Aortic Dissection Presenting as Acute Subtotal Left Main Coronary Artery Occlusion: A Case Approach and Review of the Literature

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Abstract

Aortic dissection is the most common fatal condition of the aorta, yet it is often missed on initial clinical presentation. Aortic dissection associated with acute coronary syndrome (ACS) is relatively rare, but if it occurs, it can be diagnostically challenging, and the condition can be fatal. Here we describe a case of aortic dissection presenting as ST-segment elevation myocardial infarction (STEMI) managed via the transradial approach. We describe the current literature on the subject.

Keywords: Aortic dissection; Left main coronary artery; Occlusion

Introduction

Aortic dissection is a medical and surgical emergency that occurs in two out of every 10,000 people between 40 and 70 years of age. Typical patient presentation involves the symptoms of chest pain with radiation to the back and scapular regions. On clinical exam, patients may have discrepancies in blood pressure between right and left arms as well as auscultation of a diastolic murmur. CT angiography with dissection protocol has been the diagnostic imaging modality used with highest yield in the acute setting. However, other simpler diagnostic measures such as ECG analysis and chest X-ray can offer clues to the diagnosis. In the setting where CT angiography cannot be utilized, trans-esophageal echocardiography offers diagnostic assessment. Clinical presentation spans the spectrum of significant discomfort with normal vitals, to cardiogenic shock, and sudden death [1-3]. Aortic dissection can mimic other cardiovascular emergencies providing challenging diagnostic dilemmas for physicians. Unfortunately, timely recognition of this syndrome has significant and direct impacts on patient mortality. We present the case of a 61-year-old male with acute onset of substernal chest pain with initial ECG analysis consistent with ST elevation myocardial infarction found to have a type A aortic dissection on coronary angiography.

Case Report

A 61-year-old male with a past medical history of hypertension presented to our emergency room with the acute onset of substernal chest pain that began 45 min prior to arrival to the emergency department. The pain was characterized as pressure-like, progressive in nature with radiation to the back and interscapular region. The presenting vital signs showed a blood pressure of 93/49 mm Hg, heart rate of 70 bpm, with normal oxygen saturation. An initial 12-lead ECG revealed ST elevations in leads I, AVL, V1-V3 with significant ST depressions in the inferior leads (Fig. 1). The patient was given aspirin 325 mg, clopidogrel 600 mg, and a heparin bolus of 5,000 units. The patient was immediately taken to the catheterization lab for diagnostic angiogram and possible percutaneous coronary intervention.

In the cath lab the right radial artery was cannulated with a 6-French sheath. A Launcher EBU 3.5 guide catheter (Medtronic, Minneapolis, MN) was used to engage the left coronary ostium. Coronary angiogram revealed a subtotal occlusion of the left main coronary artery (Fig. 2). A Runthrough wire (Terumo Medical Corporation, Somerset, NJ) was utilized to cross the lesion and a 3.0 x 15 mm Emerge balloon (Boston Scientific, Natick, MA) was used for initial angioplasty. Since patient became hypotensive, intraaortic balloon pump was placed from the right femoral artery. Two 4.0 × 12 mm Promus Element Everolimus-Eluting stents (Boston Scientific, Natick, MA) were deployed in the left main artery with good angiographic result (Fig. 3). Intravascular ultrasound (IVUS) was performed to confirm the stent expansion.

After the stent placement, the chest pain improved and the ST segments elevations resolved. However, the patient later continued to have persistent chest pain. On review of the angiogram, a significant amount of aortic insufficiency was noted. An aortogram was performed revealing severe aortic regurgitation with a possible dissection flap (Fig. 4). Urgent trans-esophageal echocardiography was performed in the cath
lab confirming aortic dissection of the ascending aorta (Fig. 5, 6). On review of IVUS, dynamic flat was seen outside the left main ostium (Fig. 7). The patient underwent emergent repair of a type A aortic dissection.

In the operating room, patient developed PEA arrest, which required resuscitation, and the pericardium was opened revealing hemopericardium. The proximal aorta was then mobilized and the aorta resected to just above the sinotubular ridge. The three leaflets of the aortic valve appeared normal, and the dissection flap was noted to extend down into the non-coronary sinus. The left main coronary artery was intact but surrounded by a substantial hematoma external to the aorta. There was no evidence of extension of the dissection into the left main coronary artery. Post-op course was complicated by minor stroke, but patient was transferred to rehabilitation floor with good recovery.

Discussion

One of the first reported cases of dissection presenting as ACS was in a patient with anterior ST elevations who was found to have an aortic intimal flap occluding the left coronary artery, resulting in cardiac arrest and death [2]. Myocardial ischemia has been reported in 19.9% of cases of aortic dissection and new Q wave or ST elevations in 6.0% of cases [3]. ST-segment elevation myocardial infarction (STEMI) during type A dissection is rare, but if it happens, it is a serious condition with high mortality rate if not recognized and treated promptly. The incidence of malperfusion of coronary artery in the patients who underwent surgery for type A aortic dissection is reported to be 6.1-11.3% [4, 5]. The initial presentation of STEMI was seen in 4.6% of patients, and involvement of right coronary artery (RCA) is more common than left main artery (eight inferior and two anterior in one series) [4].

Neri et al [5] classified the mechanism of coronary ostia involvement into three types. Type A is an ostial dissection, with a disruption of the inner layer limited to the area of the coronary ostium. The type B dissection, with a coronary false channel, is a retrograde extension of the aortic dissection extending into the coronary artery wall. Type C is circumferential
detachment with an inner cylinder intussusception. Our patient had a type A dissection where the coronary artery occlusion resulted from compression by the bulging dissected false lumen or by secondary extravasation of blood into the pericardial or perivascular tissue. One unique aspect of this case was the use of a radial approach for the PCI, which may have made it easier to locate the true lumen.

The left main occlusion may represent a slit-like lesion, which can be dynamic due to the compression of the artery, and not necessarily from plaque or thrombus. If these findings are observed, it is important to consider the possibility of dissection. Intravascular ultrasound (IVUS) has been used to help diagnose aortic dissection flap that extends into the coronary artery [6]. In our case, however, the IVUS image is showing the flap outside left main ostium, which has not been described previously.

We found 14 cases of type A aortic dissection presenting as acute myocardial infarction due to left main occlusion in English literature (Table 1) [7-19]. While the definitive treatment is surgery, successful stabilization of the left main artery lesion while awaiting surgery has been reported [8, 12, 15-17, 19]. As PCI techniques have evolved, the management approach has changed from direct surgical approach to PCI of left main artery as the bridge to the definitive surgery. One
case even reported the use of PCI and an endograft as a means of repair [8].

Early diagnosis is critical in successful treatment of this condition. In our cohort of studies half of the aortic dissections were diagnosed before PCI, and PCI was performed with the intention to stabilize the patient. As illustrated in our case, patients with hemodynamic instability or persistent symptoms may benefit from initial coronary stenting as a bridge to definitive treatment with cardiac surgery.

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