SOLACI SOCIME'25
MEXICO CITY

CATHETER-DIRECTED THROMBECTOMY FOR INTERMEDIATE-HIGH RISK BILATERAL PE

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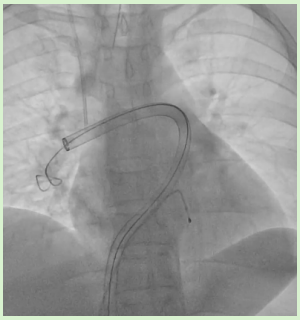
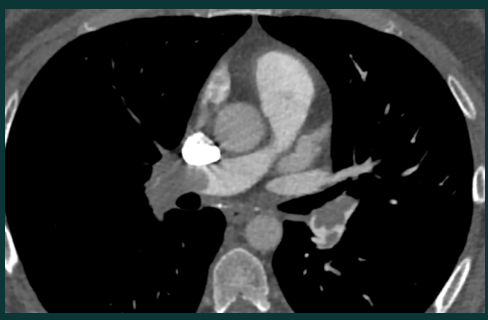
INTRODUCTION

While high-risk PE mortality remains concerning, LBMT offers:
RV recovery within 24h (PASP↓18mmHg)
4x lower ICH risk vs thrombolytics
50% shorter hospital stays.

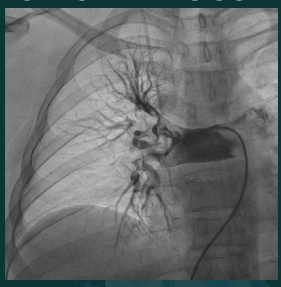


CLINICAL CASE

This 45-year-old with recent combined tibial and fibular fracture presented with sudden dyspnoea and imaging-confirmed bilateral PE—a provoked, intermediate-high risk case requiring urgent tertiary care. Clinical decline with: Hemodynamic collapse, biomarker surge (BNP/troponin,) echo-confirmed RV failure PSAP 54 mmHg, Urgent thrombectomy approved by Heart Team." CT Pulmonary angiography (CTPA) bilateral pulmonary embolism.



PULMONAR ANGIOGRAPHY



Angiogram confirms bilateral PE with:
Right: Segmental thrombus extending to RLL/RML
Left: Lobar thrombus with distal intrasegmental propagation

MECHANICAL THROMBECTOMY

A 24-mm mechanical thrombectomy catheter was employed, successfully extracting a high thrombus burden. The patient subsequently exhibited clinical improvement. At 72 hours, transthoracic echocardiography (TTE) revealed normalization of right ventricular diameters, resolution of failure signs, and a pulmonary systolic artery pressure (PSAP) of 28 mmHg.

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