

Myocardial Infarction with ST Elevation

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Keywords: Arrhythmias • Ventricular tachycardia • Idioventricular rhythm

Editorial

Maintaining myocardial blood supply as soon as feasible is the most essential step in the treatment of ST elevation myocardial infarction. Thrombolytic therapy and percutaneous coronary intervention are the two most used treatments for myocardial reperfusion today. Reperfusion arrhythmias were studied to see if they were markers of coronary artery patency or if there was still ischemia following revascularization. The early trials of thrombolytic treatment guided revascularization in acute myocardial infarction used reperfusion arrhythmias. Electrocardiographic data, as well as clinical and laboratory parameters, are utilised by doctors to establish the presence of vascular patency and effective reperfusion of the myocardium following thrombolytic therapy. ST elevation, T-wave inversion, and any other arrhythmia seen on electrocardiography can all be normalised or reduced by more than 50%. Ventricular premature contractions, sustained or nonsustained episodes of ventricular tachycardia, accelerated idioventricular rhythm, atrial fibrillation, and ventricular fibrillation are the most commonly reported arrhythmias that are characterised as reperfusion arrhythmias. The presence of these arrhythmias is regarded to be a sign of effective reperfusion. Ventricular Tachycardia (VT) and Ventricular Fibrillation (VF) can occur in acute myocardial infarction due to total blockage or reperfusion. Ischemic arrhythmias are defined as arrhythmias that occur as a result of increased myocardial perfusion, whereas reperfusion arrhythmias are defined as arrhythmias that occur as a result of increased myocardial perfusion. Early reperfusion and continued arterial patency may be indicated by an accelerated idioventricular rhythm. In a previous study, the presence of accelerated idioventricular rhythm combined with normalisation of ST segments

was shown to indicate successful reperfusion in patients treated with thrombolytics, and this group of patients did not require emergency coronary angiography or rescue Percutaneous Coronary Intervention (PCI). The goal of this study is to analyse the arrhythmias recorded in the first 48 hours following different revascularization treatment modalities (thrombolysis or primary) and determine if they are markers of arterial patency or ischemia due to continued vascular occlusion. In addition, after thrombolysis and percutaneous revascularization, reperfusion arrhythmias were compared in this study. There was no significant difference in the incidence of reperfusion arrhythmias detected in the first 48 hours between the two treatment groups. At least one reperfusion arrhythmia was seen in 83.3 percent of primary PCI patients and 88.7% of thrombolytic patients. The development of AF in acute MI occurs in around 5%-10% of cases, and it is well understood that AF in acute MI is mainly caused by reduced left ventricular function or inadequate reperfusion. In patients with inadequate reperfusion, the risk of AF may rise. In this study, both groups of patients had normal left ventricular functioning. As a result, instead of decreased left ventricular functioning, residual ischemia or poor reperfusion was assumed to be the aetiology of AF. In conclusion, the frequency of reperfusion arrhythmia is not statistically different between patients treated with primary PCI and those treated with thrombolytics, despite the fact that PCI is known to improve arterial patency. AIVR may imply myocardial injury and continued ischemia rather than vascular patency, as it is now characterised as a reperfusion arrhythmia. To prove this concept, more big prospective investigations are needed.

How to cite this article: Mano likar. "Myocardial Infarction with ST Elevation." J Coron Heart Dis 5 (2021): 127.

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Received 17 September 2020; **Accepted** 24 September 2021; **Published** 29 September 2021