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Conclusions. PCI in acute setting as in STEMI there could be high thrombus load in IRA. Stenting in such scenarios would cause the thrombus to migrate proximally or distally leading to slow-flow/no-flow phenomenon, which in turn leads to high mortality. Deferred stenting is preferred strategy in high thrombus burden IRA. By deferring stenting along with parenteral anticoagulant, it allows gradual resorption of thrombus, improvement in TIMI flow to distal vessels and lesser incidence of slow-flow/no-flow phenomenon. The ideal time for deferment is still debatable, ranging from 48-72 hours up till 7 days. Longer deferral time gives more time for thrombus resorption, but it is not practical with longer hospitalization.

TCTAP C-012
Stormy Primary Percutaneous Coronary Intervention During COVID-19 Pandemic
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CLINICAL INFORMATION
Patient Initials or Identifier Number. TPS HK
Relevant Clinical History and Physical Exam. 85-year-old patient with underlying hypertension, dyslipidemia presented with chest pain for 2 days duration, radiating to left shoulder with shortness of breath to our emergency department. Blood pressure was 130/80 mmHg with heart rate of 80bpm. There was no murmur and lungs showed bibasal crepitation.

Relevant Test Results Prior to Catheterization. Electrocardiogram at emergency department showed ST elevation at anterolateral leads with ST depression at inferior leads. Patient was diagnosed with acute anterolateral ST elevation myocardial infarction (STEMI) and catheterization lab was activated for primary percutaneous coronary intervention (PCI).

Relevant Catheterization Findings. Primary PCI team has been alerted and everyone wore full personal protection equipment as universal precaution prior to starting procedure. Vessel assessed via right femoral approach, using JR 3.5 6Fr showing mild disease at mid right coronary artery.

Left system was engaged with EBU 3.0 6Fr which showed mild disease mid to distal left main stem, mild disease mid left circumflex artery and severe stenosis proximal left anterior descending artery and ostial diagonal 1.

INTERVENTIONAL MANAGEMENT
Procedural Step. EBU 3.0 6Fr was used to engage left system. After diagnostic shots were taken, noted patient became bradycardia and subsequently asystole. Cardiopulmonary resuscitation (CPR) was started according to advanced cardiac life support. Primary PCI continued during CPR with wiring down LAD with Sion Blue wire. There was difficulty in wiring through severe stenosis at LAD and hence balloon support technique was used.

After crossing stenosis at proximal LAD, an attempt to pass Thrombuster but failed. Stenotic lesion at proximal LAD was balloon using Sapphire 2.5x15 mm and then 3.0x15 mm. Post-balloon
dilatation. Thrombuster able to pass through but only noted minimal thrombus after suction.

Runthrough floppy was wired to diagonal 1 and subsequently stented with Xience Sierra 3.0x30 mm. Stent was post dilated with Sapphire non-compliance balloon 3.5x15 mm.

During PCI, patient was intubated by anesthesiology team and CPR continued. Return of spontaneous circulation (ROSC) attained post PCI and patient was sent to coronary care unit (CCU) for close monitoring.

Conclusions. Primary PCI during COVID-19 pandemic is challenging with full PPE. PCI during CPR is technically challenging as well but it is possible with experienced operator. We should not give up easily during procedure but to try our best in giving the best care to our patients during COVID-19 pandemic.

TCTAP C-013
Successful Emergency PCI in a Case With Severely Angulated Left Anterior Descending Artery Using S-Shaped Wire
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CLINICAL INFORMATION
Patient Initials or Identifier Number. ZLZ
Relevant Clinical History and Physical Exam. A 55-year-old woman with severe chest pain for 5 hours visited the emergency department of our hospital. The pain was squeezing and radiated to her left arm. She had a history of hypertension for 5 years and no other comorbidities. She presented diaphoretic and weakness with blood pressure of 165/101 mmHg, pulse 84 bpm, respiratory rate 21, and body temperature 36.1°C. Physical examination showed no significant findings.

Relevant Test Results Prior to Catheterization. The electrocardiography showed sinus rhythm with elevation of J point and-segment on leads V1-V5. Laboratory tests came out with significantly raised high-sensitivity cardiac troponin-I level of 100 ng/ml. The patient was diagnosed with acute myocardial infarction (AMI) and was given a loading dose of aspirin 300 mg and ticagrelor 180 mg. She was immediately transferred to our catheter lab for emergency coronary angiography (CAG).