Question 53
Which one of the following interventions is most beneficial for improving prognosis in patients with cardiogenic shock complicating myocardial infarction with acute ST elevation

A. Infusion of intravenous adrenergic agent
B. Early coronary revascularization
C. Insertion of a Swan-Ganz catheter to monitor therapy
D. Intra-aortic balloon counter pulsation
E. Administration of intravenous heparin

Fibrinolysis not appropriate therapy in cardiogenic shock so E wrong

Guidelines for the management of acute coronary syndromes 2006

Management of STEMI
Reperfusion therapy
Reperfusion may be obtained with fibrinolytic therapy or PCI. A combination of fibrinolysis and PCI may also be used (facilitated or rescue PCI). Coronary artery bypass graft (CABG) surgery may occasionally be more appropriate — particularly in patients who have suitable anatomy and are not candidates for fibrinolysis or PCI. CABG surgery may also be considered in patients with cardiogenic shock 19 or in association with mechanical repair.12


9.2.4. ST-Segment Elevation MI (STEMI)
Class I
1. Emergency or urgent CABG in patients with STEMI should be undertaken in the following circumstances:
   a. Failed angioplasty with persistent pain or hemodynamic instability in patients with coronary anatomy suitable for surgery. (Level of Evidence: B)
   b. Persistent or recurrent ischemia refractory to medical therapy in patients who have coronary anatomy suitable for surgery, who have a significant area of myocardium at risk, and who are not candidates for PCI (Level of Evidence: B)
   c. At the time of surgical repair of postinfarction ventricular septal rupture or mitral valve insufficiency. (Level of Evidence: B)
   d. Cardiogenic shock in patients less than 75 years old with ST-segment elevation or left bundle-branch block or posterior MI who develop shock within 36 hours of MI and are suitable for revascularization that can be performed within 18 hours of shock, unless further support is futile because of the patient’s wishes or contraindications/unsuitability for further invasive care. (Level of Evidence: A)
   e. Life-threatening ventricular arrhythmias in the presence of greater than or equal to 50% left main stenosis and/or triple-vessel disease. (Level of Evidence: B)
Class Ila
1. CABG may be performed as primary reperfusion in patients who have suitable anatomy and who are not candidates for or who have had failed fibrinolysis/ PCI and who are not in the early hours (6 to 12 hours) of evolving STEMI (Level of Evidence: B)
2. In patients who have had an ST-segment elevation MI or non–ST-segment elevation MI, CABG mortality is elevated for the first 3 to 7 days after infarction, and the benefit of revascularization must be balanced against this increased risk. Beyond 7 days after infarction, the criteria for revascularization described in previous sections are applicable. (Level of Evidence: B)
Year 2003 Paper one: Questions supplied by Tricia

*Class III*

1. Emergency CABG should not be performed in patients with persistent angina and a small area of myocardium at risk who are hemodynamically stable. (*Level of Evidence: C*)

2. Emergency CABG should not be performed in patients with successful epicardial reperfusion but unsuccessful microvascular reperfusion. (*Level of Evidence: C*)