eComment: Complications of late thrombolytic therapy in the elderly
Murat Ugurlucan, Murat Basaran, Nuri Kurtoglu and Melih H. Us
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eComment: Complications of late thrombolytic therapy in the elderly

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We read with great interest the article by Firstenberg et al. [1] presenting a case of post-myocardial infarction (MI) ventricular septal defect (VSD) and intracranial hemorrhage following thrombolytic therapy after acute stent occlusion. We would like to comment the authors’ article with our modest experience of similar complications.

Myocardial or aortic rupture, aortic dissection, intracranial hemorrhage, or even splenic rupture are potential fatal complications of thrombolytic therapy following acute myocardial infarction. They usually occur in elderly (>65 years of age), moderate body weight (<70 kg) female subjects. Hypertension at presentation and usage of tissue plasminogen activator (t-PA) rather than streptokinase have shown to be additional risk factors. Of the most important, timing of the lytic therapy is accepted as the critical factor for post-MI VSD and intracranial bleeding. Initiation of the therapy beyond 12 h following the onset of MI is a major risk. Although the mechanism behind such complications following thrombolytic agents is not clear, it is suggested that recanalization with medical thrombolysis may lead to microvascular hemorrhage, interstitial edema and contraction band necrosis as well as to a decrease in fibrinogen and elongated partial thromboplastin times especially with the usage of t-PA [2–4].

At our institution, we have been faced with one post-MI VSD and another intracranial bleeding in two female patients aged 74 and 78 years who underwent thrombolytic therapy at 12 and 18 h of the onset of symptoms for the left anterior descending coronary artery occlusion related acute MI. Both patients were managed accordingly and successfully (unpublished data).

In order to better study the risks of such complications, it would be more appropriate if the authors could give detailed information about the blood pressure of the patient on admission and at the time of the intervention. Additionally, what was the time interval between the diagnosis and the initiation of the thrombolytic therapy?

We would like to congratulate the authors for their successful management [1] in such a challenging case.

References


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