2021 euroPCR

Astonishing presentation of ACS

Patient Identification

Male, 61 years old.

Admission:

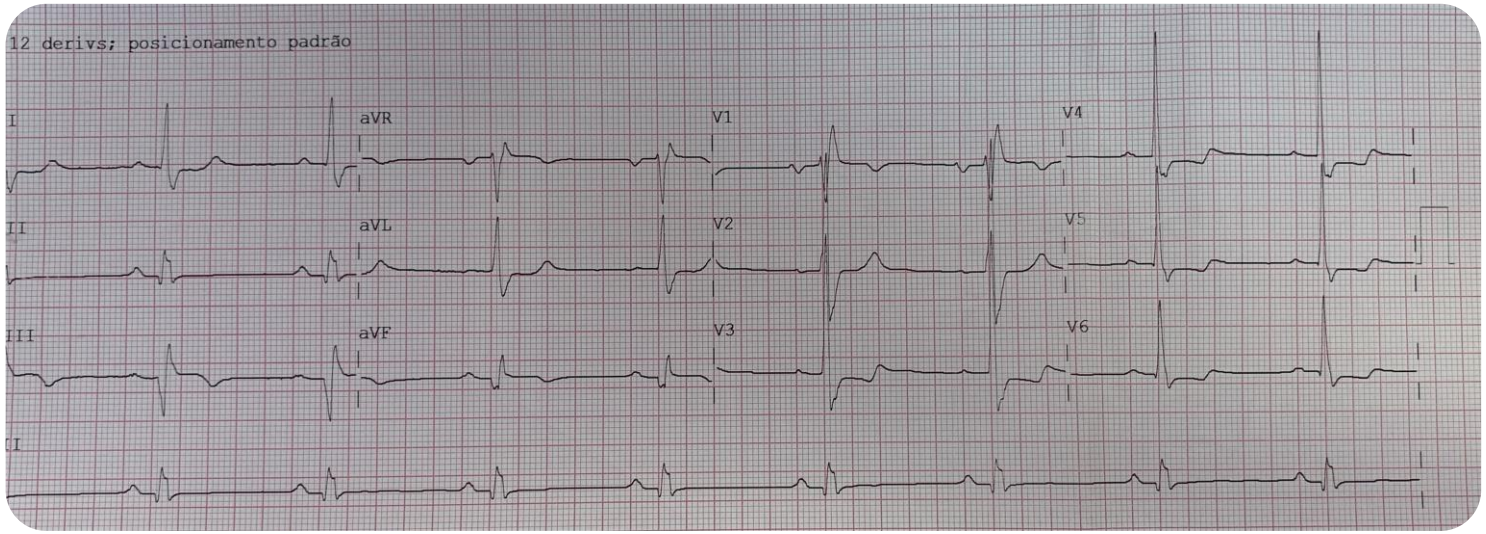
Acute Chest Pain

- Definitely anginous pain in the beginning of dawn (2:00 am);
- High Intensity;
- Irradiation to the left upper arm;

Previous Pathological History of:

Hypertension;
Type II Diabetes;
Dyslipidemia;
Current smoker: 15 pack-years.

Admission in the ER



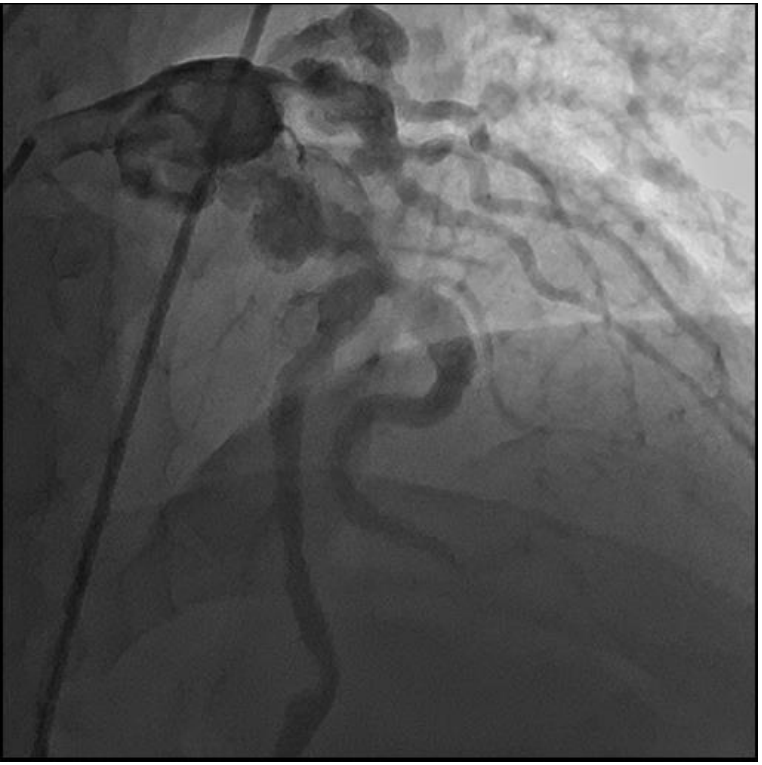
ECG: Right Bundle Branch Block – New or previous one ?

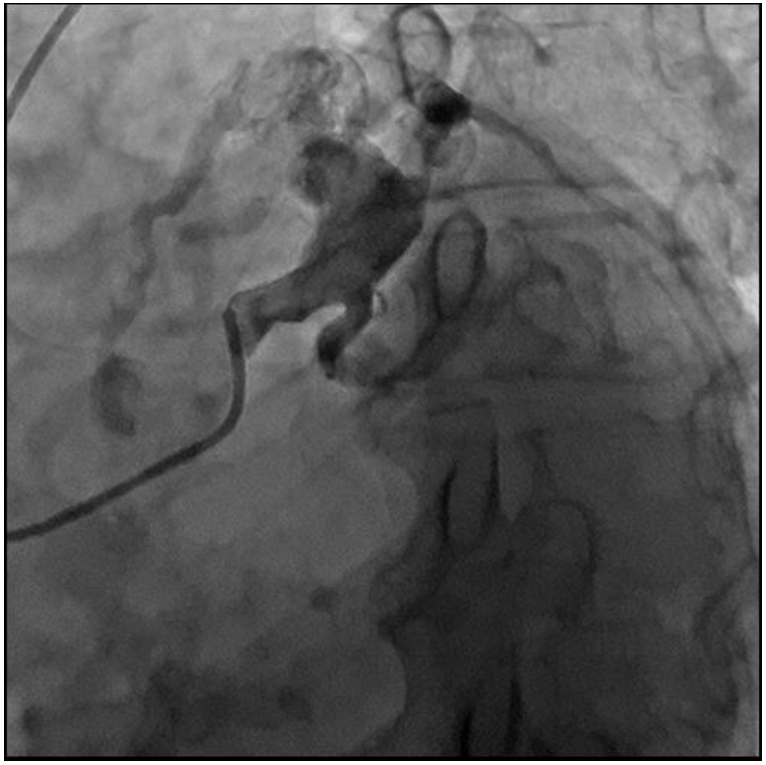
Physical examination:

-Conscious and communicative state.
-No changes on cardiopulmonary examination
-BP: 130 / 90mmHg
-HR: 88bpm
-O2 -Sat: 96%

Initial Approach

Acute pain + Probabily new RBBB... → cardiac catheterization





Left coronary artery : ectasic and calcified with the presence of a large aneurysm in the left main and in the LAD.
Right coronary artery: non-catheterized. (supposedly occluded??)

Follow - up

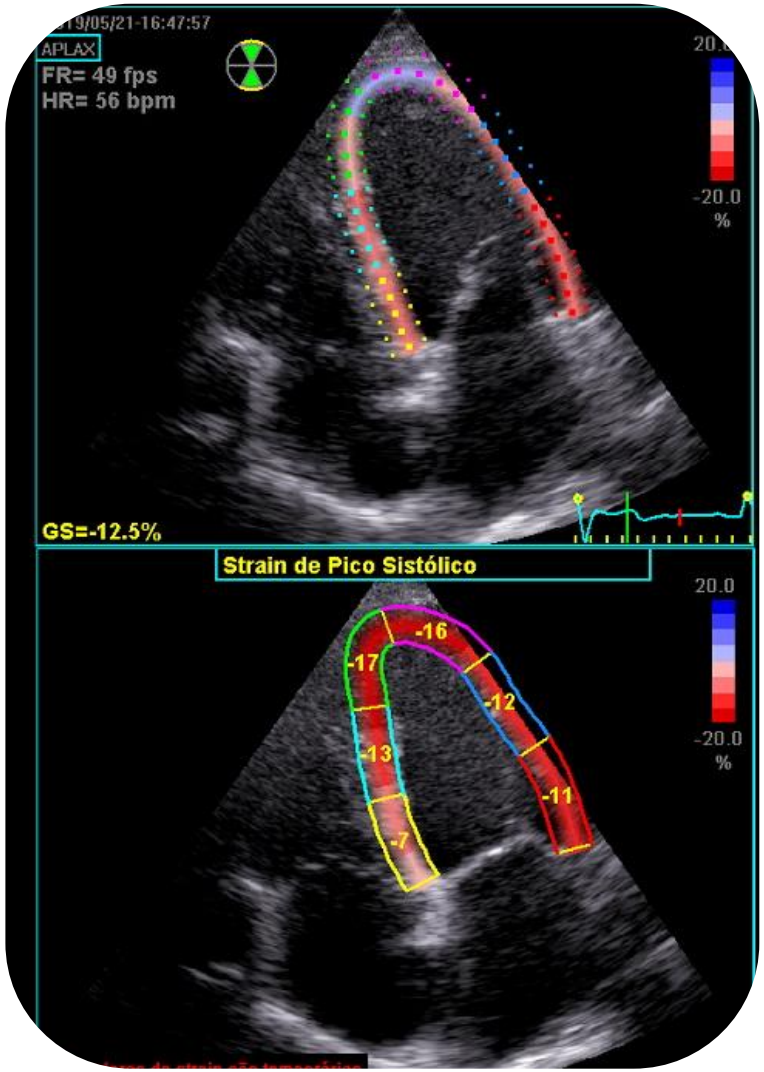
	hs-cTn (<14 ng/dl)
Zero Hour	Negative
6th Hour	327 ng/dl
2nd day	729-1008 ng/dl
3rd day	1419 ng/ dl

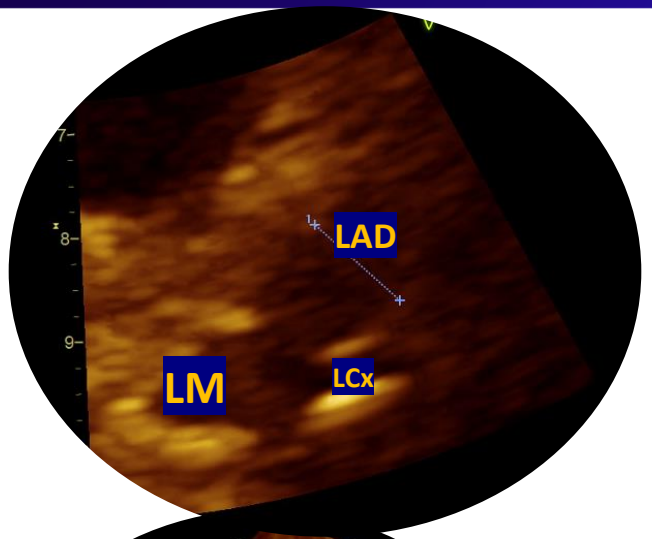
FAN: Non-reactive
Hepatitis B: Non-reactive
Hepatites C: Non-reactive
HIV: Non-reactive
Syphilis: Non-reactive

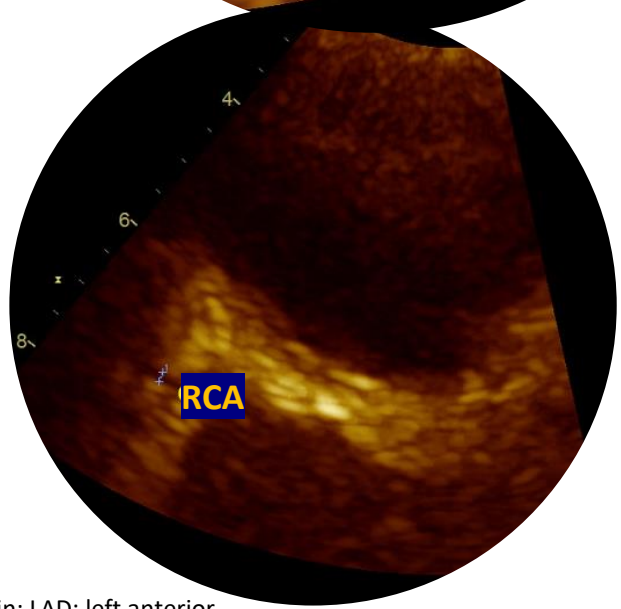
Chol T	90mg/dL
LDL	40mg/dL
HDL	30mg/dL
Trig	97mg/dL
HbA1c	5,3%
TSH	1,08uUI/,L

Follow - up

Echocardiography

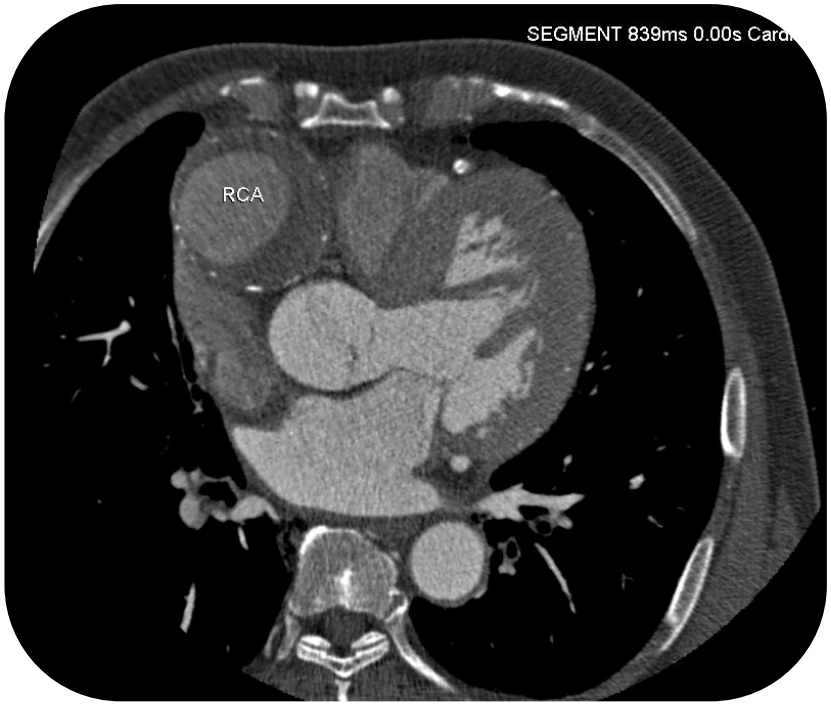


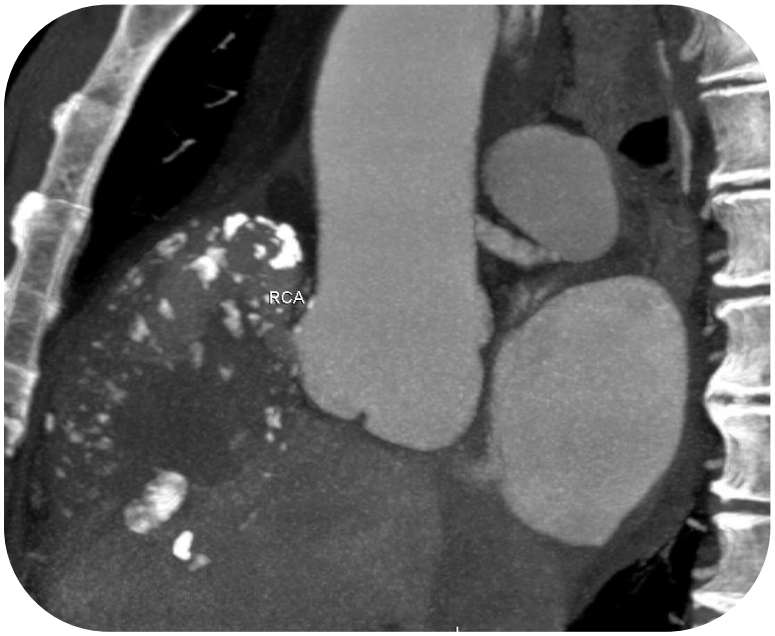




LM: Left main; LAD: left anterior descending; LCX: = left circumflex ; RCA: right coronary artery

Coronary angiotomography:

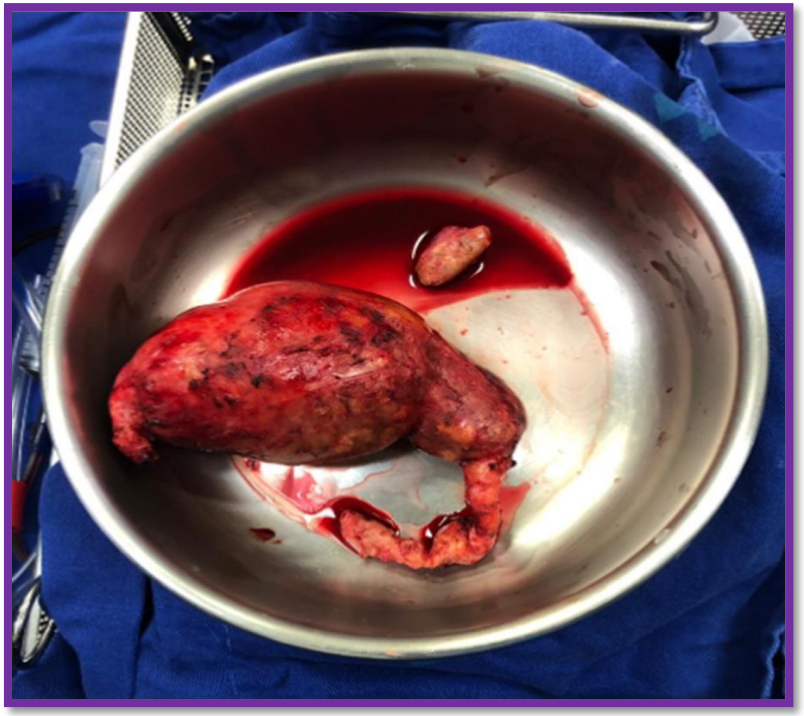


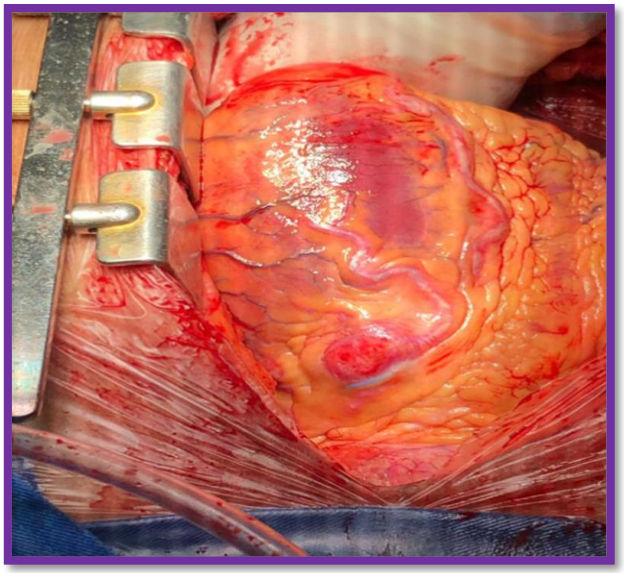


Sacular aneurysm of the right coronary (RCA), with parietal calcification, partially thrombosed, with approximately 11.5 cm longitudinal extension and maximum diameter 6.2 cm, causing a discreet commpression of the right atrium.

Management

The case was discussed with the heart team → CABG!





The patient was submitted to three grafts + withdrawal of the RCA: ITA → LAD, Saphenous vein → OM1, and Saphenous vein → Dg1.

Follow up

After leaving the cardiopulmonary bypass, the patient evolved with right ventricular failure, with no response to the established measures, and deceased.

Anatomo-pathological:

Chronic active coronary artery inflamation, predominantly lymphocyte and without granuloma formation, and multiple scars causing the formation of giant aneurysms with parietal thrombus.

This case proved to be very challenging for the diagnosis and especially for the therapeutic definition.
It is a little known and studied entity, with no specific conduct in the literature.

Thanks!!!