A 63-year-old man was admitted to our emergency department with an episode of sudden cardiopulmonary arrest attributable to ventricular fibrillation (Figure 1). Before admission, cardiopulmonary resuscitation by a bystander and emergency personnel with two 200-J direct-current shocks was conducted; thereafter, spontaneous circulation returned. The patient’s vital signs and level of consciousness were normal at admission. ECG at admission revealed a sinus rhythm with ST elevation in leads aVR and V1, and ST depression in leads II, III, aVF, and V3 through 6. Echocardiography showed reduced left ventricular wall motion from the antero-septal wall to the apex. Moreover, emergency coronary angiography demonstrated 99% stenosis of segment 6; thus, bare metal stent implantation was performed (Figure 2). After the patient was transferred to the hospital ward, his blood pressure suddenly decreased and he developed a state of shock. Ultrasonography showed a collapsed inferior vena cava, fluid accumulation in front of the liver, and no change in left ventricular wall motion. Therefore, rapid transfusion of normal saline and red blood cells was conducted. Contrast-enhanced computed tomography revealed significant intra-abdominal hematoma, left-lobe liver injury, and active bleeding from the left hepatic artery (Figure 3A and 3B). Hence, we continuously performed transcatheter arterial embolization at the left hepatic artery (Figure 3C and 3D). After embolization, the patient’s blood pressure suddenly recovered to a normal level. There was no evidence of abdominal bruising based on the information from a colleague, and cardiac compression was strongly suspected as the cause of the liver injury. Serious trouble never happened during the hospitalization, and he was discharged 3 weeks after admission.

Disclosures
None.

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Shock After Successful Primary Percutaneous Coronary Intervention for Ventricular Fibrillation

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Figure 1. Ventricular fibrillation recorded on an automated external defibrillator. After the second 200-J direct-current shock (arrow), the patient recovered to sinus rhythm.

Figure 2. Left coronary arteriography from the right anterior oblique (30°) to caudal view (30°) on admission, showing 99% stenosis of LAD 6 (arrow). LAD indicates left anterior descending.
Figure 3. A, Early-phase axial contrast-enhanced computed tomography scan, showing extravasation from the left liver lobe (arrow). A large amount of intra-abdominal fluid accumulation is seen; the attenuation value of the fluid is 65 to 80 Hounsfield Units. B, Late-phase axial contrast-enhanced computed tomography scan, showing retained contrast at the anterior surface of the liver. Contrast media also are seen along the left side of the diaphragm. C, Left hepatic artery angiography. The arrow indicates the area of extravasation. D, Axial contrast-enhanced computed tomography scan after infusion of histoacryl and lipiodol at the left hepatic artery. Extravasation is not seen.
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