24th Asmiha
Annual Scientific Meeting of Indonesian Heart Association

The Current and Future Landscape of Cardiovascular Disease Management

April 10 - 12, 2015
Ritz-Carlton Hotel, Jakarta

Scientific Program:
- Workshops
- Symposiaums
- Joint Sessions
- Working Group Track
- Free Papers
- Young Investigators Award
- IHA for General Practice Physician

Accepted Abstracts will be Published at ASEAN Heart Journal

Joint Sessions:
- American College of Cardiology
- ASEAN Federation of Cardiology
- Asian Pacific Society of Cardiology
- European Society of Cardiology
WELCOME MESSAGE

Dear Colleagues and Friends,

On behalf of the Indonesian Heart Association (IHA), I am pleased to inform you that the 24th Annual Scientific Meeting of Indonesian Heart Association (the 24 ASMIHA) will take place in Jakarta, from 10-12 April 2015.

The meeting will be held in collaboration with the European Society of Cardiology (ESC), American College of Cardiology (ACC), Asian Pacific Society of Cardiology (APSC), and ASEAN Federation of Cardiology (AFC).

Our world is facing an epidemic of cardiovascular disease and in preparation for AFTA 2015, it is therefore necessary to promote in depth discussions with the theme: "The Current and Future Landscape of Cardiovascular Disease Management".

The scientific program will include lectures, debates, clinical case presentations as well as industry symposia. Experts from all over the world will discuss the latest developments of clinical trials and clinical research and its implications for daily practice. During the three days of scientific sessions, attendees will hear the latest updates on acute cardiac practice, heart failure, prevention, cardio-metabolic syndrome, surgery, interventions, and interact with colleagues from around the globe.

Delegates will have the possibility to participate in oral or poster abstract presentations and share their research and clinical projects. The meeting will also provide a unique opportunity by which our Industry Partners may network with attendees.

I encourage you to participate in this meeting. I am sure that this meeting will offer you an enjoyable scientific program and entertaining social program.

Warmest regards

Anwar Santoso, MD, PhD, FIHA
President of Indonesian Heart Association

Antonia Anna Lukito, MD, PhD, FIHA
Chairman of the 24th ASMIHA
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Acute ST-segment Elevation Myocardial Infarction (STEMI) in 25 year old Male: A Case Report

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Background: STEMI is a major cause of cardiovascular mortality worldwide. Coronary atherosclerosis begins early in life, but acute coronary syndrome in young adult uncommon. Its incidence varies from 2% to 10%.

Methods: 25 year old heavy smoker male was referred to our emergency department with continuous severe retrosternal chest pain since 17 hours with nausea and dyspnea before admission. Initial Electrocardiography (ECG) taken at a private hospital showed anterior extensive ST-segment elevation. Ticagelor 180 mg, Aspilet 160 mg, ISDN 5 mg, Ramipril 1.25 mg, and Fondaparinux 7.5 mg were given. Laboratory result showed a high haemoglobin count of 18.78 g/dl, hemocrit of 57.16% and erythrocyte of 6.96 10^6/µL suggesting polycymia. Elevated leucocyte count of 17.23 10^3/µL and cardiac enzymes (CK 2909 U/L, CK-MB 378 U/L, troponin Ths 3573 pg/mL) support the diagnosis of STEMI.

Results: Emergent coronary angiography revealed the presence of total occlusion in proximal LAD and high thrombus burden. Thrombosisuction, pharmacoinvasive (Heparin and Intergrilline) and balloon angioplasty were done resulting in TIMI 1 flow. Echocardiography three days later showed hypokinetic in anterior and apex region, decrease contractility of LV function with LVEF 45%.

Conclusion: ACS in young patients is an uncommon condition with a variety of possible aetiologies and distinct risk factors. Smoking could be the most important modifiable risk factor in young patients with STEMI. Hereditary thrombophilia may have contributed in thrombotic process.

An Omnious ECG Pattern of Harbringer of Infarction: A Case of Wellens' Syndrome

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Wellens' syndrome is a characteristic T-wave either deeply inverted or biphasic on an electrocardiogram (ECG) in a patient with intermittent chest pain. These findings reliably suggest a high-grade stenosis of the proximal left anterior descending (LAD) coronary artery.
56 year old longstanding hypertensive female present to our emergency department with intermittent stabbing chest pain radiating to the back at rest lasting around 20 – 30 minutes since three days prior admission. ECG showed biphasic t-waves in V2 and V3; ST-segment depression in V4-V6. Laboratory findings was normal except blood glucose of 287.7 mg/dl and cardiac enzymes were elevated (CK 177 U/L, CK-MB 25.4 U/L, troponin T 306.6 pg/mL).

Urgent coronary angiography showed subtotal occlusion in proximal LAD, 80% mid and 60% proximal stenosis in LCX, and less than 30% distal stenosis Left Main; diffuse proximal to mid 40-60% stenosis. Balloon angioplasty and a bare metal stent was deployed in proximal LAD resulting in TIMI 3 flow.

Wellen’s syndrome presents with characteristic EKG findings that we need to recognize due to the significant percentage of patients who will develop anterior wall myocardial infarction if aggressive intervention is not undertaken.

Incidence of Pericardial Effusion Following Myocardial Infarction as Determined by Two Dimensional Echocardiography

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Background: Pericardial effusion (PE) is not an uncommon finding in serial echocardiographic evaluation of patients with AMI, especially when infarction is anterior and extensive. In our hospital setting frequency, time course and outcome of PE after AMI are unknown. The objective of this study was to determine the frequency of pericardial effusion after first myocardial infarction.

Method: This was an observational study. Total 45 patients admitted into our Dustira Hospital Emergency Department diagnosed with first acute myocardial infarction with consistent ECG findings and treated with or without thrombolytic. This study was performed from August 2014 to January 2015. Pericardial effusion was considered to be present when separation between two pericardial layers is present throughout the cardiac cycle on two dimensional echocardiography, Mild PE < 5 mm, Moderate PE 10-20 mm, Large PE > 20 mm. Patients were evaluated within 0 and days 14. Images were obtained in standard parasternal long & short axis and apical four chambers view. Echocardiographic findings were interpreted by our experienced Cardiologist.
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