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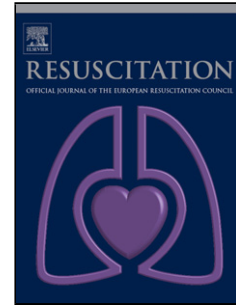
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Immediate coronary angiography after cardiac arrest – friend or foe?

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Increasing number of out-of-hospital cardiac arrest (OHCA) patients are being admitted to hospitals due to improvement in pre-hospital “chain of survival” (1). The majority of patients remain comatose after return of spontaneous circulation and the aetiology of cardiac arrest and patient’s long term prognosis cannot be easily determined in the acute setting although finding and treating the cause of the arrest can improve morbidity and mortality as well reducing the arrest recurrence. Both pathological and angiographic studies established that coronary heart disease is the most common cause underlying OHCA, accounting for 50–70% of aetiologies in adults (2). As a consequence, coronary angiography (CAG) is routinely performed as a part of diagnostic algorithm. However, there are other possible causes of OHCA, as illustrated by the high rate of either stable unobstructive or even normal coronary angiograms. In these patients, a neurological or a pulmonary cause should be suspected, and appropriate morphologic investigations (ultrasound, computed tomography (CT) scan) should be performed to investigate such causes.

Several studies have suggested that immediate CAG (iCAG) with percutaneous coronary intervention (PCI) may improve hospital survival in patients with cardiac arrest that have a concomitant acute coronary lesion (3-5). Identifying these patients has proven challenging. Pre-arrest symptoms reporting in this setting is not uniform and often depends on the presence of bystanders witnessing the event. The decision to perform iCAG is often made with incomplete information and is usually based on post-arrest 12-lead ECG. In patients with STEMI in post-resuscitation ECG a culprit coronary lesion is found in more than 90% of patients (6) and these patients are routinely taken directly to catheterization laboratory via STEMI “fast track”. Data from nonrandomized trials also show that almost one third of post-arrest patients without ST elevation on ECG will be found to have an acute culprit lesion that could potentially benefit from emergent PCI. Guidelines therefore suggest that it is reasonable to perform CAG also in these patients if non-coronary cause of arrest is not found (7). But do we do a harm in a small percentage of patients with non-cardiac cause of arrest with delaying other diagnostic and therapeutic procedures?

In the present issue of Resuscitation Stephane Legriel and co-workers from Paris Sudden Death Expertise Centre published data from their registry of OHCA patients (8). Their primary focus was on 247 (7%) patients with neurological cause of OHCA (OHCA-NC) and their aim was to identify pitfalls in diagnostic algorithm that could potentially lead to delayed and inappropriate patient management. A retrospective etiological diagnosis of neurovascular

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