Nightmares are not only in cath. labs

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History

FM Female patient

74 years old

Known to be hypertensive

diabetic on oral hypoglycemic

IHD (PCI IN 2003)with BMS

History of present illness

This patient was presented with recurrent attacks of typial chest pain and dyspnea which persist inspite of intensive medical treatment

ECG : showed non specific changes

Echocardiography : Normal LV cavity size with EF52%.

No resting SWMA .

CT coronary Angio was done revealing significant proximal LAD lesion with patent stent to OM

The decision taken to do coronary angiography for PCI to LAD

The patient was discharged one day after on DAPT, Bblocker, statin , nitrate,with no chest pain ordyspnea.

Echo was the same .

ECG within normal

2 days later

The Pt was presented with dehydration,hyperglycemia ;anemia, abdominal pain and acute kidney injury (rise of S. creatinin from 1.6 to 2.2 and oligourea)

Patient admitted to ICU and received medical treatment in form of fluids , insulin infusion and patient received one unit of packed RBCs

The day after admission

Urine output reaches normal range, and blood sugar controlled , but abdominal pain persist with 2 attacks of melena.

Surgical consultation was done with surgeon decision of outpatient ttt with PPI infusion.

Patient referred for GIT and surgical consultation

Patient underwent surgical abdominal exploration which

Rintestinal obstruction due to intracavitary lymphoma

One day after severe abdominal pain and vomiting .

Again surgical consultation.

Intestinal obstruction For exploration.

What to do??????

Now we have a patient with PCI 4 days ago , with abd. Exploration, anemic,

Q1 What about bleeding risk?

Q2 How we can deal with antiplatlet and antithrombotic agents ?