

thrombolysed with IV Tenecteplase 50mg and subsequently admitted to ICU. Patient showed overall marked improvement. CT-PA done later showed right pulmonary artery embolism.

### **DISCUSSION AND CONCLUSION**

The above case was a classic presentation of massive pulmonary embolism which is marked with persistent hypotension. CT-PA is the gold standard for diagnosing pulmonary embolism but in unstable massive pulmonary embolism it is not possible to be done. In the latest guidelines by European Heart Journal and American College of Physician recommended the use of prediction probability test to proceed with the treatment. In cases of uncertainty and with many differential diagnosis, it is important to combine history taking, clinical findings and other modalities such as prediction probability test and bedside echocardiography to determine diagnosis and management.

## **PP 52**

### **ARISE FROM THE DEAD, CASE REPORT**

A H Mohd Mustamam<sup>1</sup>, M F Mohd Abdul Kader Jailani<sup>1</sup>, N Z'aba<sup>1</sup>,  
S L Balakrishnan<sup>1</sup>, N Mohd Ali<sup>1</sup>  
<sup>1</sup>Hospital Tengku Ampuan Rahimah,  
Klang, Selangor, Malaysia

### **INTRODUCTION**

Lazarus phenomenon is a rare clinical condition, first reported by Linko et al. in 1982. The pathophysiology is not well understood. Hyperinflation, myocardial stunning, hyperkalaemia, delayed action of drugs, countershock asystole, and unobserved minimal vital signs amongst others have been considered to be the most common mechanisms.

### **CASE REPORT**

40 year old Indian male, presented to emergency department with sudden onset of typical chest pain. Patient developed ventricular fibrillation en route to PCI center. CPR commenced immediately and resuscitation per ACLS guidelines was done. In view of refractory VF, resuscitation continued with IV Vasopressin 40, IV methylprednisolone 40mg and IV esmolol 30mg, despite the additional medications and CPR for 45 minutes, there was no ROSC and cardiac monitor deteriorated to asystole and resuscitative effort discontinued. Patient was extubated and explained to family members regarding poor prognosis. Death was not pronounced to family members in view of the presence of agonal breathing. After 30 minutes cessation of CPR noted patient had good spontaneous respiratory effort and started moving his upper limb and localizing pain, cardiac monitor showed sinus rhythm. Airway was then secured. Patient was then thrombolysed and admitted to ICU.

### **DISCUSSION AND CONCLUSION**

The decision to stop CPR is a challenging clinical task. In general, CPR should continue as long as shockable rhythm or the other reversible cause for cardiac arrest persists. It is widely accepted that asystole for more than 20 minutes without reversible factors is a reasonable cause. The decision to stop is based on resuscitation team judgement, time before initiation of CPR, primary rhythm, comorbidity, and duration of resuscitation.