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Optimizing Antiplatelet Therapy and Addressing Rare Vascular Diseases

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Description

Antiplatelet medicines differ in their clinical efficacy and safety for different patients, which increases the chance of recurrent ischemia episodes in some patients while they are receiving treatment. Genetic variations in the enzymes involved in medication metabolism are frequently the cause of this variability. Personalized antiplatelet medication can be achieved through pharmacogenomics, the study of how genetic variations impact an individual's reaction to pharmaceuticals. Genetic profiles can be used to customize treatment, which can lead to better results by adjusting drug selection or dose. For instance, the overwhelming body of research favors directing dual antiplatelet medication based on CYP2C19 genetic variations. A genotype-guided de-escalation strategy can lower bleeding risk in patients receiving ticagrelor or prasugrel treatment, while an escalation strategy for patients receiving clopidogrel treatment may help prevent ischemic events. Even with encouraging clinical outcomes, hospitals are still not using these tactics to their full potential. New discoveries in research, expanding experience and future technological developments could all aid in removing these obstacles. When treating or avoiding thromboembolic events, such as deep vein thrombosis, pulmonary embolism, atrial fibrillation, coronary and cerebral artery stenting and following the implantation of a mechanical heart valve, dual antiplatelet medication is frequently recommended.

Adenocarcinoma

This therapy carries a potentially fatal bleeding risk, despite the fact that it greatly lowers morbidity and death. One of the most common and serious side effects associated with long-term usage of dual antiplatelet medication is Gastrointestinal (GI) bleeding. Studies show that the gastrointestinal tract is the site of origin for over half of significant bleeding events linked to dual antiplatelet medication. We report the case of a 74-year-old lady who, on dual antiplatelet therapy, developed lower gastrointestinal hemorrhage. She received an effective endovascular treatment with coil embolization. Pancreatic ductal adenocarcinoma is the most common diagnosis made when a solitary pancreatic mass is found; solitary pancreatic metastasis is a rare source of pancreatic tumors. Although the head of the pancreas is where most pancreatic ductal adenocarcinomas occur, other neoplastic and non-neoplastic lesions can also develop in or around this region, imitating the appearance of pancreatic ductal adenocarcinoma. For a conclusive diagnosis, a histological study is therefore essential. One uncommon reason for a single pancreatic head tumor is isolated metastases from original lung cancer. We describe a case where the diagnosis of solitary lung adenocarcinoma metastatic to the pancreatic head was made possible by imaging and histology, which in turn helped to determine the patient's course of treatment. A rare genetic thrombophilia known as protein S and protein C deficiency makes people more likely to become hypercoagulable, which can cause clots to develop in a variety of places, including deep veins, cerebral veins and rarely the portal vein. We describe a case of a guy, age 21, who had Persistent Portal Vein Thrombosis (PVT) without cirrhosis and who arrived at the emergency hospital with hematemesis and melena.

Vein thrombosis

Diagnostic imaging verified splenic vein thrombosis, splenomegaly and portal vein thrombosis and cavernous transformation. Protein S and C levels were shown to be lower using coagulation profiling, which validated the diagnosis. To control thromboembolic risk, management includes direct oral anticoagulants in combination with indefinite anticoagulant therapy. This instance emphasizes how important it is to take uncommon coagulation abnormalities into account when treating young patients who have unexplained thrombosis. About 0.8% of instances of laparoscopic cholecystectomy result in vascular injuries, which are usually caused by direct trocar penetration or thermal injury (electrocautery). Only 0.06% to 0.6% of cases of a pseudoaneurysm of the hepatic artery an uncommon but dangerous complication have been documented following acute or chronic injury to the hepatic artery. Hepatic artery pseudoaneurysms are primarily treated by endovascular embolization, which has a good success rate. If embolization is unsuccessful, the pseudoaneurysm becomes infected, or other vascular structures get squeezed, surgical intervention may be necessary. We describe the case of a 48-year-old man who developed jaundice and abdominal pain and whose right hepatic artery pseudoaneurysm was found to be the cause. The first-line treatment for this illness, angiographic embolization, was effectively administered to the patient.