RCA'nın stentlenerek işleme devam edilmesi kararlaştırıldı.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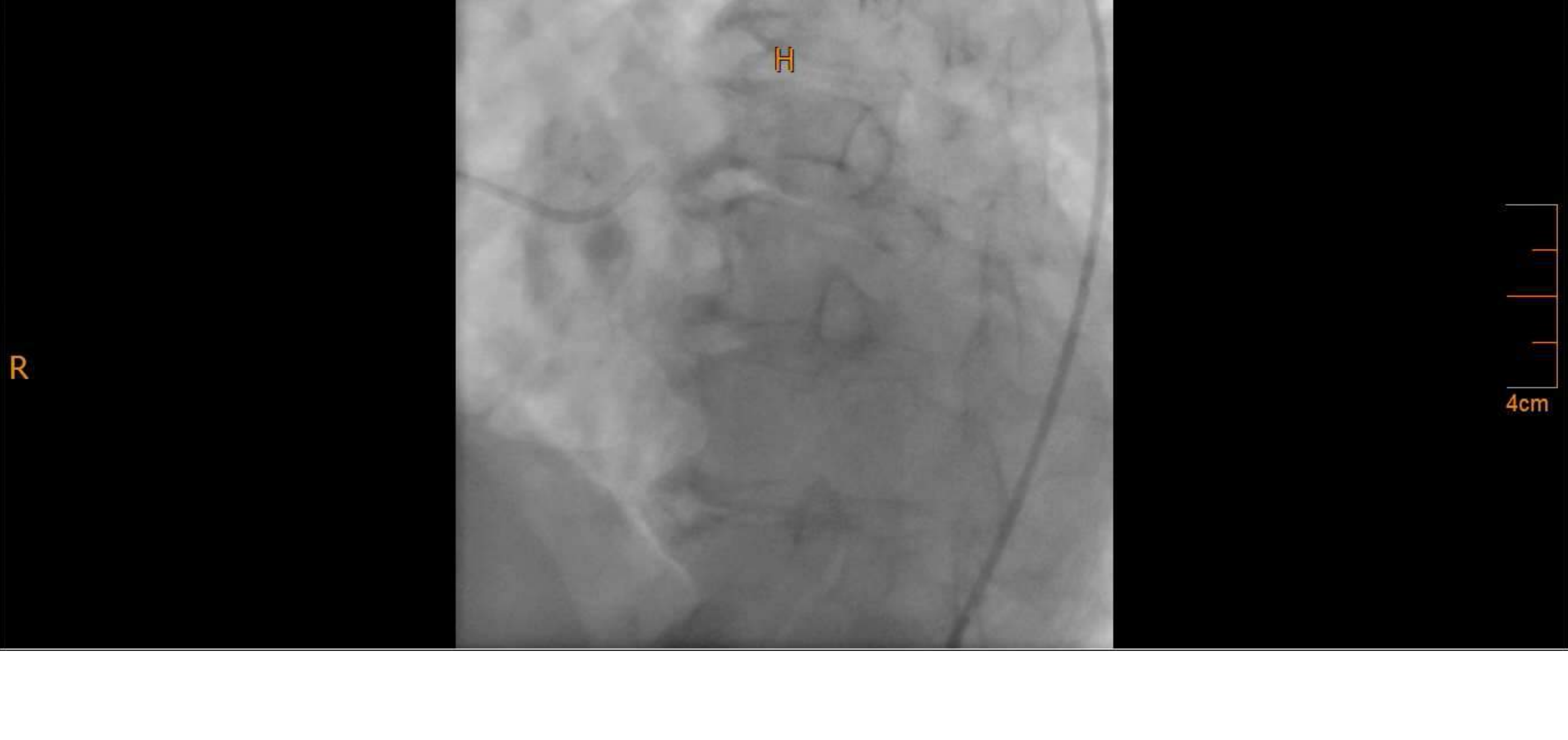
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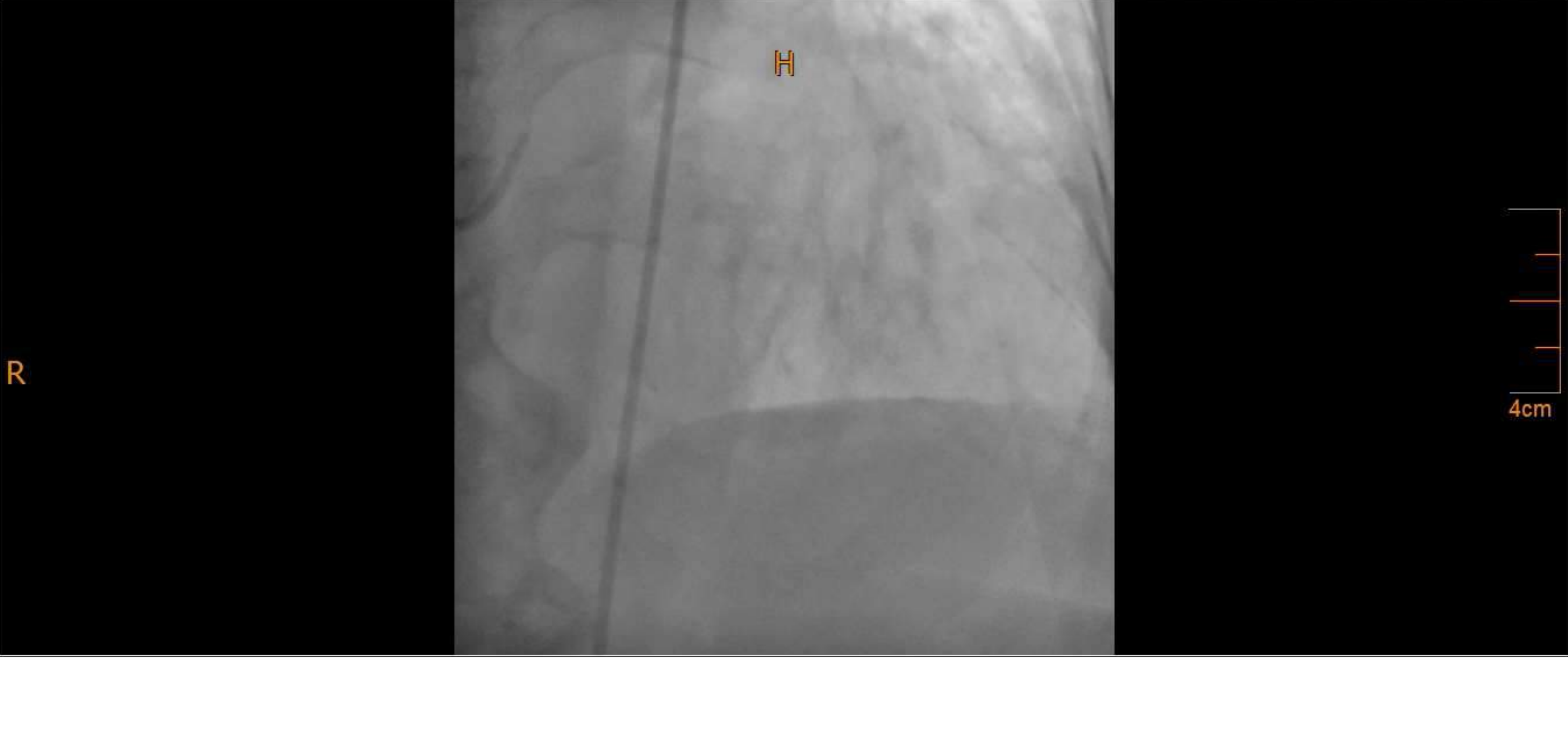
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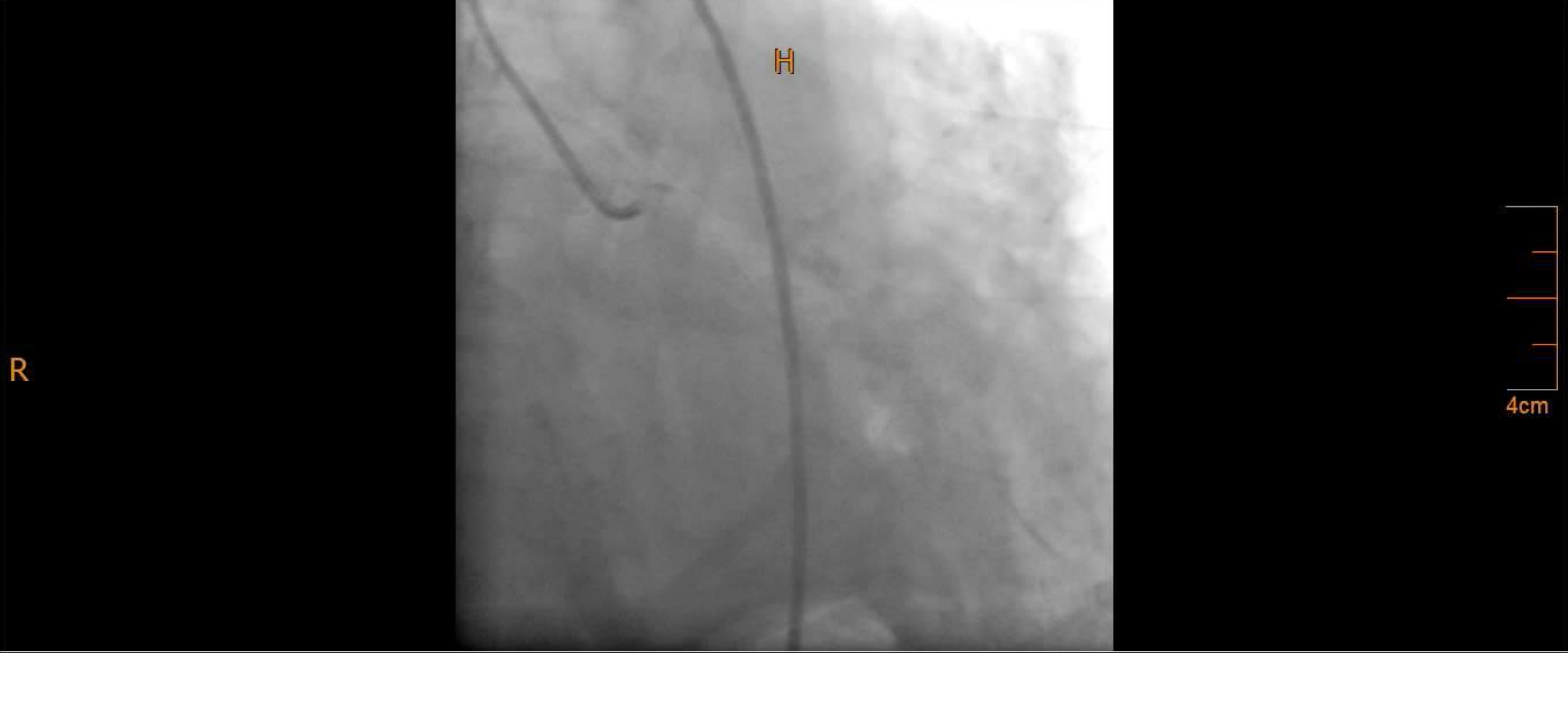
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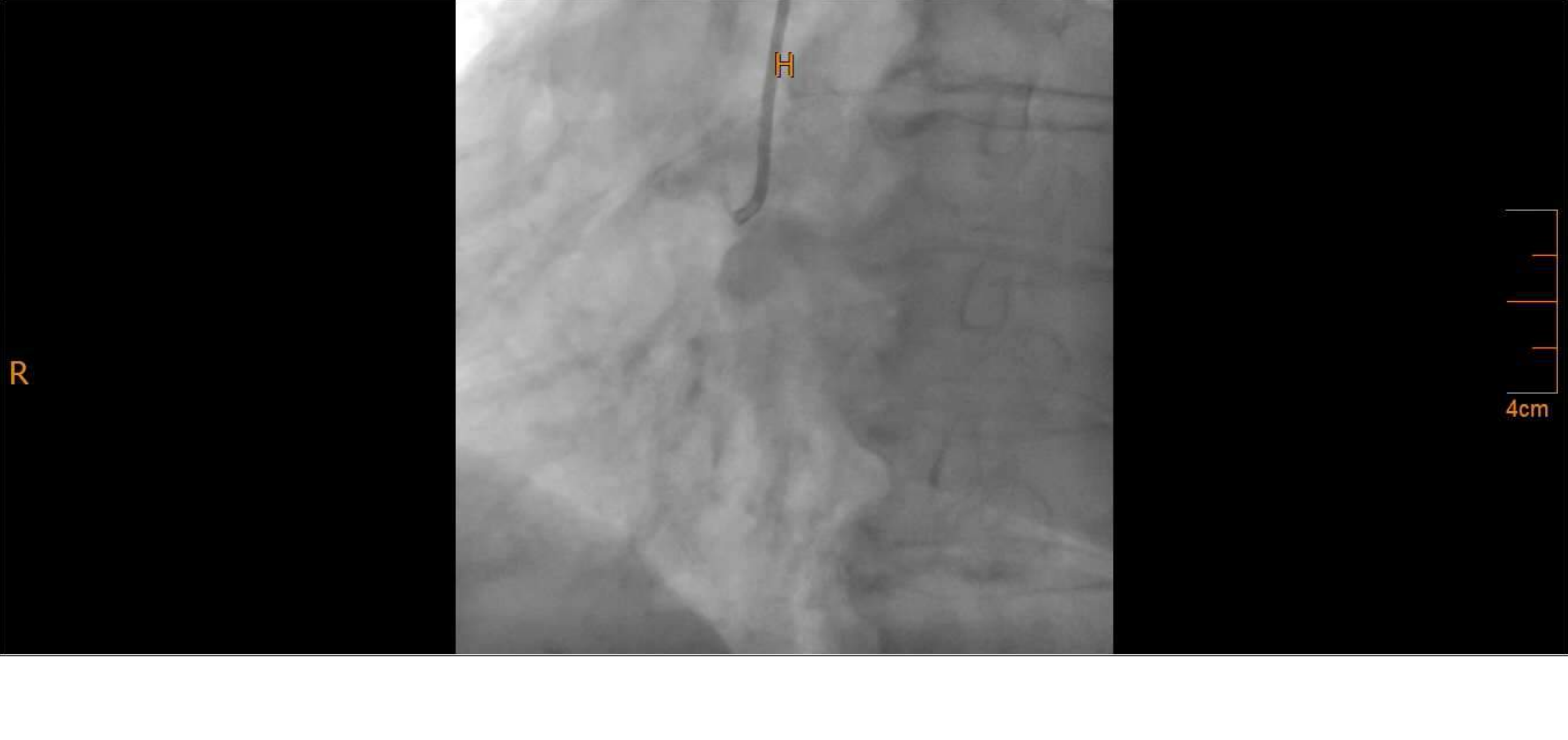
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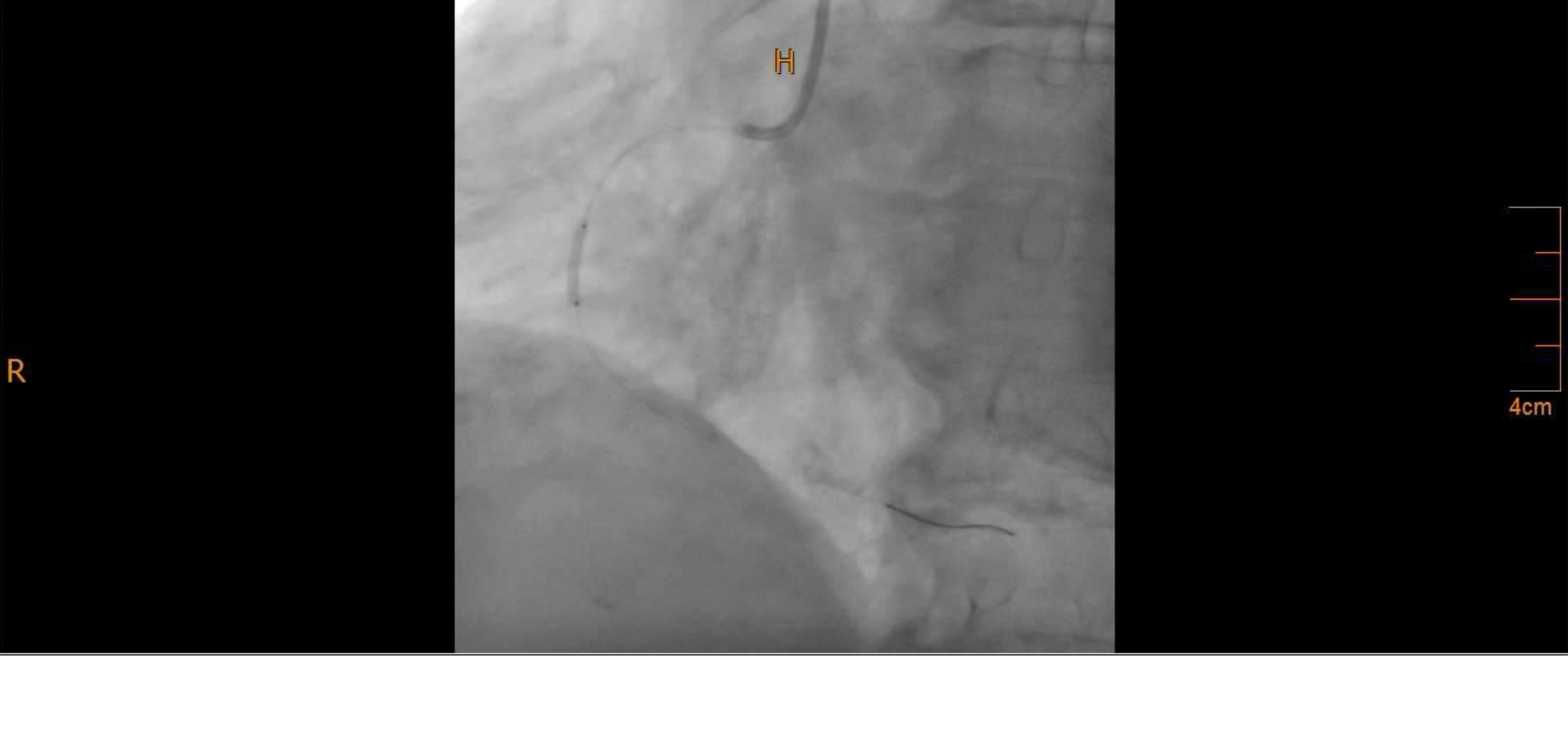
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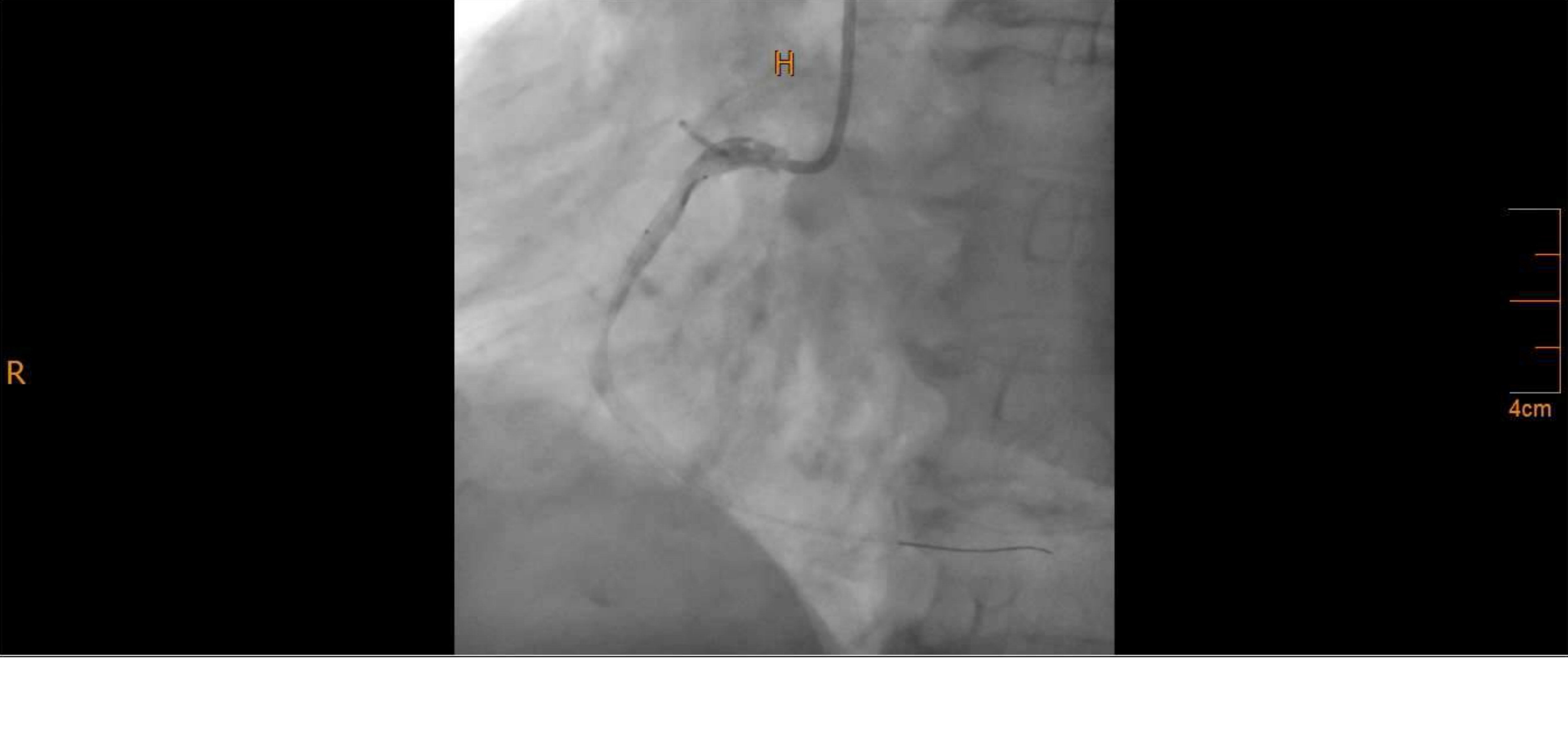
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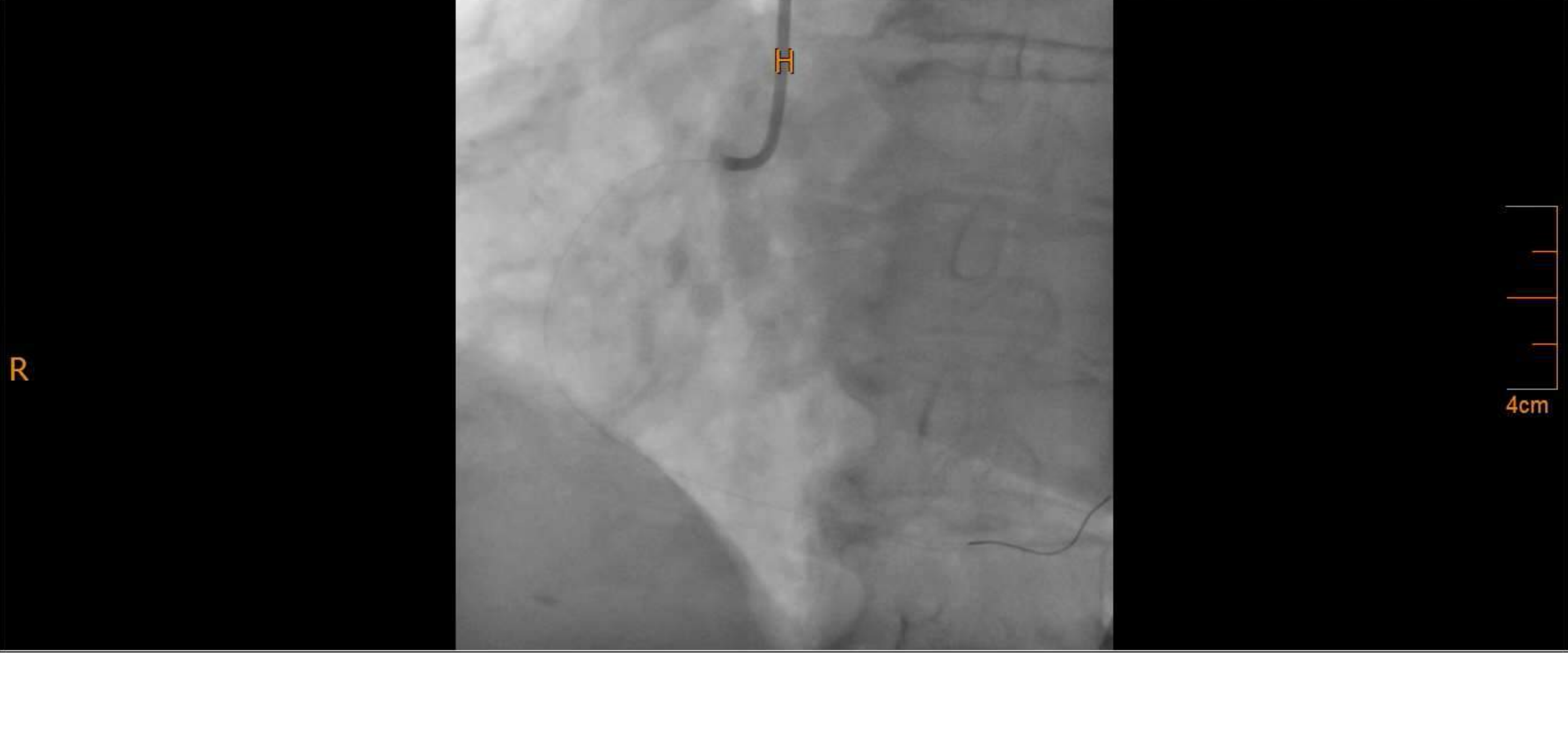

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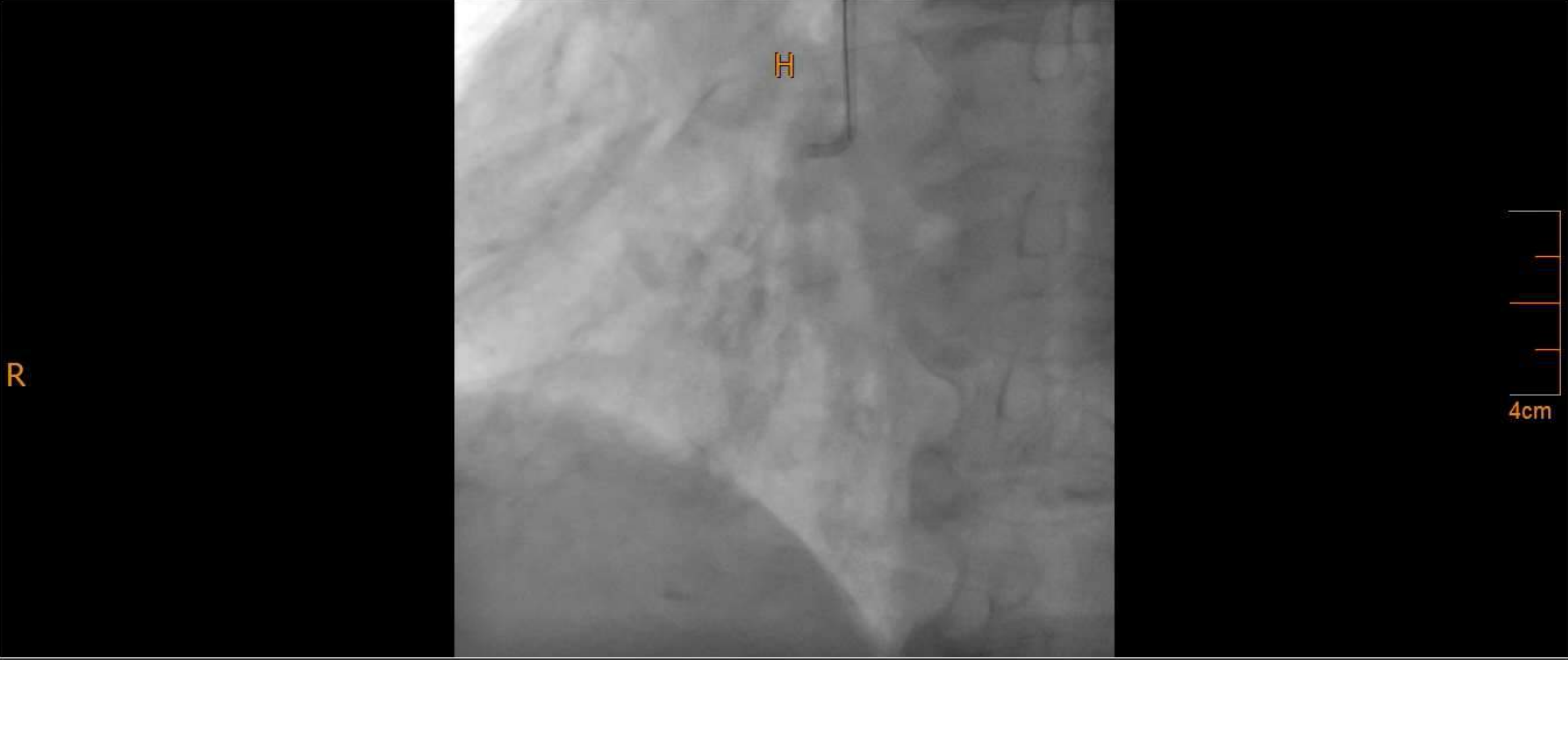
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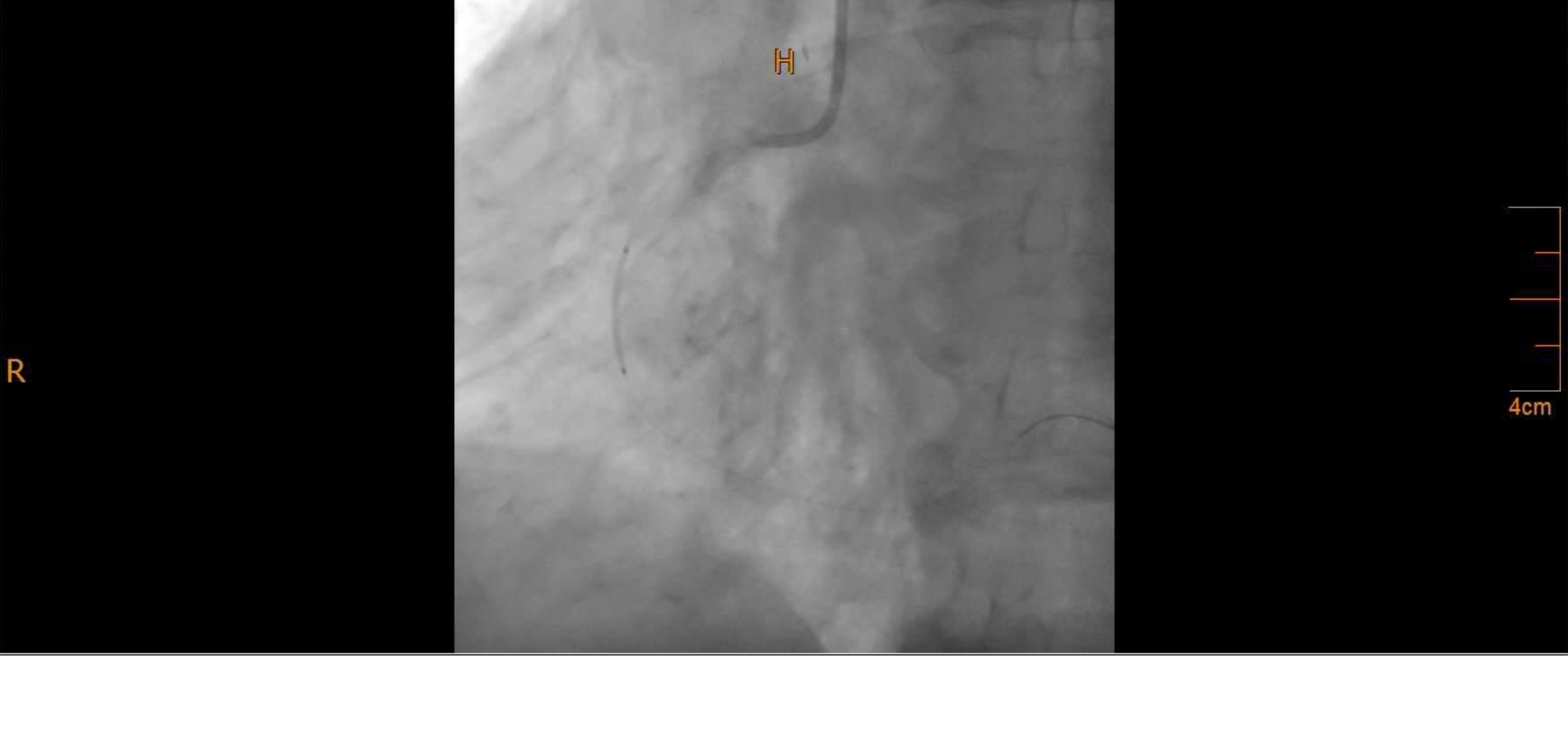
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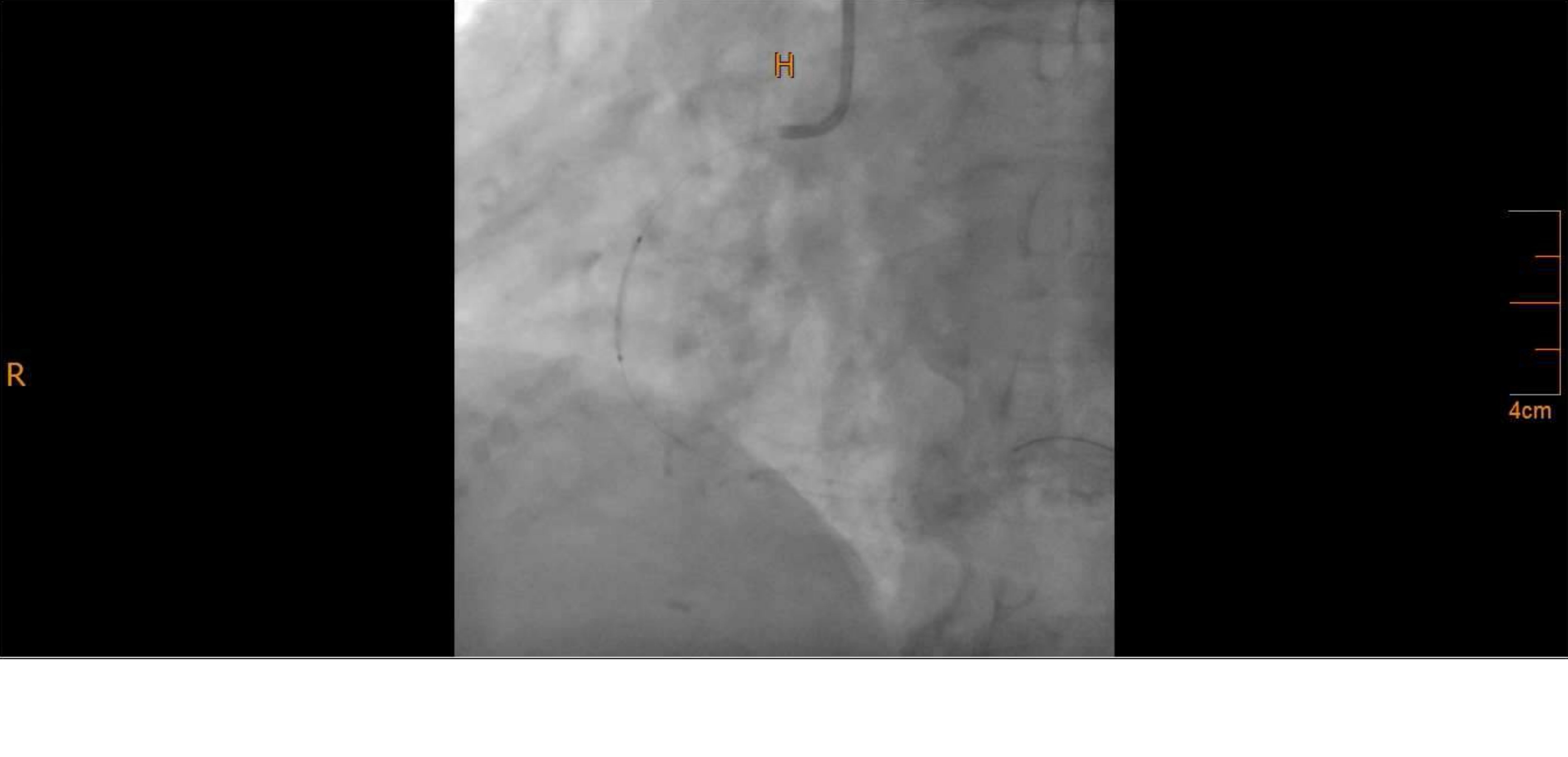
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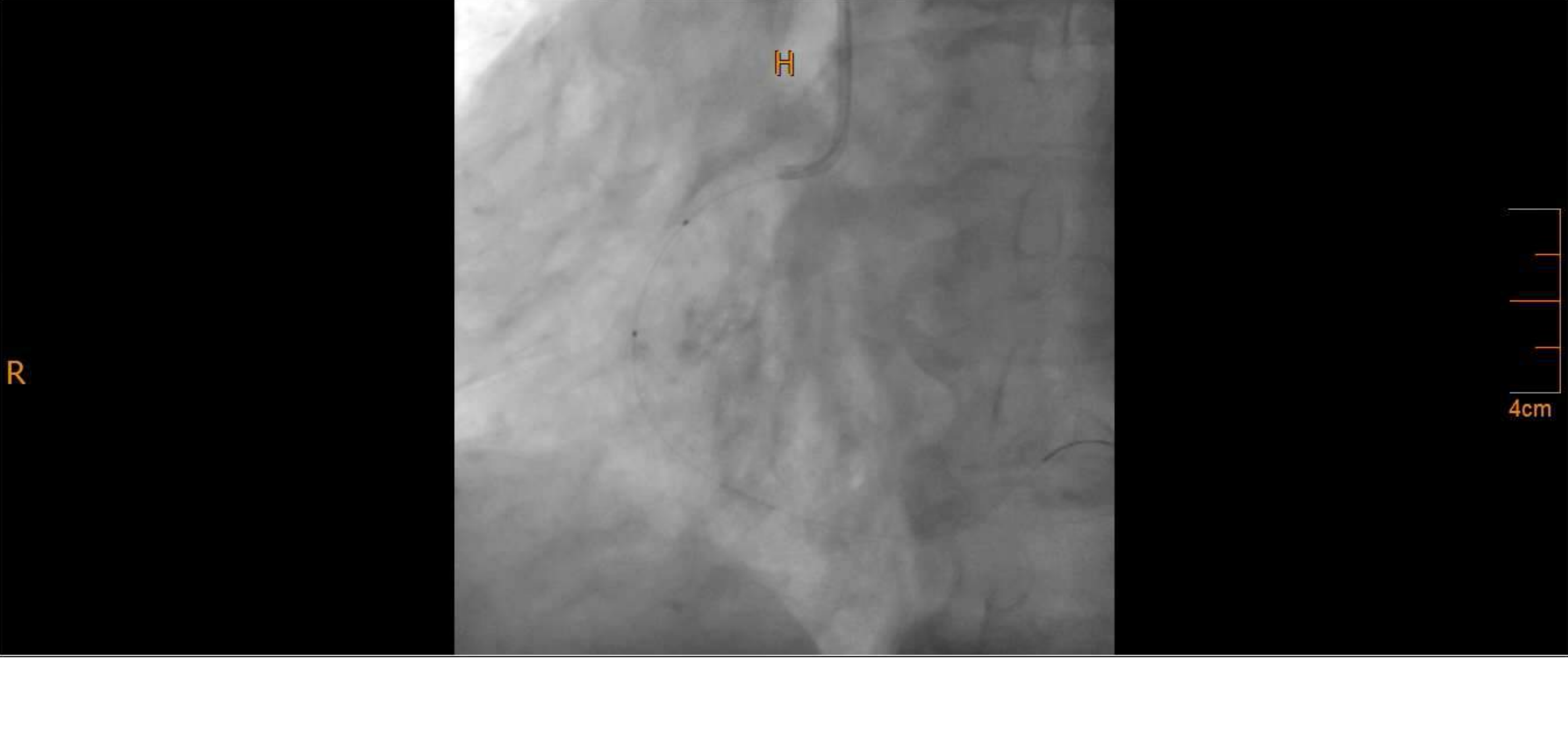
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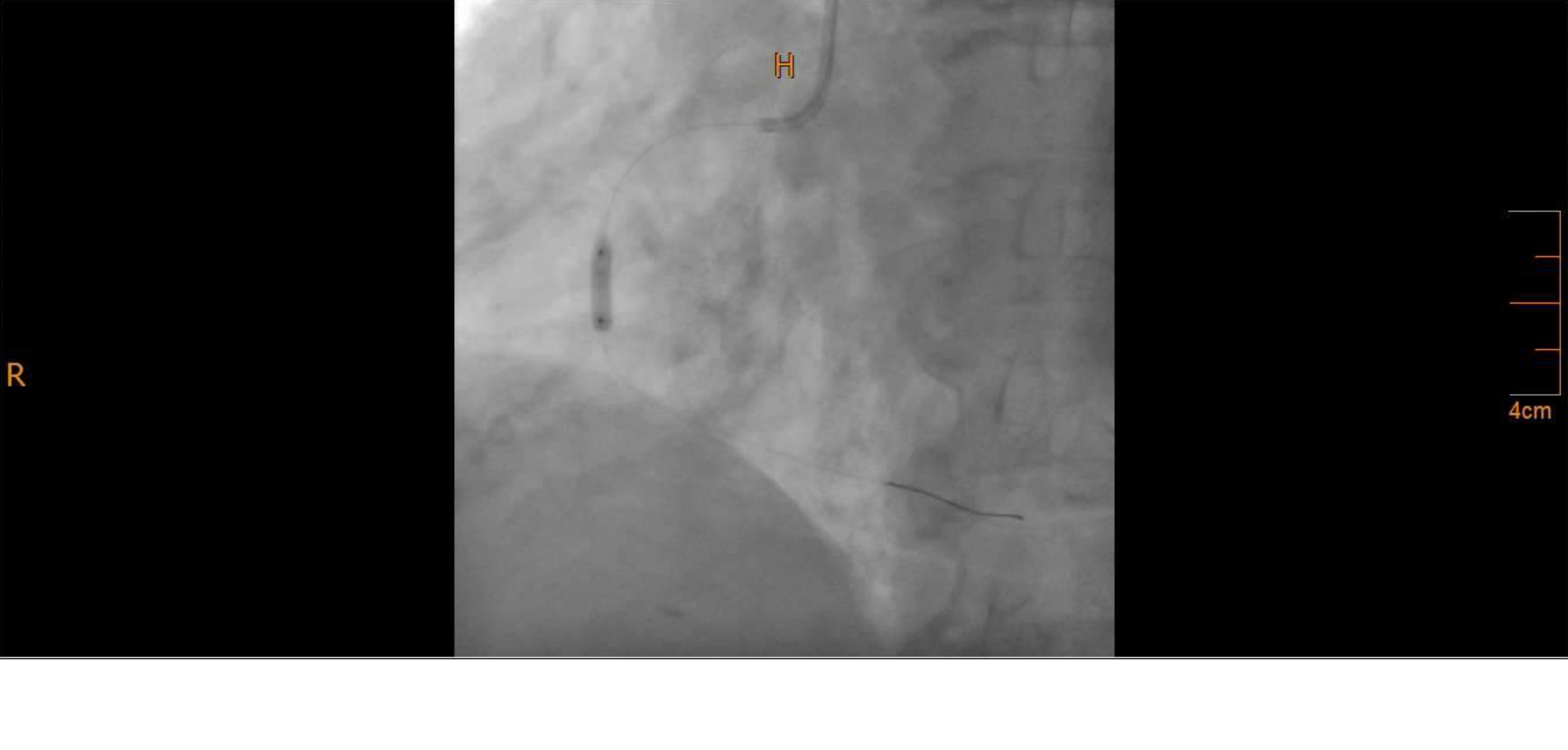

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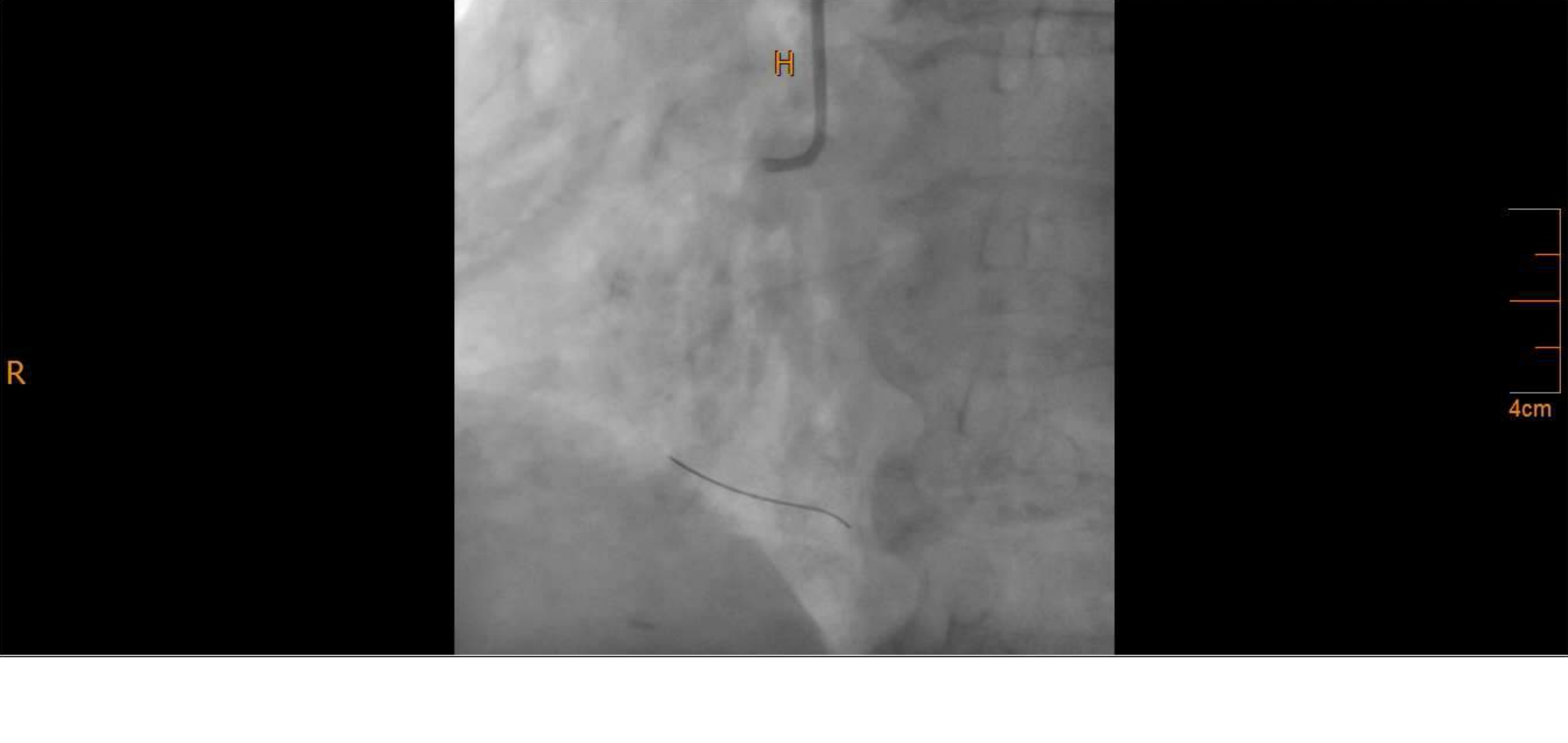
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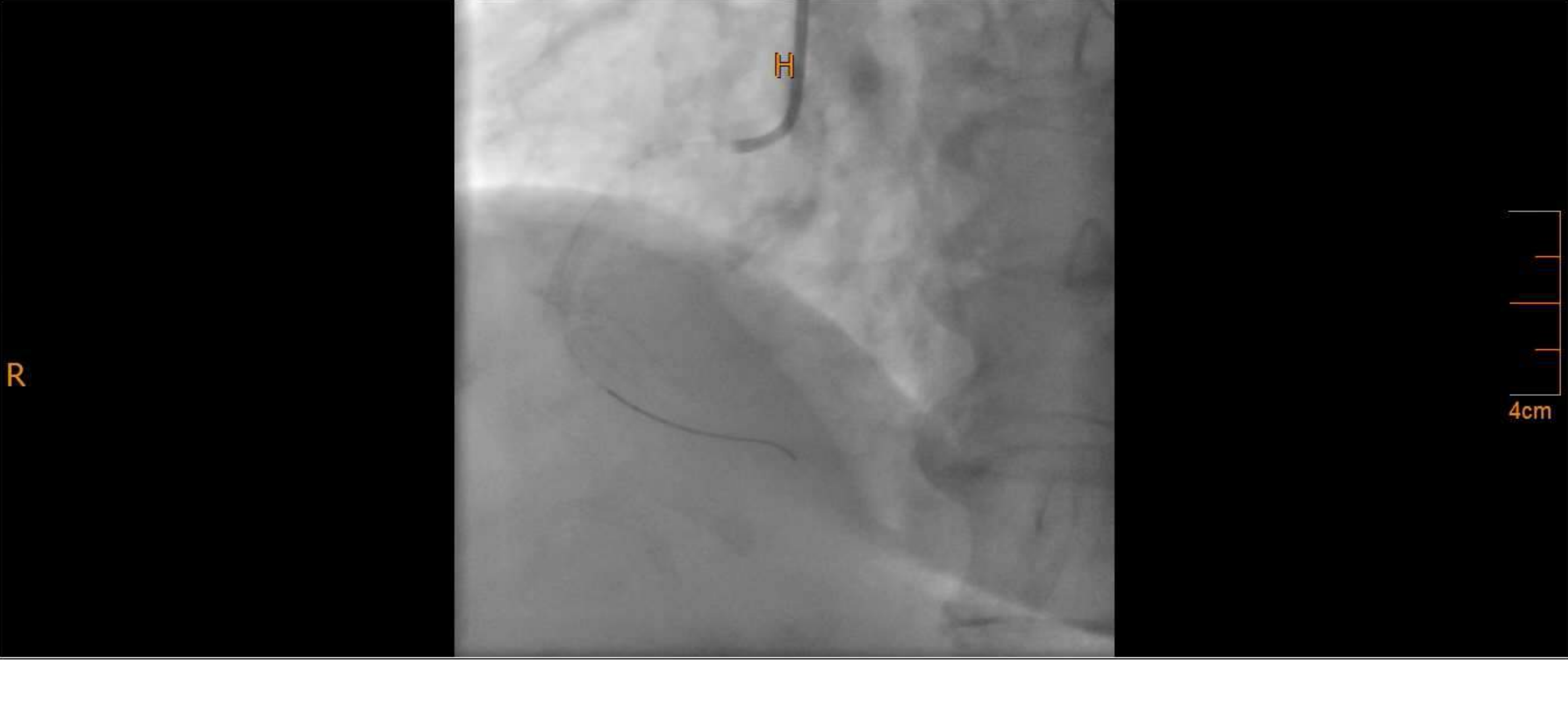
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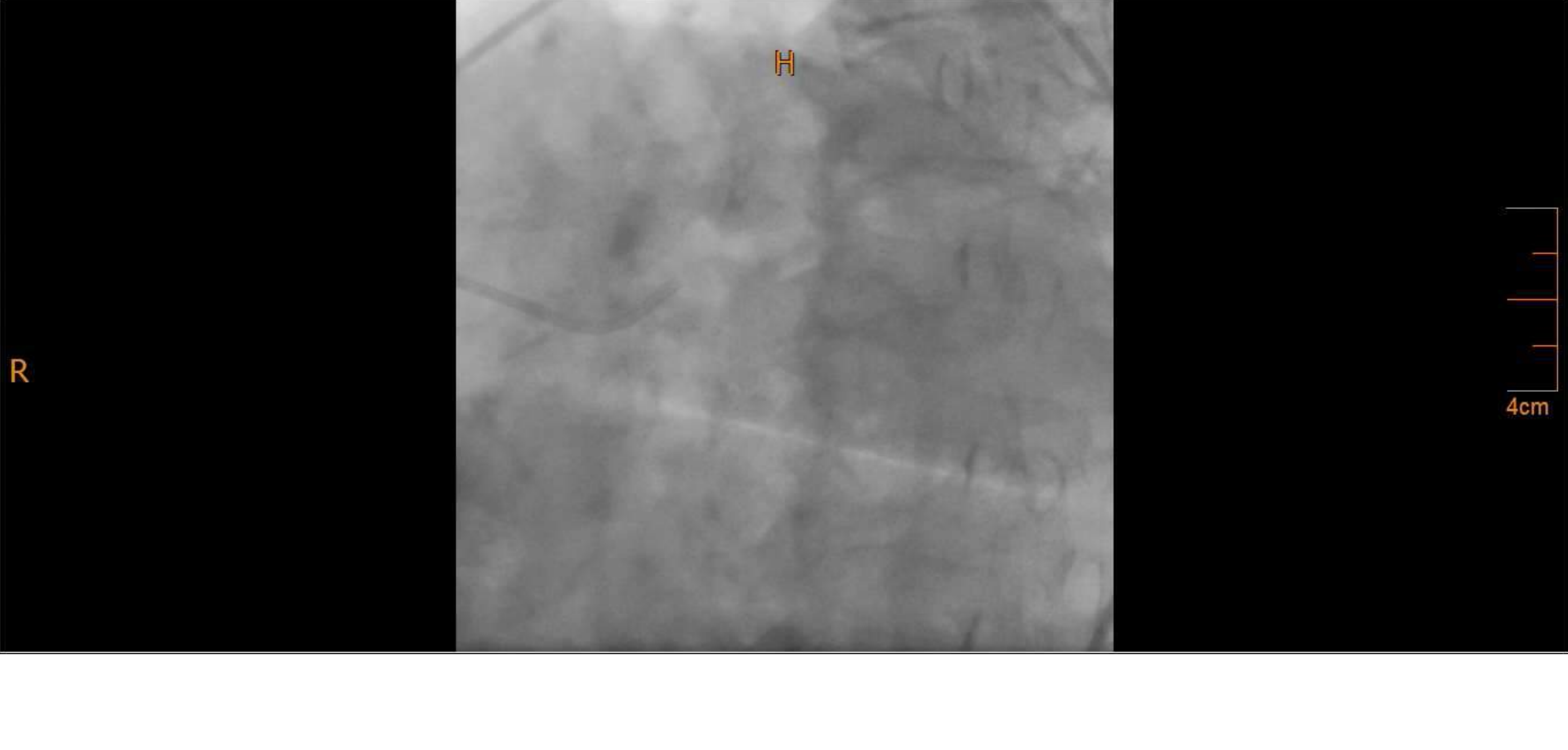
- Hasta işlem sonrası KYB’ ye alındı.
  - EKO: Global sistolik fonksiyonlar iyi; duvar hareket bozukluğu yok. 2. derece MR ve 1. derece AR (+). Mitral ve aort kapakları dejeneratif
- İzlemde sorunu olmayan ve troponin değerleri düşmeye başlayan hasta, 2 hafta sonra LAD ve CX damarlarına PKG yapılmak üzere taburcu edildi.
- Planlanan PKG işlemlerinin ertelenmesine neden olan sorunlar
  - 10 gün sonra B.astma krizi
  - Karın ağrısı, şişkinlik, kilo kaybı ve anemi nedeniyle gastro-enteroloji tarafından elektif gastroskopi ve kolonoskopi önerisi
  - 3,5 ay sonra KBB bölümünce SCC ön tanısıyla biyopsisi
  - Sallanan iki dişine ve ağız içinde gelişen hematomuna girişim
  - Depresyon sorunu nedeniyle hastaya psikiyatri bölümünce tedavi
- Sonunda 26.05.2022 tarihinde PKG işlemi için hasta yatırıldı.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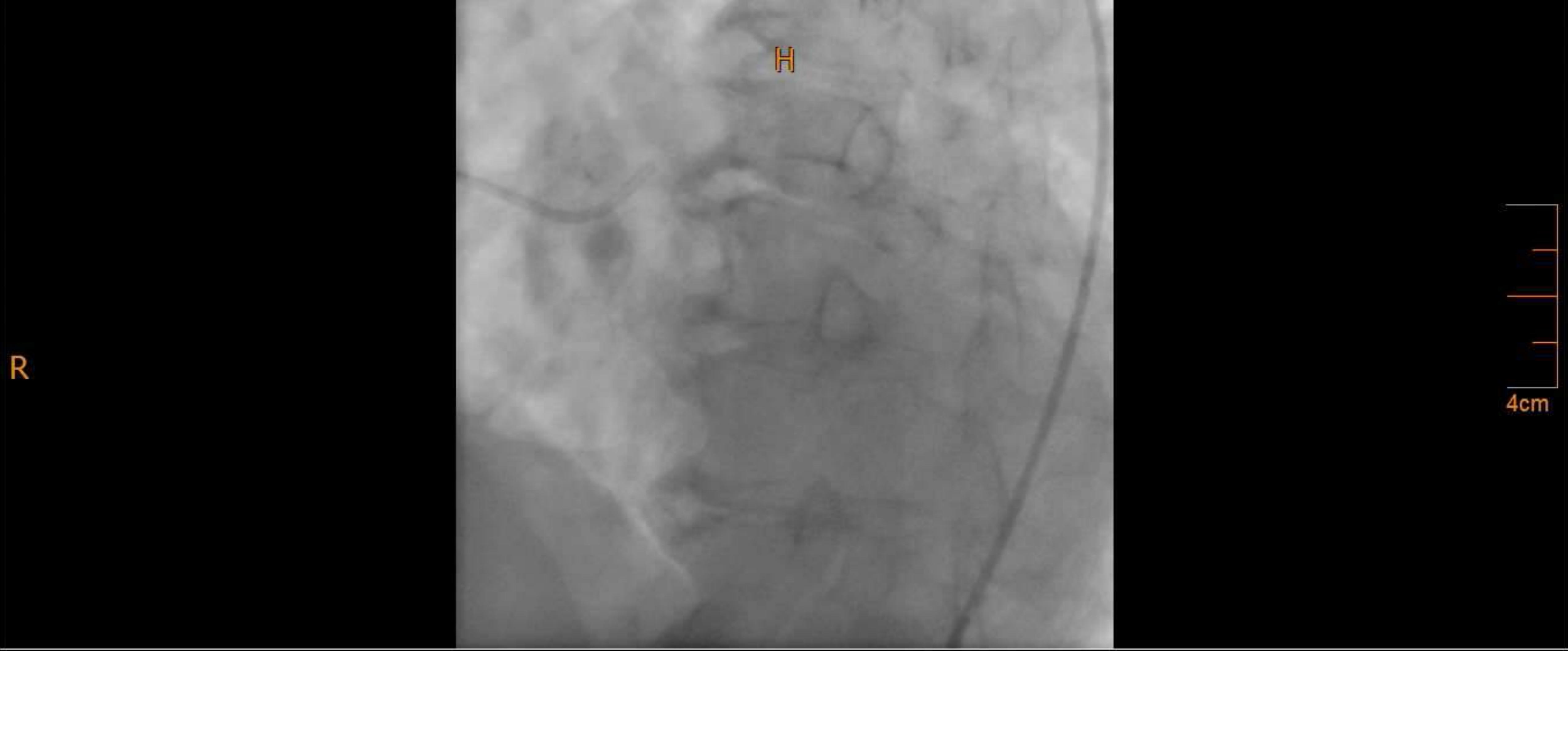
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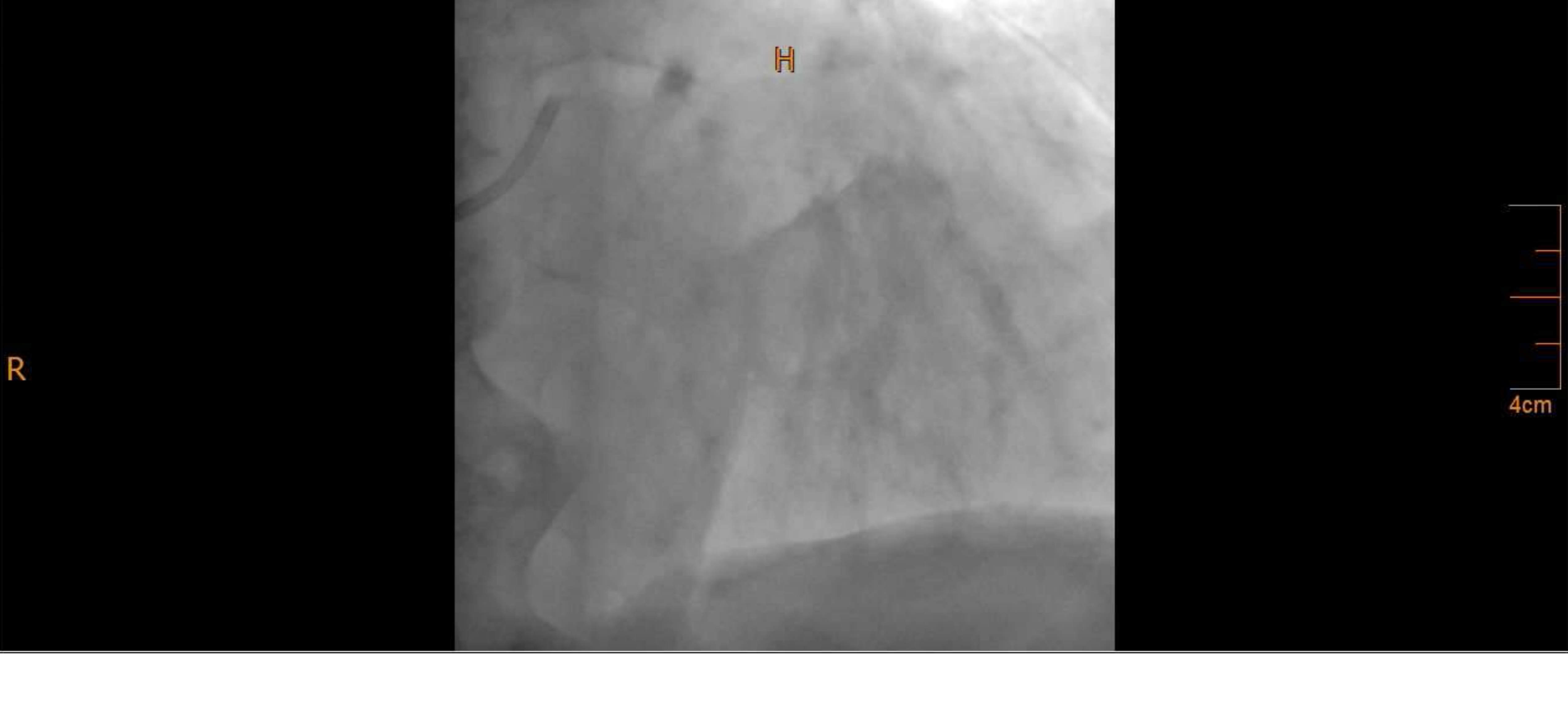
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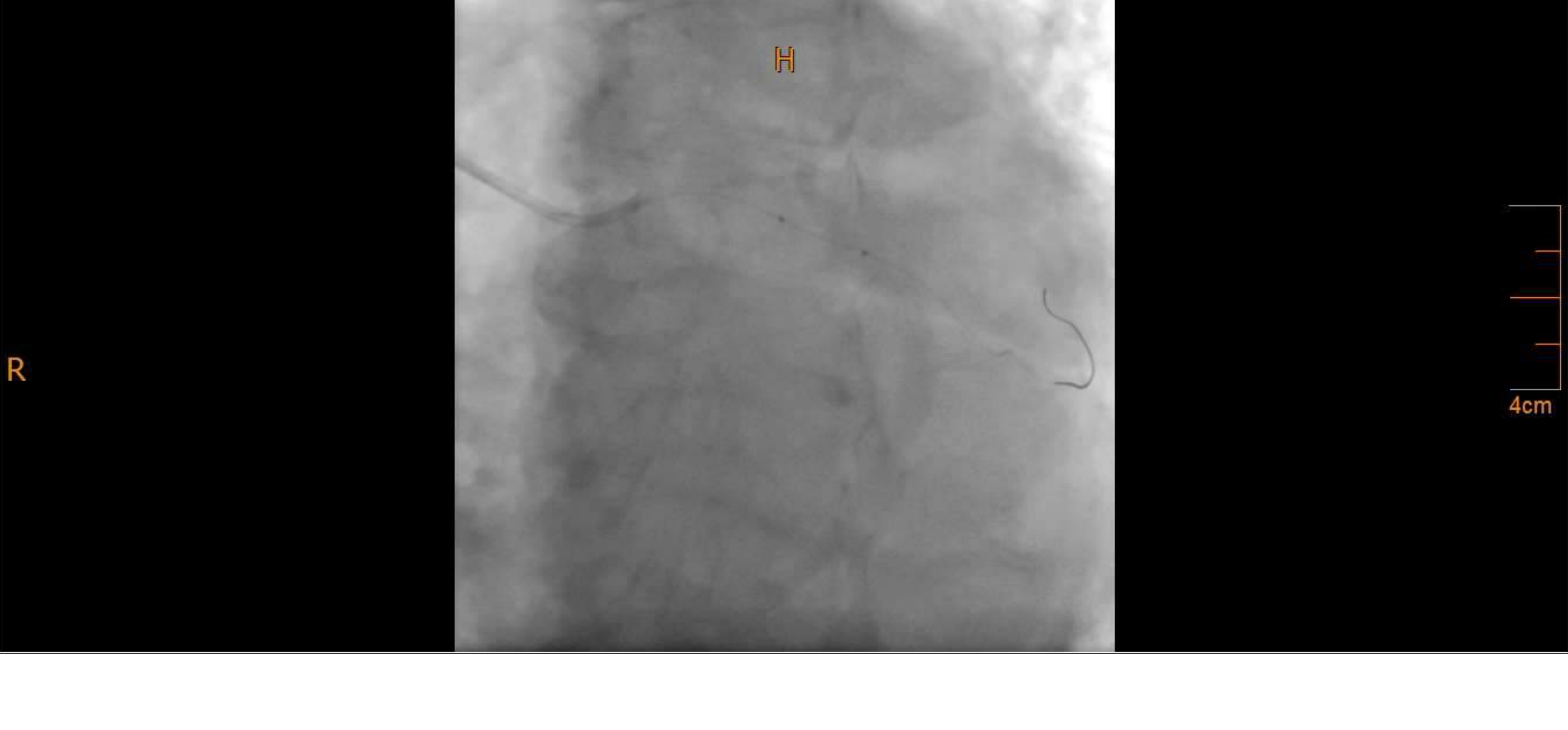
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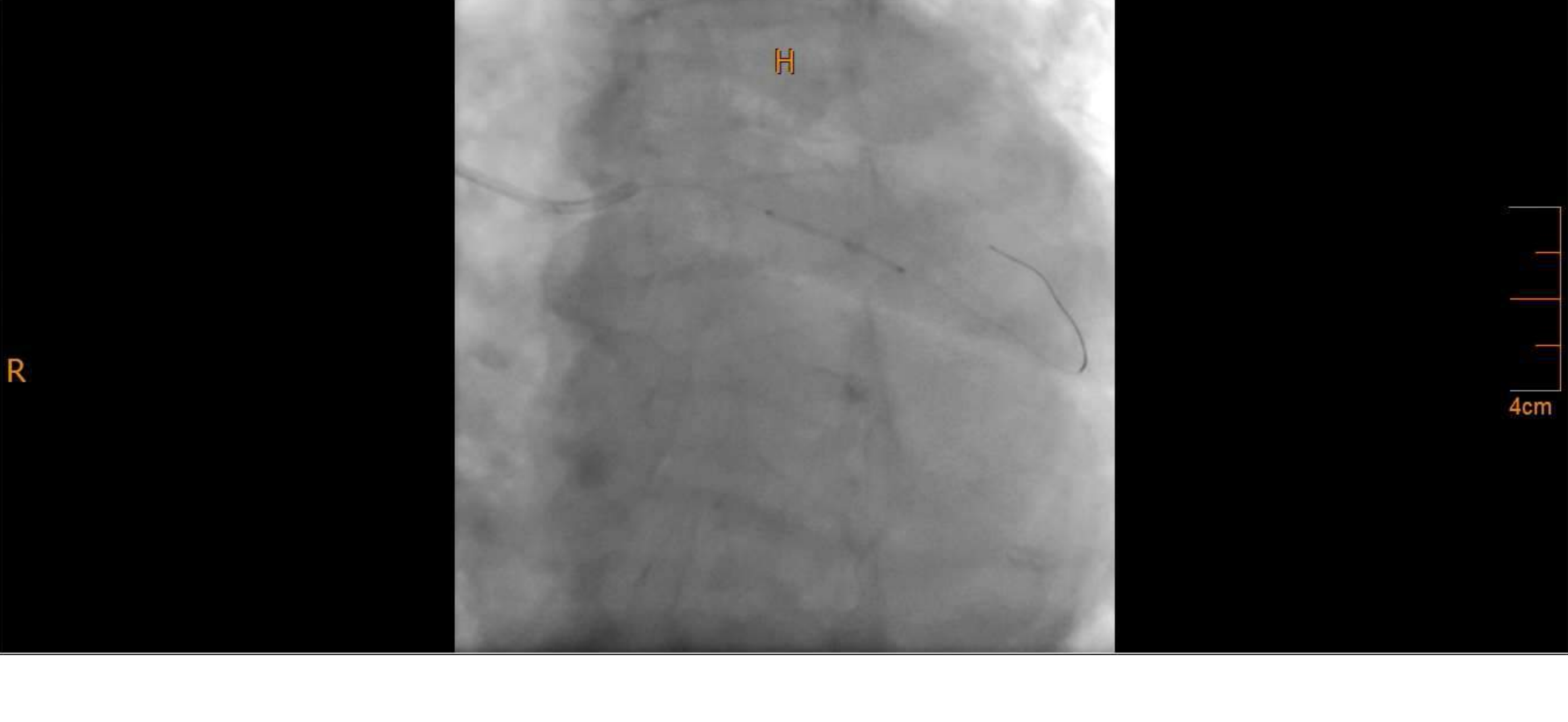
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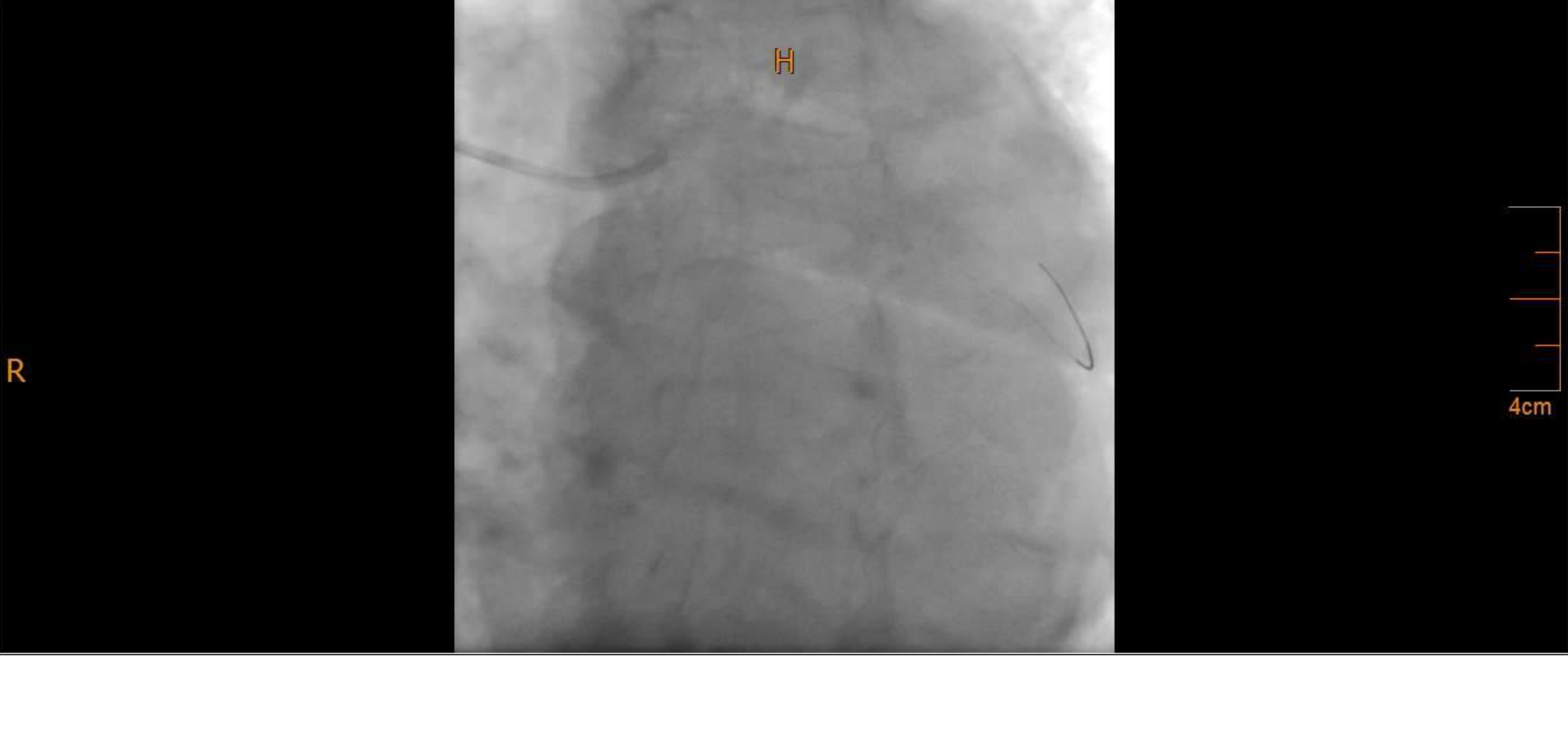
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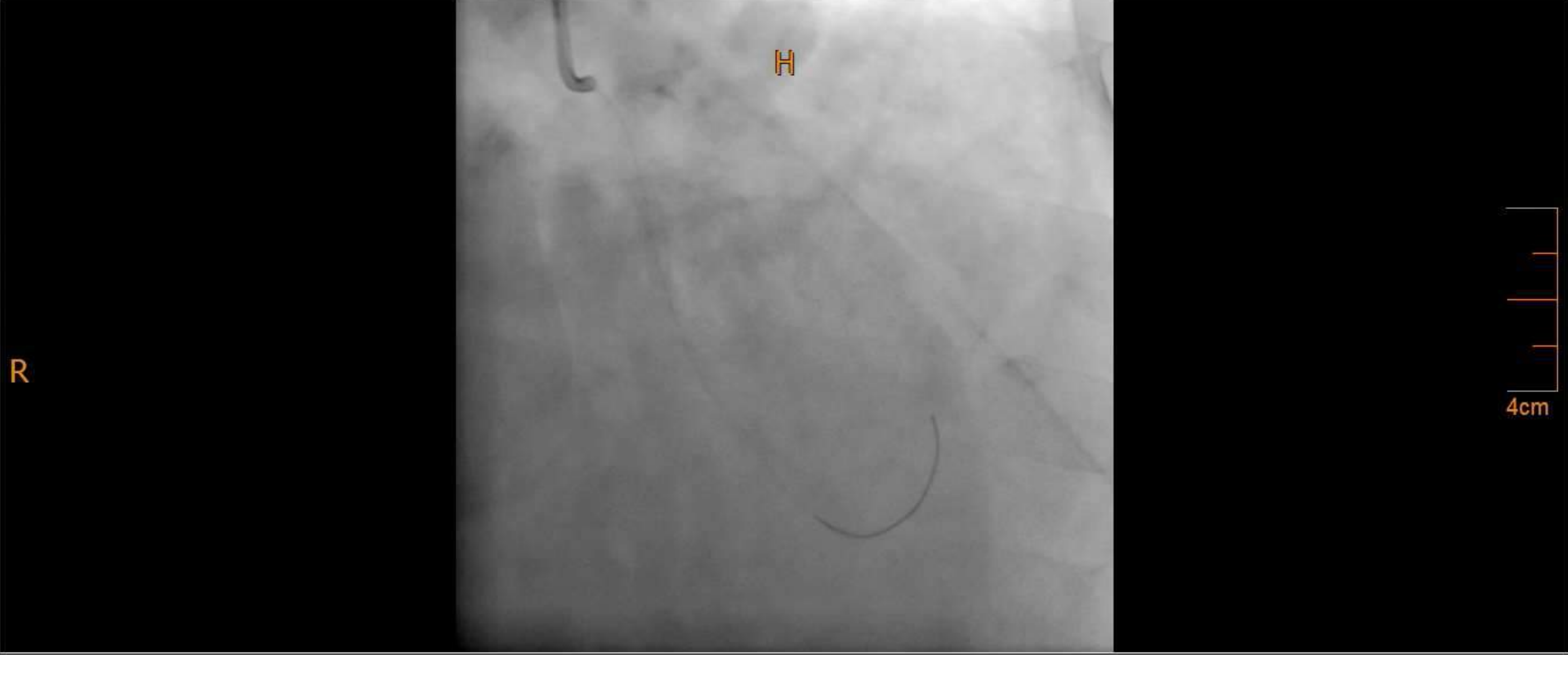
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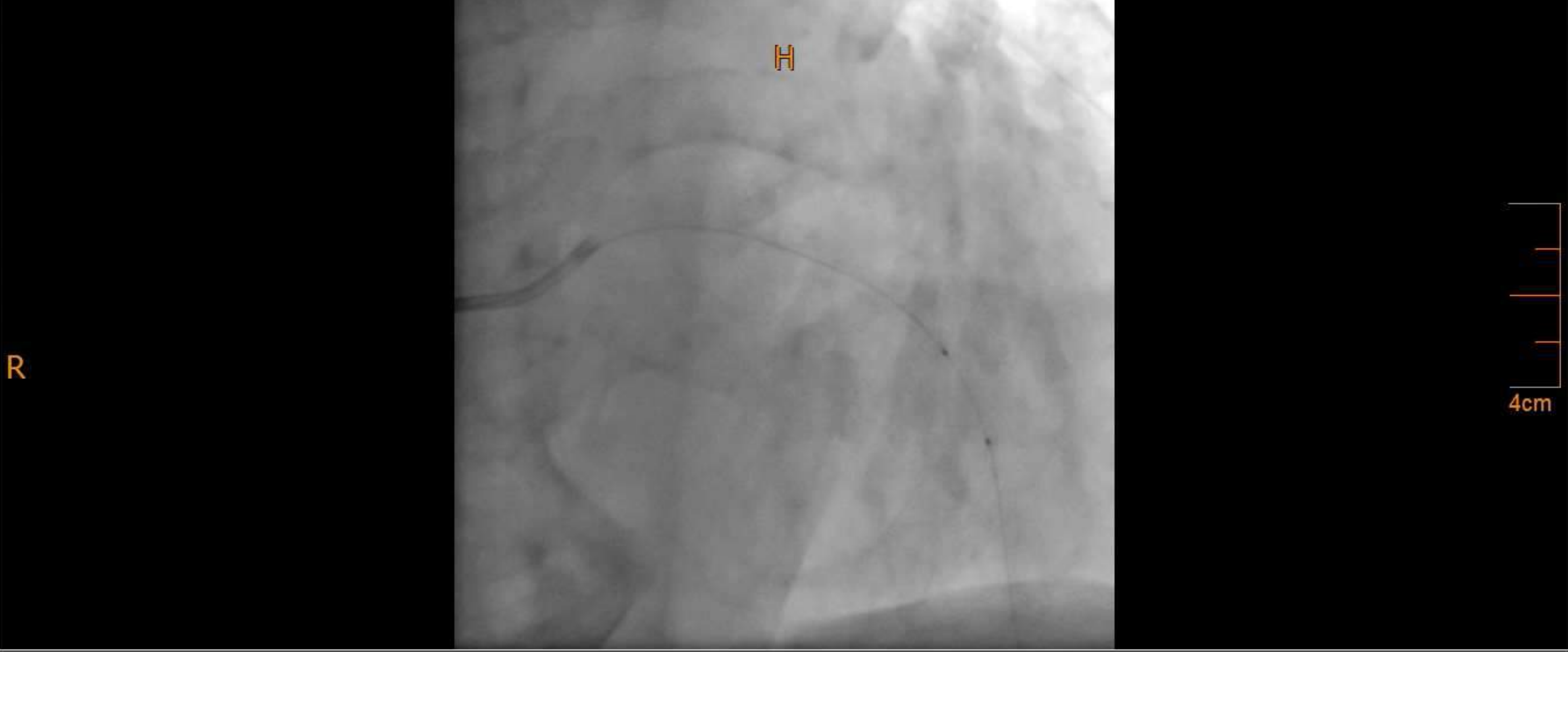
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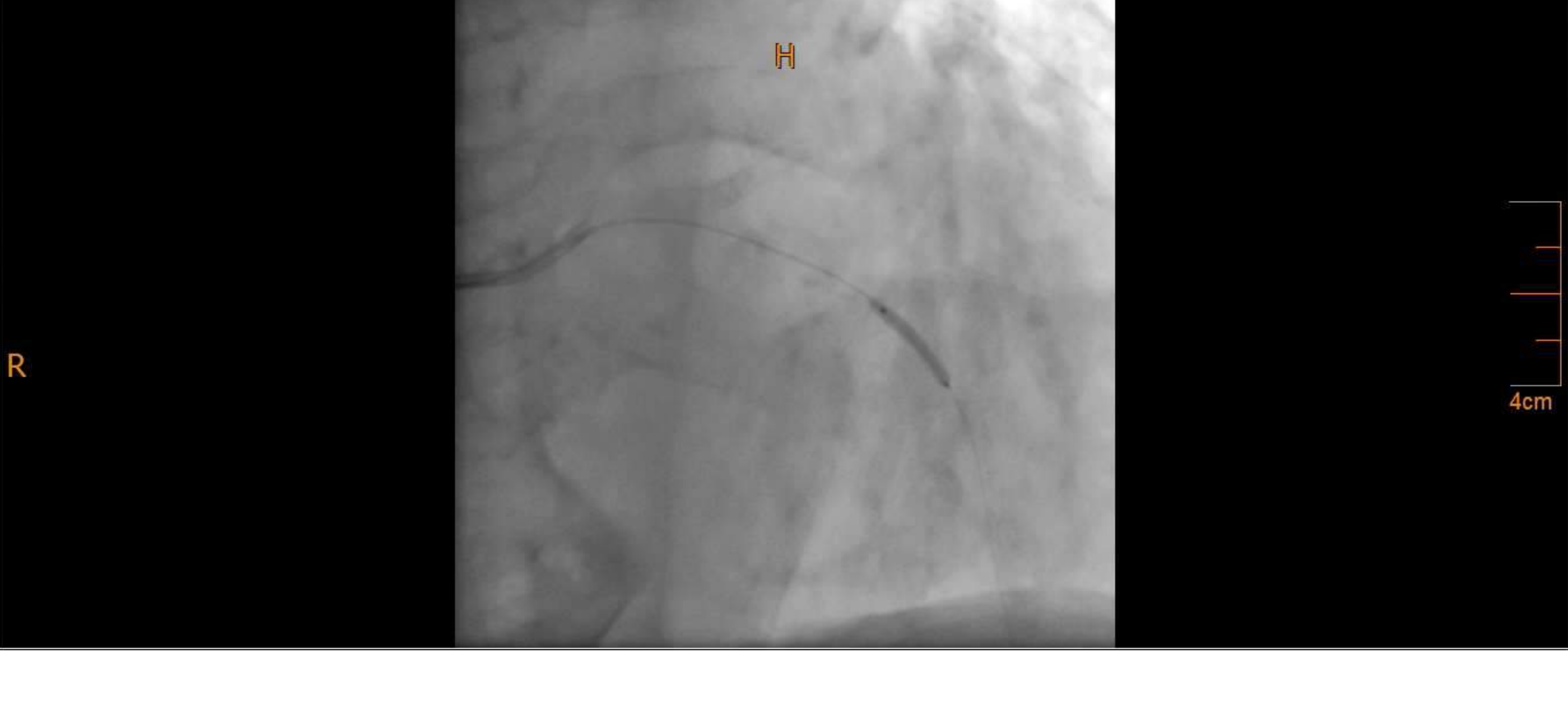
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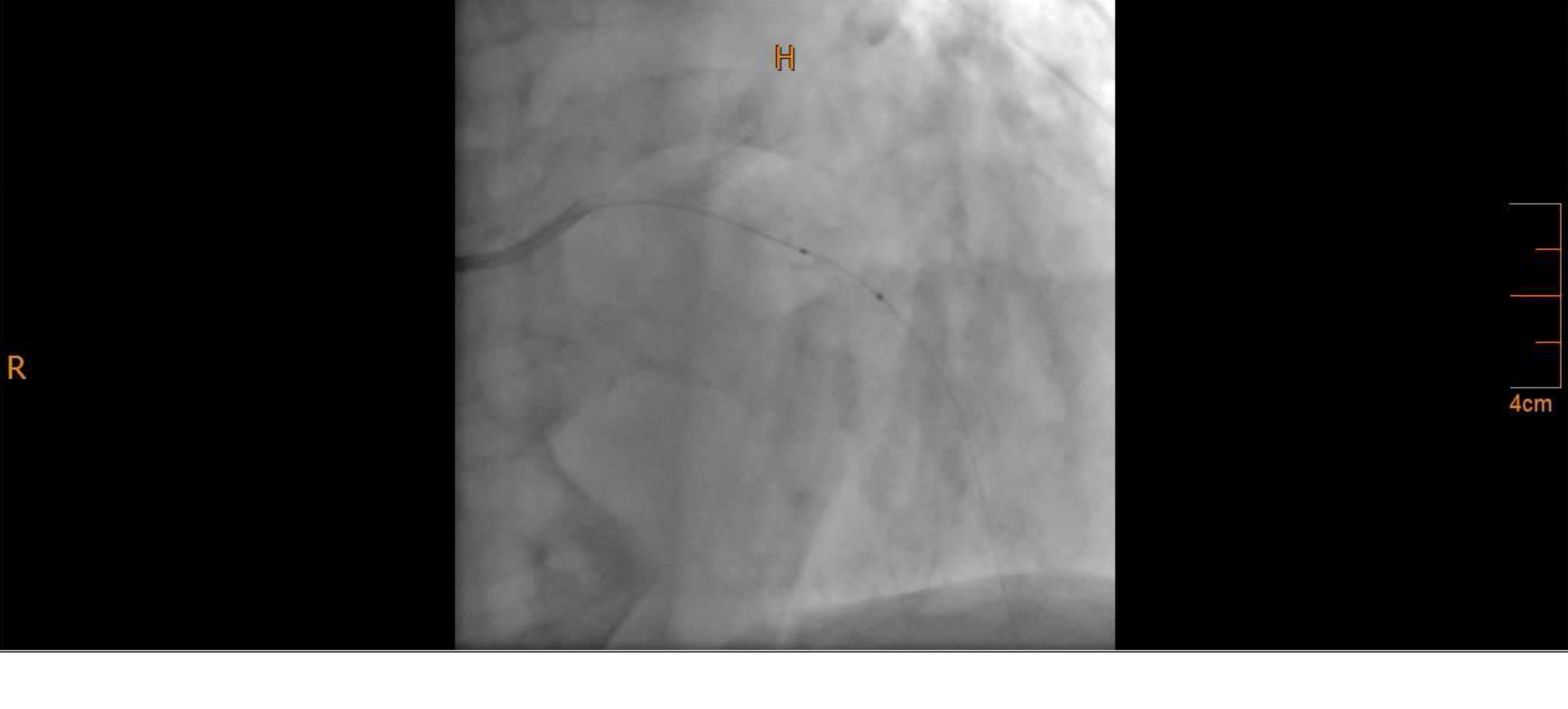

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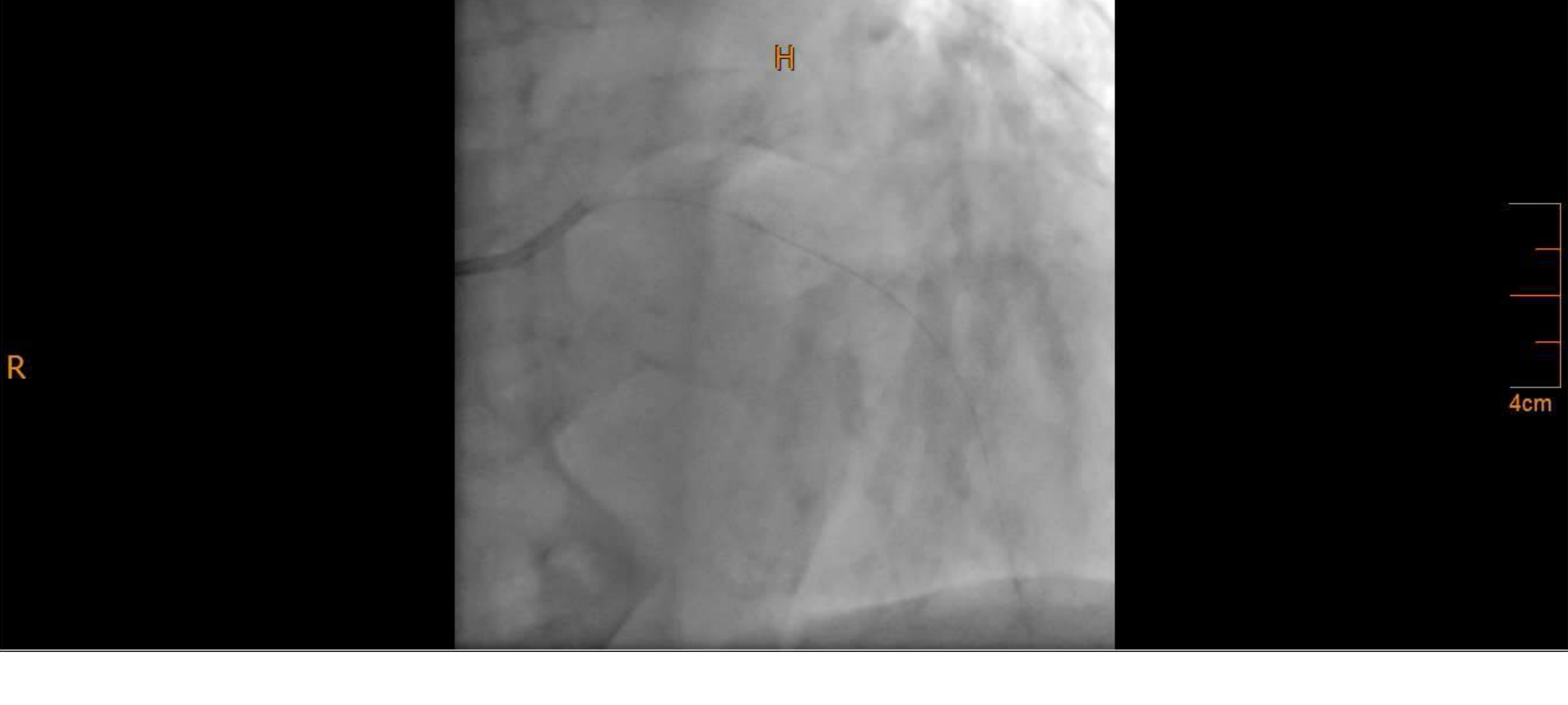
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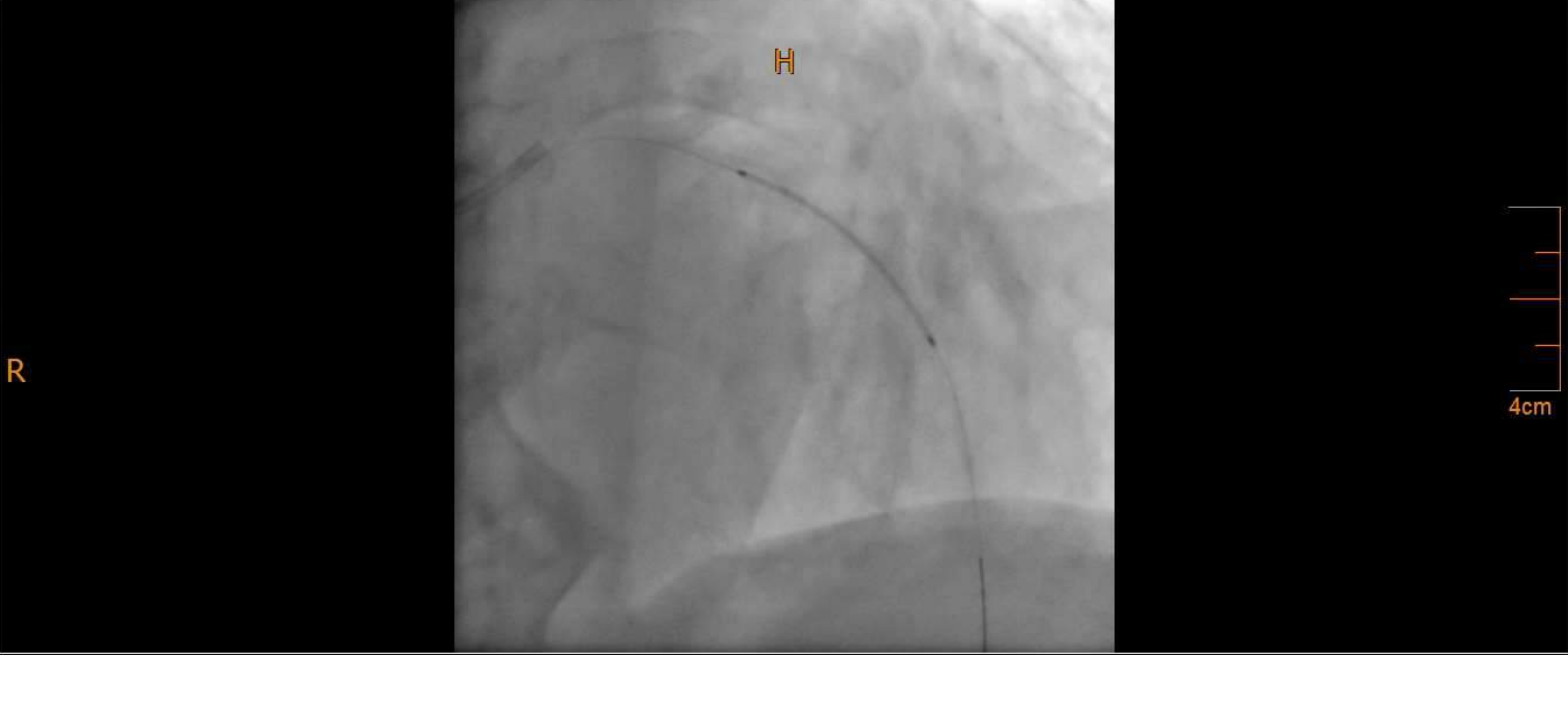
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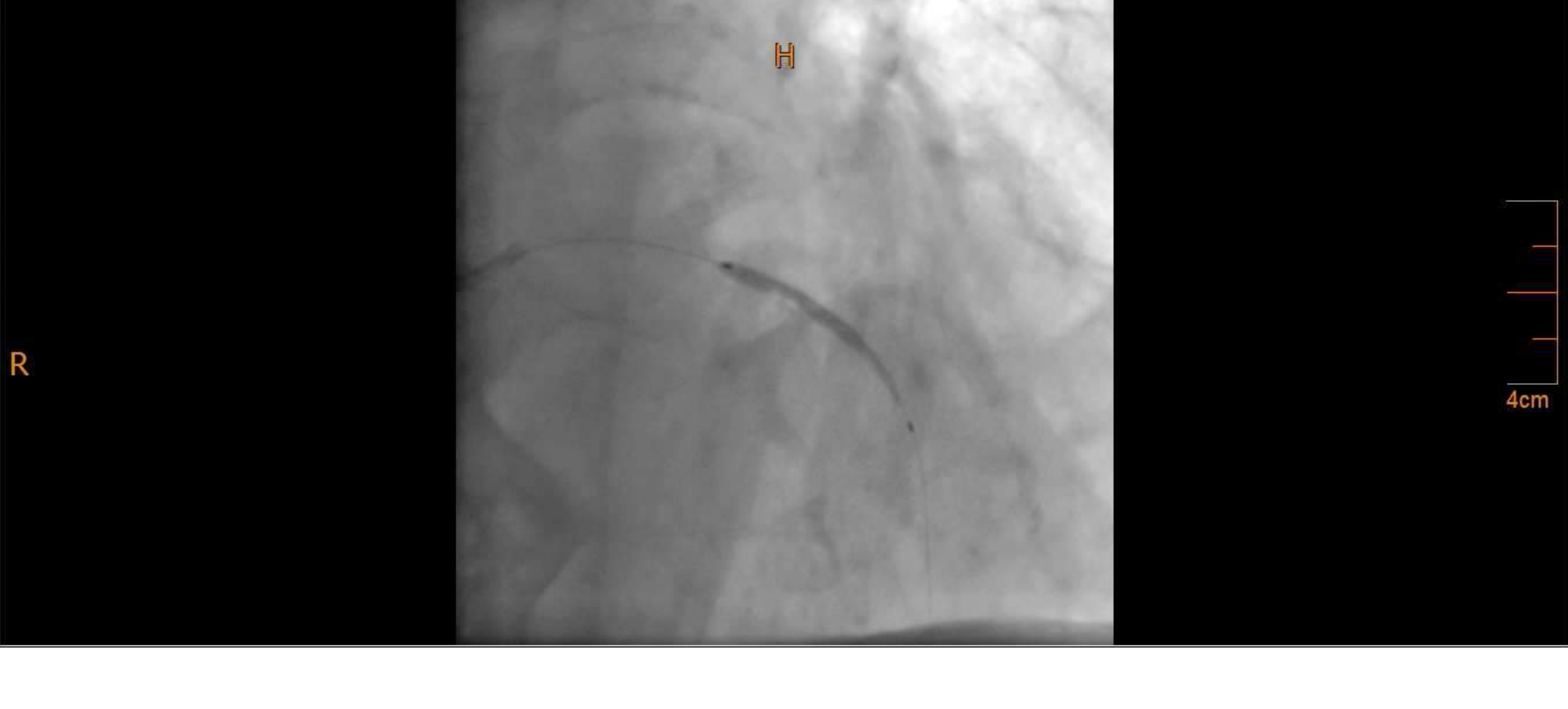
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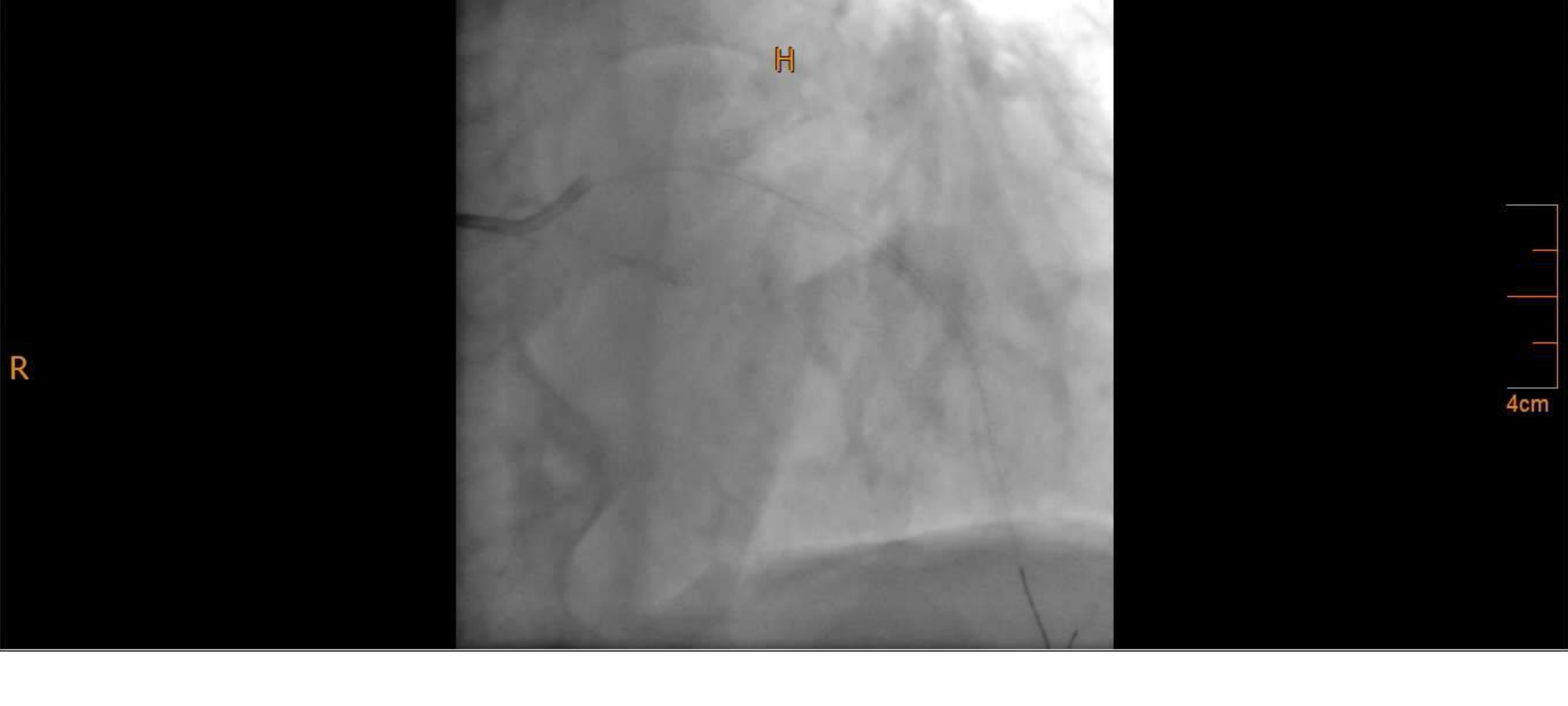
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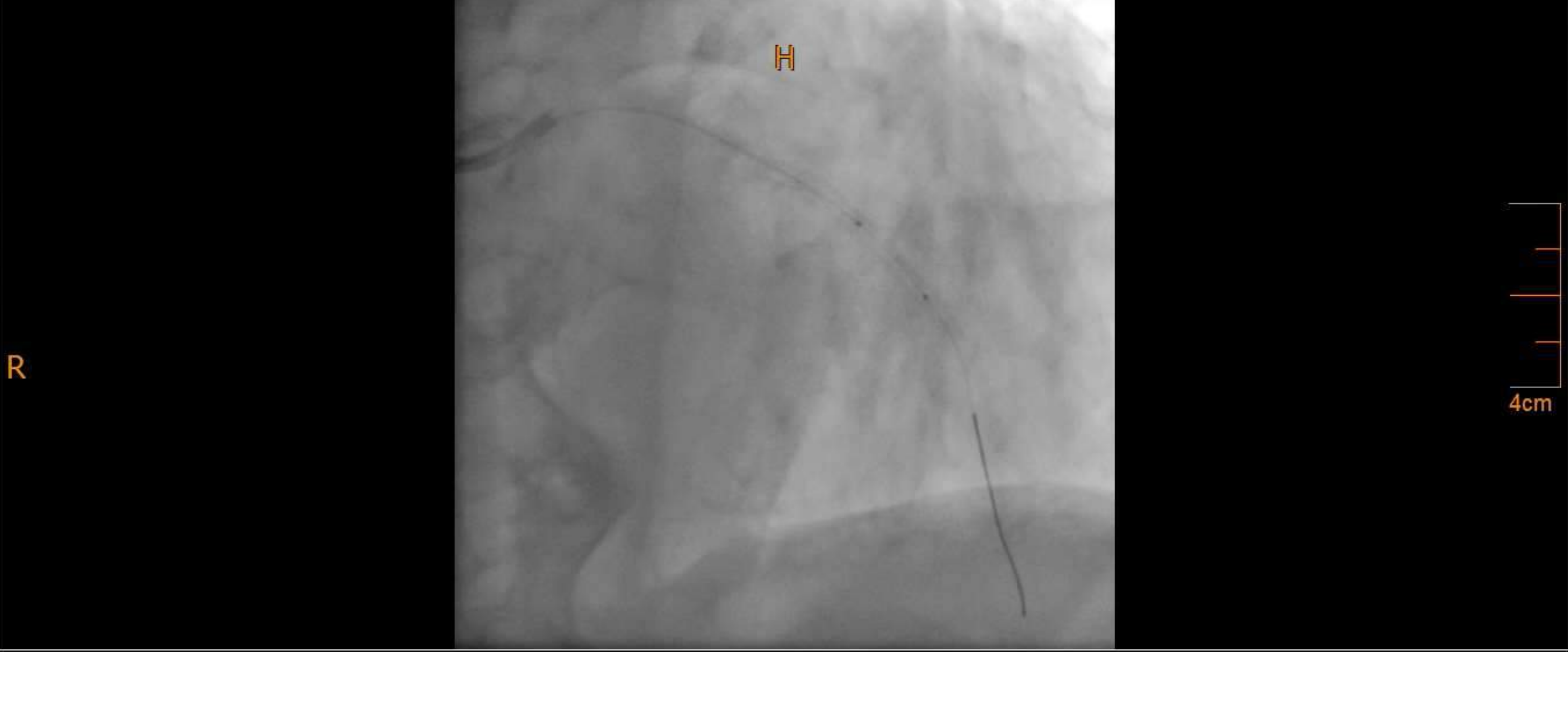
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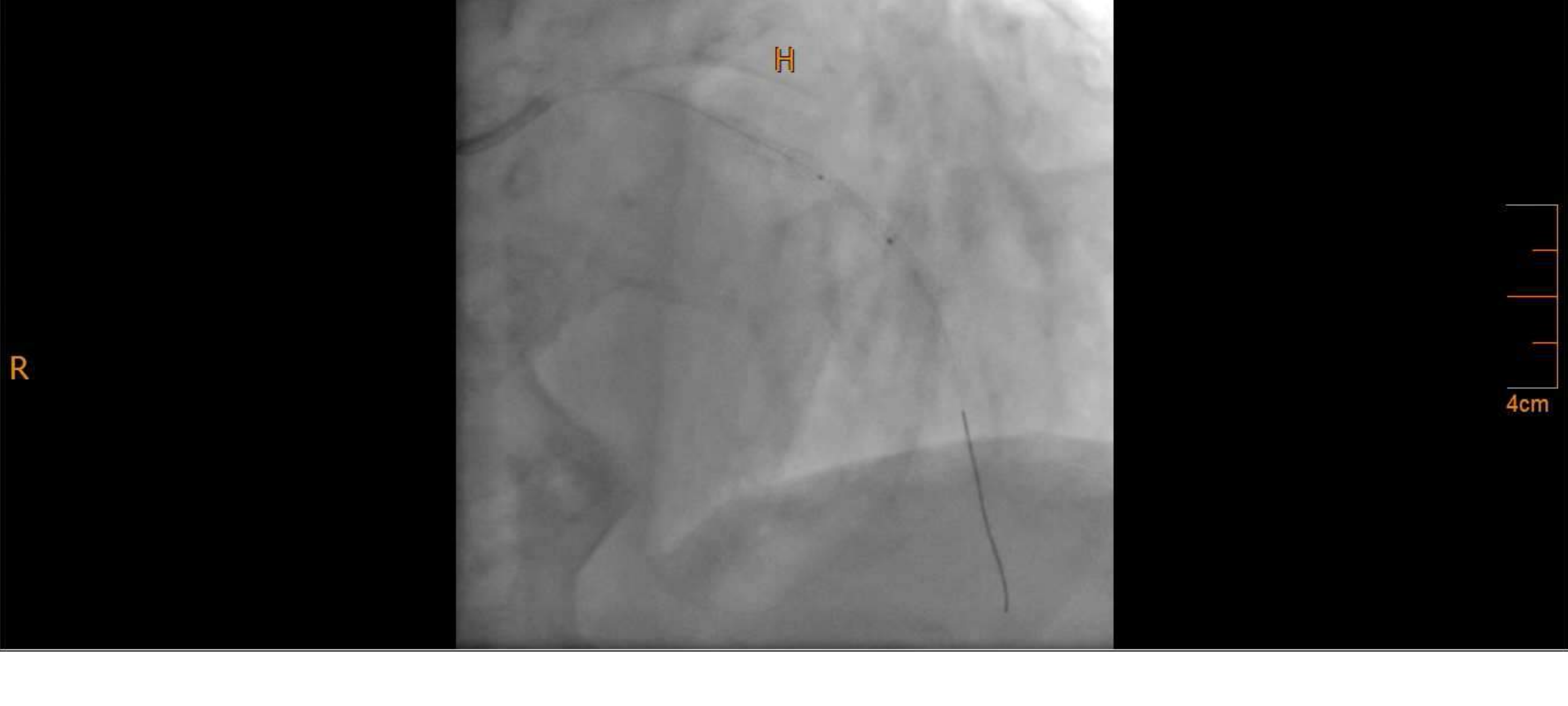
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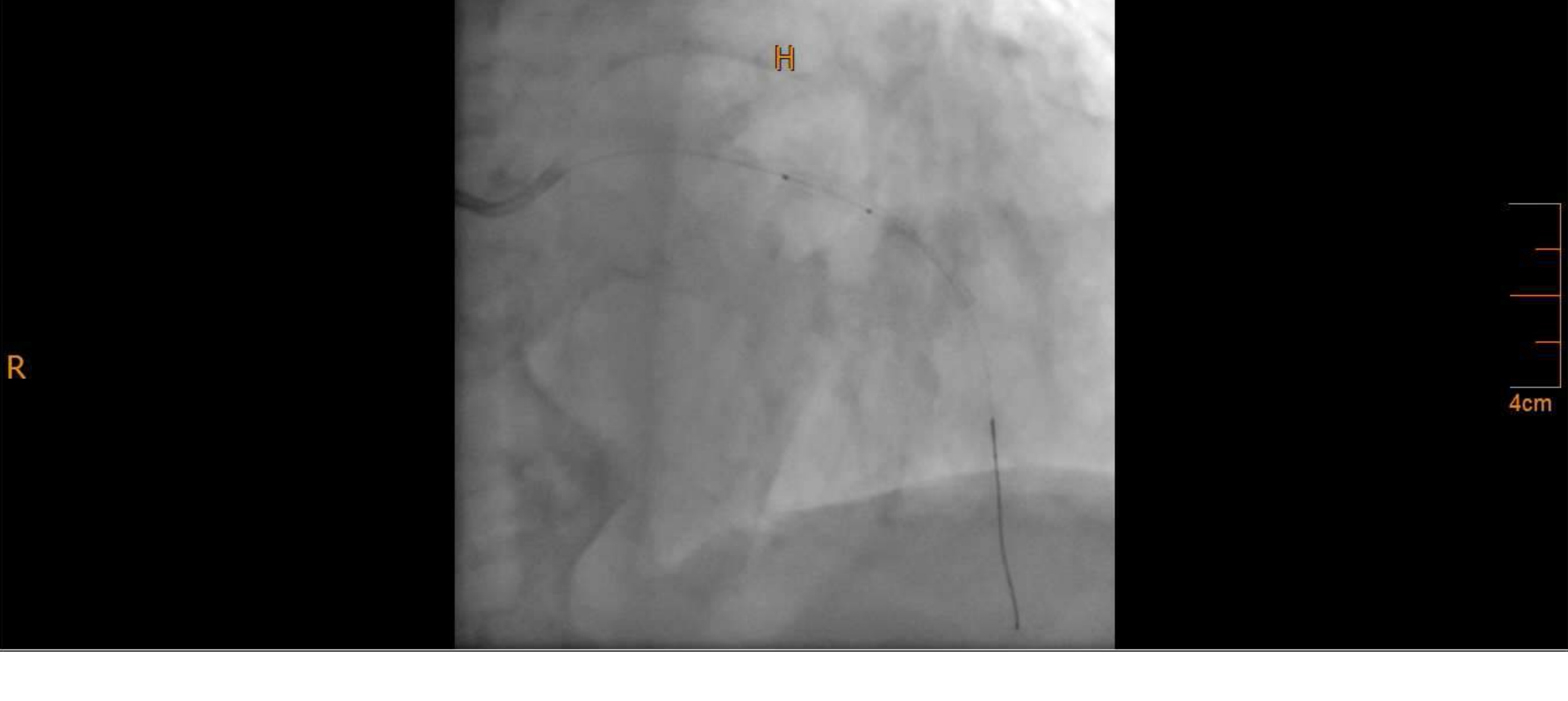
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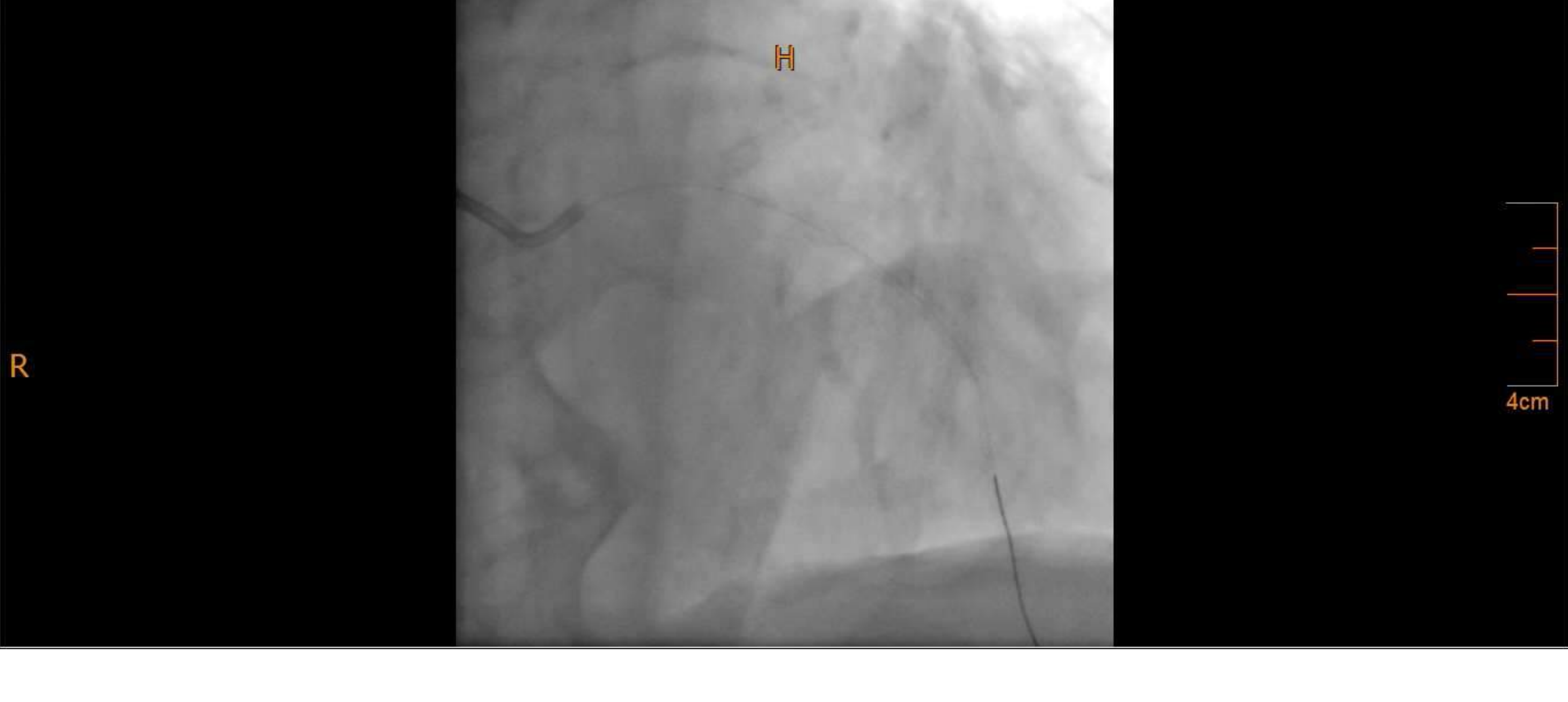
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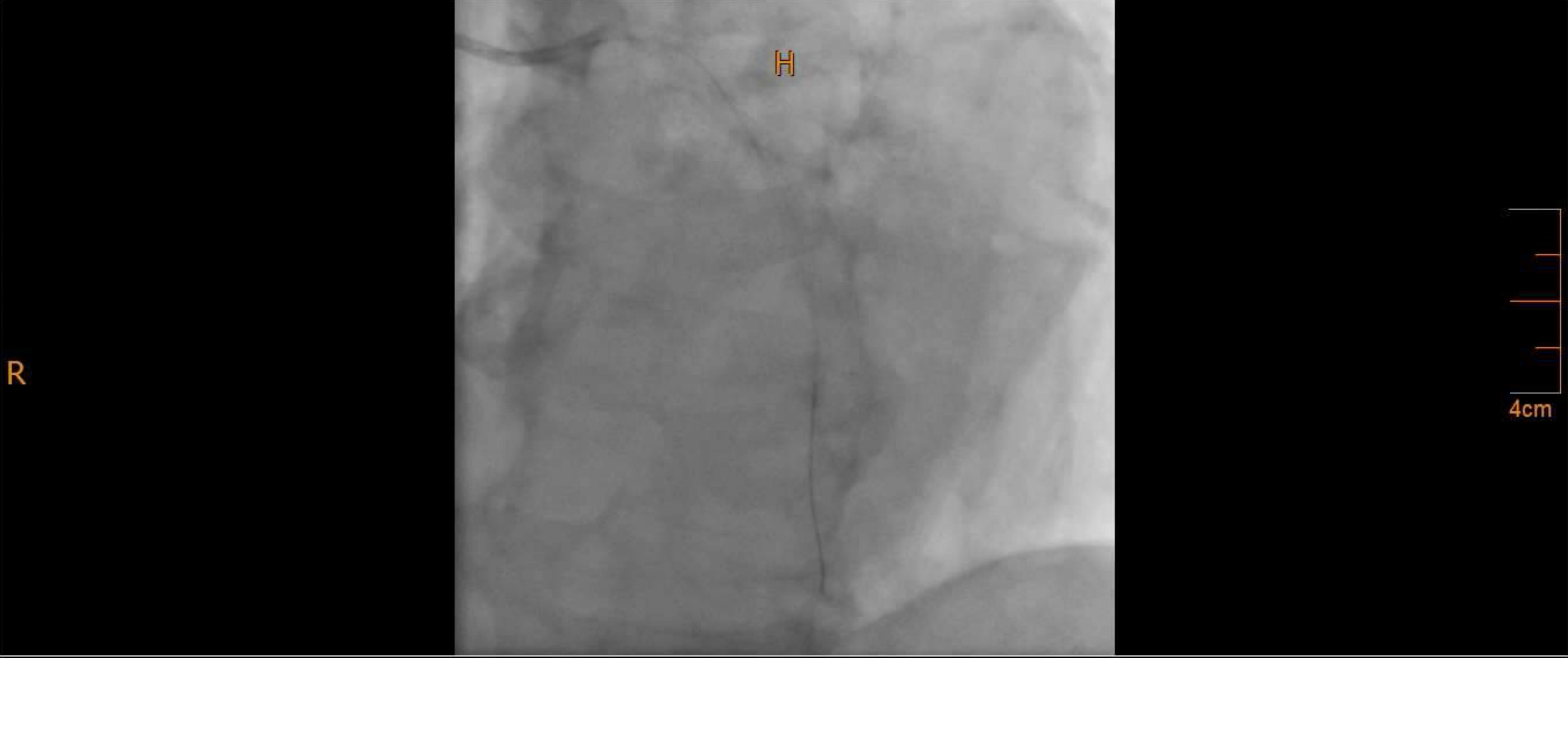

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- Taburcu olduktan sonra

  - 23.07.2022 …… Diş implant girişimi sonrası, çenedeki abse için seftriakson tedavisi sonrası anaflaksi bulguları ile yatış
  - 30.03.2023 …… Lomber spinal stenoz ve ve herni problemlerine yönelik operasyon
  - Şu anda kardiyak sorunu yok.
  - Son aylarda ortaya çıkan yaygın ödem, poliserözit nedeniyle VATS uygulandı, malignite yok.
  - Anti-Scl 70 ve ANA 1/100-1/320 (benekli) pozitifliği bulgularıyla romatoloji bölümünce araştırılmakta……