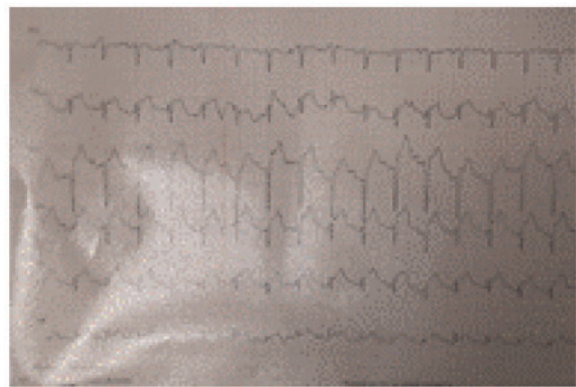


**659 Myocardial infarction and ischaemic stroke in a COVID-19 patient: nothing happens by chance**

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A 68-years-old man, affected by arterial hypertension in treatment with angiotensin-receptor blocker (cardesartan 32 mg), was admitted to emergency department for fever and dyspnoea. The molecular swab for SARS-CoV-2 was positive. Chest CT showed bilateral interstitial pneumonia with Chung severity score index 15/20. The laboratory examinations showed: PCR 21 mg/dl, IL-6 17 pg/ml, D-dimer 374 ng/ml, lymphopenia, glycaemia 218 mg/dl, total cholesterol 245 mg/dl. At COVID-19 diagnosis he started the following therapy: Azithromycin 500 mg once a day, Methylprednisolone 20 mg twice a day, Remdesivir 200 mg once a day, Enoxaparin 6000 UI twice a day, Insulin Lispro 6/8/8 UI three times a day, High Flow Nasal Cannula (FiO<sub>2</sub> 45%). No lipid-lowering therapy was prescribed. During the hospitalization, the patient experienced a progressive improvement in clinical and laboratory parameters. On the 28th day, there was a sudden worsening of dyspnoea with evidence of ST-elevation in DI, aVL, V2-V6 leads. A primary percutaneous coronary intervention at COVID-19 HUB hospital (2.9 km away) was required. Because of massive demand for emergency vehicles, the patient was admitted to the Chat Lab 3 h and 23 min later. Due to evidence of critical stenosis of the proximal and intermediate left anterior descending artery, a PTCA with stenting was performed. 12 h later, the patient developed left hemiplegia (NIHSS score: 7). The brain CT revealed an acute right frontal ischaemic lesion; no indication to fibrinolysis was given by the consultant neurologist. Our case report describes the rare concomitance of two thrombotic events in a COVID-19 patient with many cardiovascular risk factors, offering the opportunity to underline the need of their appropriate treatment during the hospitalization for SARS-CoV-2 infection. Moreover, a dedicated treatment pathways should be provided for COVID-19 patients in order to ensure the timely and correct application of the protocols suggested by the international guidelines.



**659 Figure 1** ECG performed at the onset of acute dyspnoea.



659 **Figure 2** Critical stenosis on LAD and subcritical stenosis on first and second obtuse marginal arteries.