Radial Arteriovenous Fistula after Coronary Angiography
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Introduction: Transradial approach for Coronary angiography has become an increasingly popular technique since it was first introduced in 1989. Because of fewer vascular access complications and a shorter length of hospital stay, use of transradial approach is getting more popularity. We report an extremely rare case of delayed radial arteriovenous fistula formation, 3 months after transradial coronary angiography, which was treated successfully with surgical repair. Case report: A 67-year-old man presented chest pain. He underwent diagnostic coronary angiography via right radial artery, and it was found that he didn’t have coronary artery atherosclerosis. He was discharged one day after the procedure. About 3 months after the day of the diagnostic coronary angiography, he complained of a swishing sensation on the right wrist at the outpatient clinic. An upper extremity angiography revealed arteriovenous fistula between the right radial artery and the adjacent cephalic vein around the right wrist. He was referred to a vascular surgeon and received surgical ligation of the arteriovenous fistula. Discussions: Arteriovenous fistula after transradial approach is an extremely rare complication because of the absence of large veins near the radial artery. Since first noticed in 2005, a few cases were demonstrated to have arteriovenous fistula formation after transradial approach. In this case, upper extremity angiography was performed for diagnosis of AVF formation and surgical repair was done without any complication.

Recurrent Stent Thrombosis developed using of Novel ADP Receptor Antagonist
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Stent thrombosis (ST) is a rare but fatal complication after drug-eluting stent (DES) implantation. The new ADP (Adenosine diphosphate) inhibitors have been reported to improve cardiovascular outcomes including ST. We report this case because ST developed three times despite use of new ADP inhibitor. In January 2005, a 61-year-old male with stable angina received PCI (percutaneous coronary intervention) for proximal LAD (left anterior descending artery) (Fig. 1A, B). He was loss to follow up after 6 month. In September 2012, he presented with anterior STEMI (ST elevation myocardial infarction) and cardiogenic shock by ST on LAD. ECMO (extracorporeal membrane oxygenation) and PCI was performed. (Fig. 2A, B). He was discharged with aspirin and prasugrel. After 7 month, he didn’t take an aspirin incidentally for 2 months. In July 2013, he presented with anterior STEMI by second ST in LAD. IABP (Intraaortic balloon pump) was applied and PCI was performed. In the same time, proximal LCX (left circumflex artery) showed 80% stenosis and PCI was done (Fig. 3A, B). He was discharged switched over from prasugrel to ticagrelor. In November 2013, he presented with STEMI by third ST in LAD (Fig. 4A). Cardiac arrest occurred after stenting of LAD by dissection of LCX and ECMO was applied. LCX was treated with PCI (Fig. 4B, C). He was discharged with aspirin, prasugrel and cilostazol. Triple antiplatelet therapy with new ADP inhibitor might be considered with recurrent ST.