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ED TÖRE MEKTUP / LETTER TO EDITOR

Multi Vessel Coronary Artery Dissection During Primary Angioplasty

Primer Anjiografi Esnasında Çok Damar Koroner Arter Diseksiyonu

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ABSTRACT

A 74-year-old man was admitted to our hospital with sudden onset severe chest pain. Electrocardiogram showed ischemic ST-segment elevation at anterior leads. The patient was taken to the catheterization laboratory for primary percutaneous coronary intervention. ChoICE® PT (Polymer Tip) floppy guide wire crossed the lesion subintimally. Simultaneously the patient had a new onset chest pain. Coronary angiography was proceeded which revealed a dissection in the proximal LAD until first diagonal branch (D1). On the right caudal projection very long dissections were detected in the proximal to distal parts of circumflex and intermediary arteries without any limitation in the distal coronary flow.

ÖZET

74 ya ında erkek hasta ani ba langıçlı gö üs a rısıyla hastanemize ba vurdu. Elektrokardiyografi (EKG)'de anterior derivasyonlarda ST segment elevasyonu mevcuttu. Hasta primer perkutanöz koroner giri im amaçlı kateter laboratuarına alındı. ChoICE® PT (Polimer Tip) kılavuz tel lezyondan subintimal olarak ilerledi. Bu esnada hastada gö üs a rısı ba ladı. Anjiyografide proksimal LAD den 1.diagonal (D1)'e kadar diseksiyon saptandı. Sa kaudal pozda sirkumfleks (Cx) ve ntermedier arterde proksimalden distale kadar distal akımı kısıtlamayan diseksiyon saptandı.

Dear Editor;

A 74-year-old man was admitted to our hospital with sudden onset severe chest pain. Electrocardiogram showed ischemic ST-segment elevation at anterior leads. He had 2.5 x18 mm bare metal stent implantation in left anterior descending artery (LAD) 2 weeks ago because of stable angina pectoris. A week later balloon angioplasty was done with 2.5 x 20 mm balloon due to acute stent thrombosis. Clopidogrel dose was elevated to 150 mg /day after that event.

The patient was taken to the catheterization laboratory for primary percutaneous coronary intervention. 10.000 U unfractioned heparin was given. The coronary angiogram showed %100 stent thrombosis in the LAD. 7 F left extra backup guiding catheter was inserted. Crossing the lesion with floppy wire was failed. We continued the operation with ChoICE® PT (Polymer Tip) floppy guide wire. The guide wire crossed the lesion subintimally (Figure 1). Simultaneously the patient had a new onset chest pain. Coronary angiography was proceeded which revealed a dissection in the proximal LAD until first diagonal branch (D1). Polymer Tip wire was taken back and another floppy wire was delivered into the D1. A 2.5 x 18 mm stent was implanted from LAD to the D1. Chest pain was regressed by 90%. On the right caudal projection very long dissections were detected in the proximal to distal parts of circumflex and intermediary arteries without any limitation in the distal coronary flow (Figure 2). We concluded that this was due to the antegrade progression from the first dissection because of PT floppy quide wire in the distal left main coronary artery. After sealing this dissection with LAD - D1 stenting we assume that the progression of the dissection was prevented and the patient's chest pain was resolved. Therefore no further attempt to stent circumflex or intermediate arteries was done. The patient was transferred to the cardiovascular surgery department for coronary artery by-pass graft. He underwent CABG the next day with successful safenous vein grafting of circumflex and intermediate arteries and left internal mammarian grafting of LAD. He was asymptomatic on the first month visit.

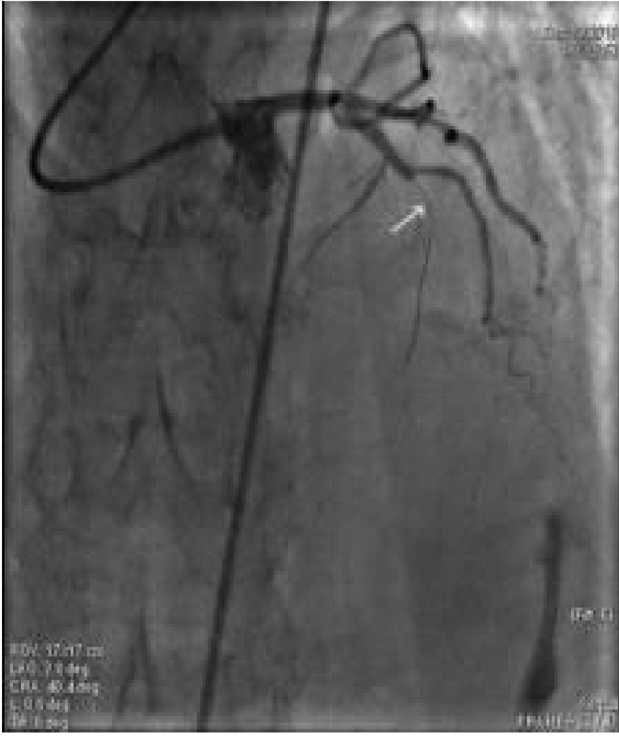

Figure 1

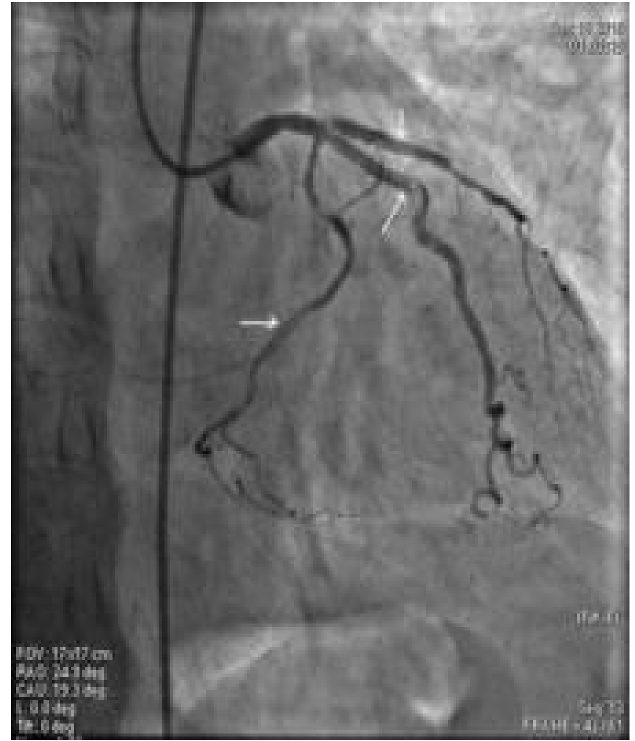

Figure 2