



Emergency LM PCI in a young patient with ACS: stepping in the dark?

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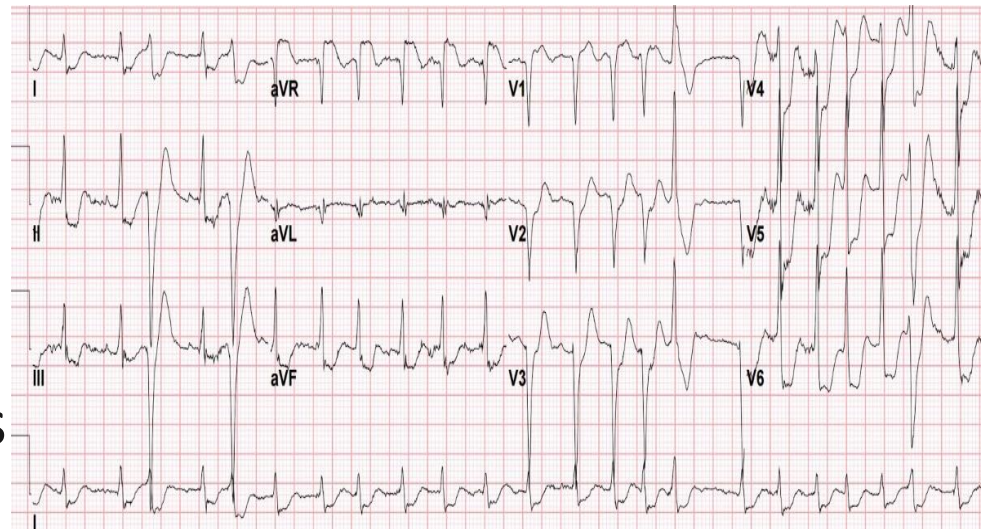
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Speaker's name: Dušan Ružičić

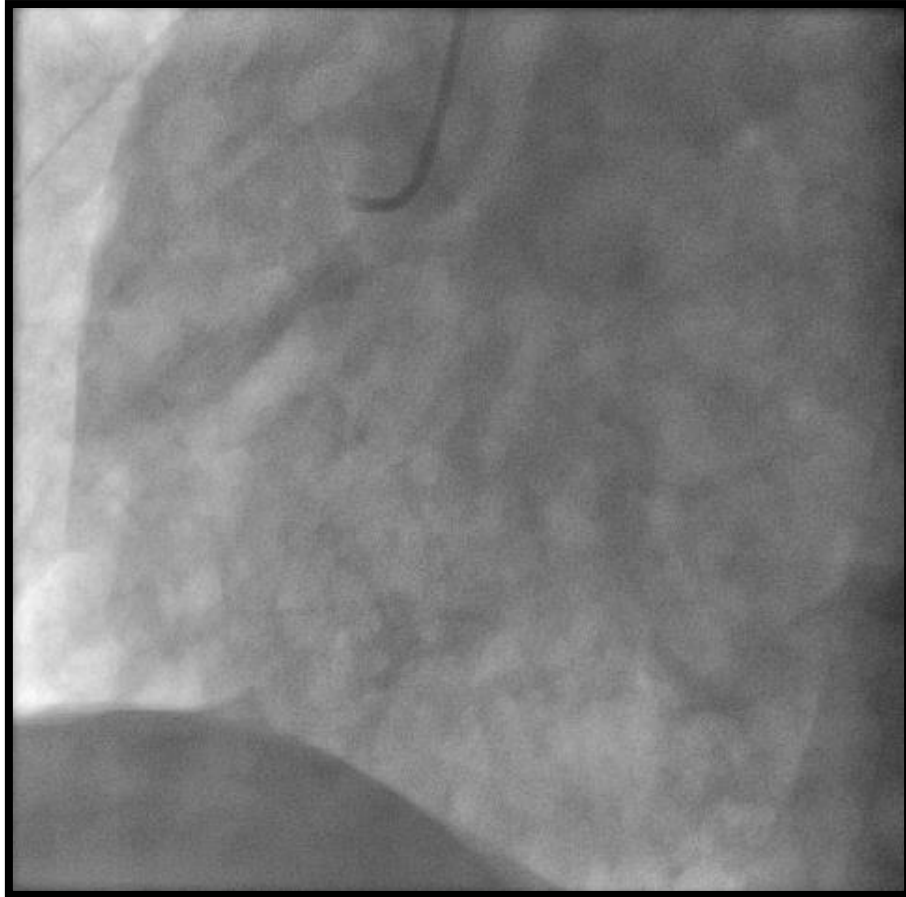
- ☒ I do not have any potential conflict of interest to report

- Male, 41 years old
- AMI with diffuse ST-depression on ECG and elevation in aVR, V1
- Hemodynamically stable - no heart failure
- Coronary angiography was performed on admission to hospital

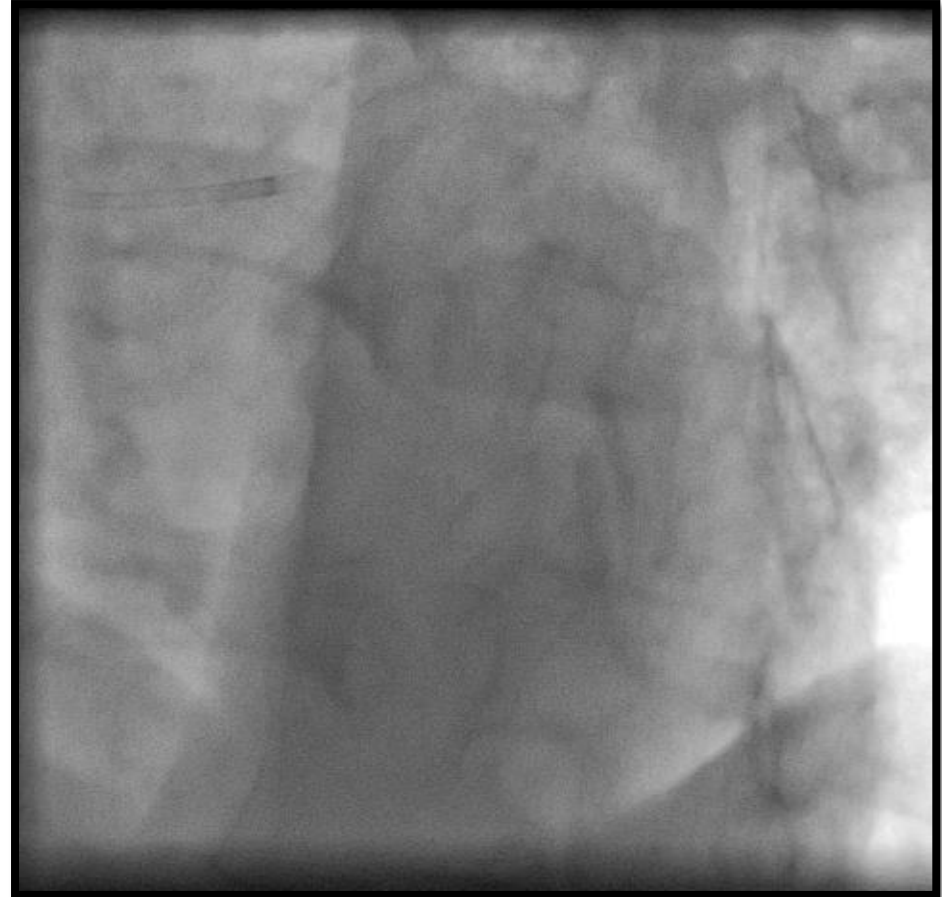
ECG on admission



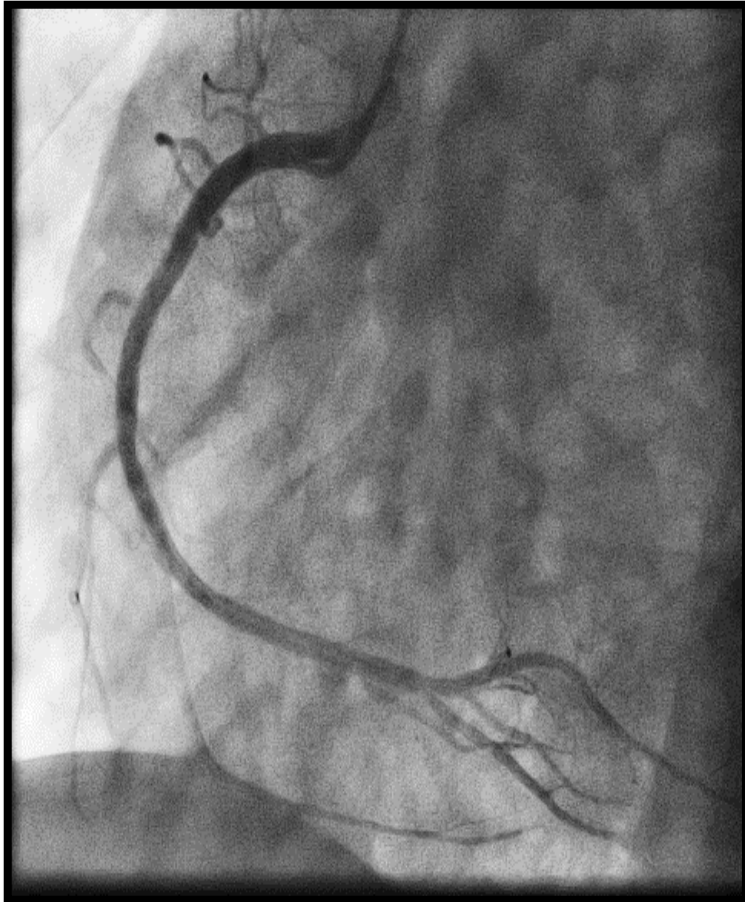
Right coronary angiogram



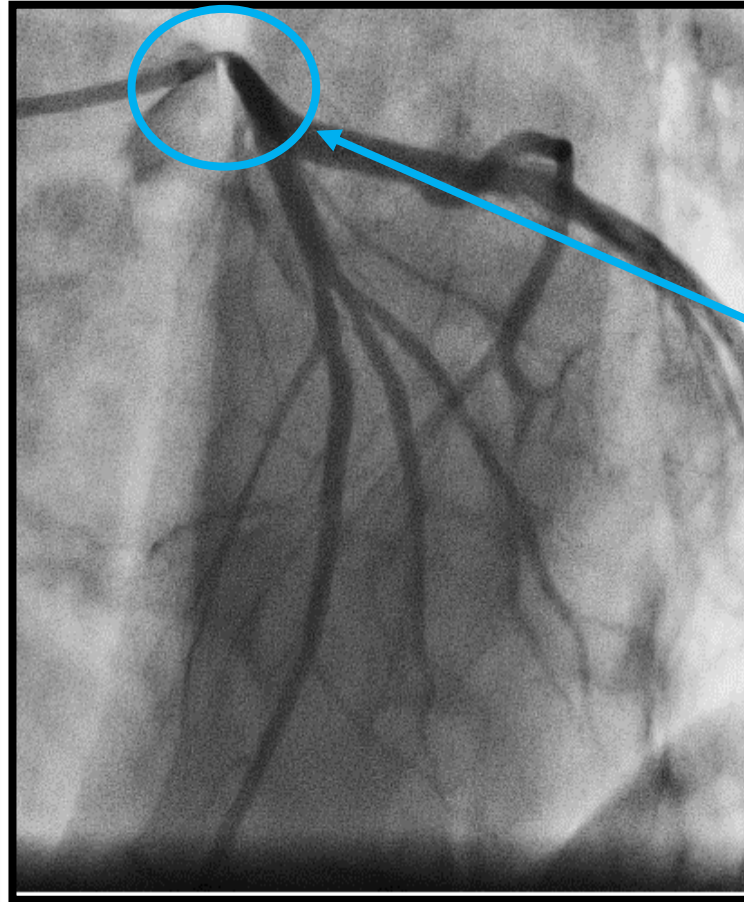
Left coronary angiogram



Right coronary angiogram



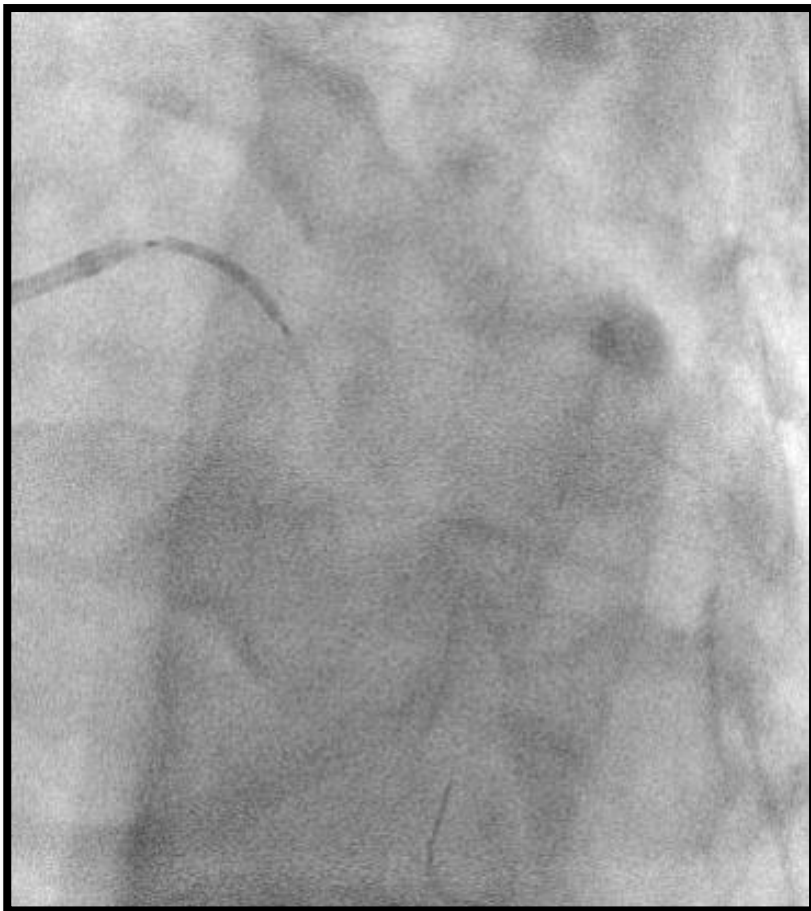
Left coronary angiogram



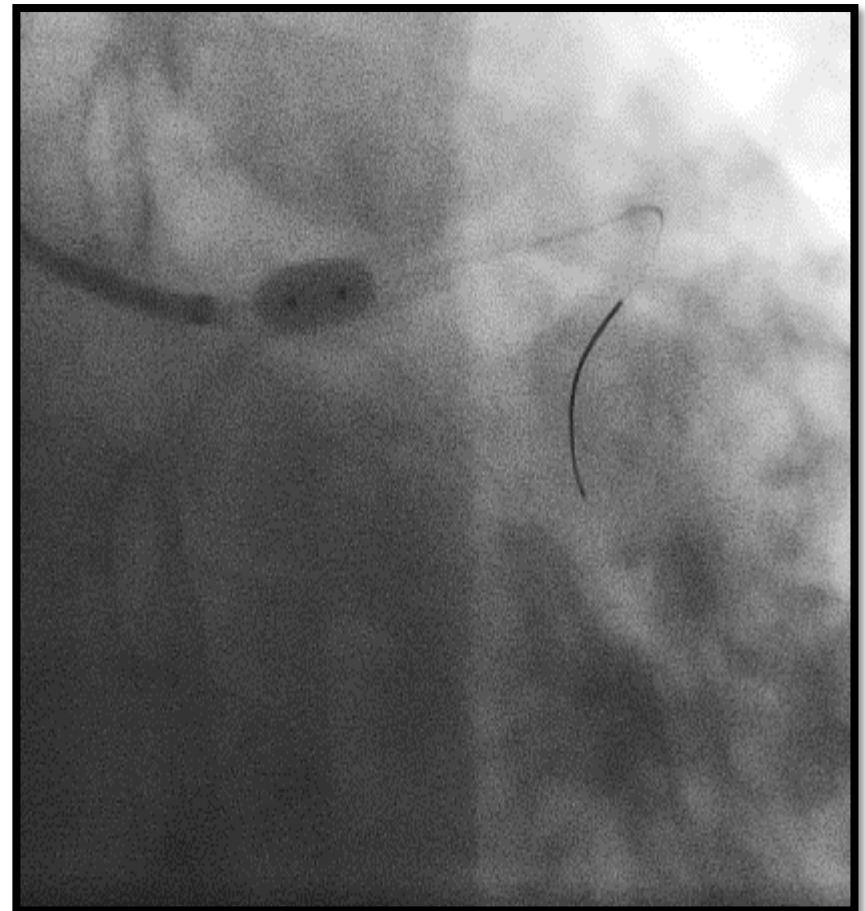
Culprit
lesion in
the ostial
LM?

PCI LM-LAD - Provisional SB stenting strategy

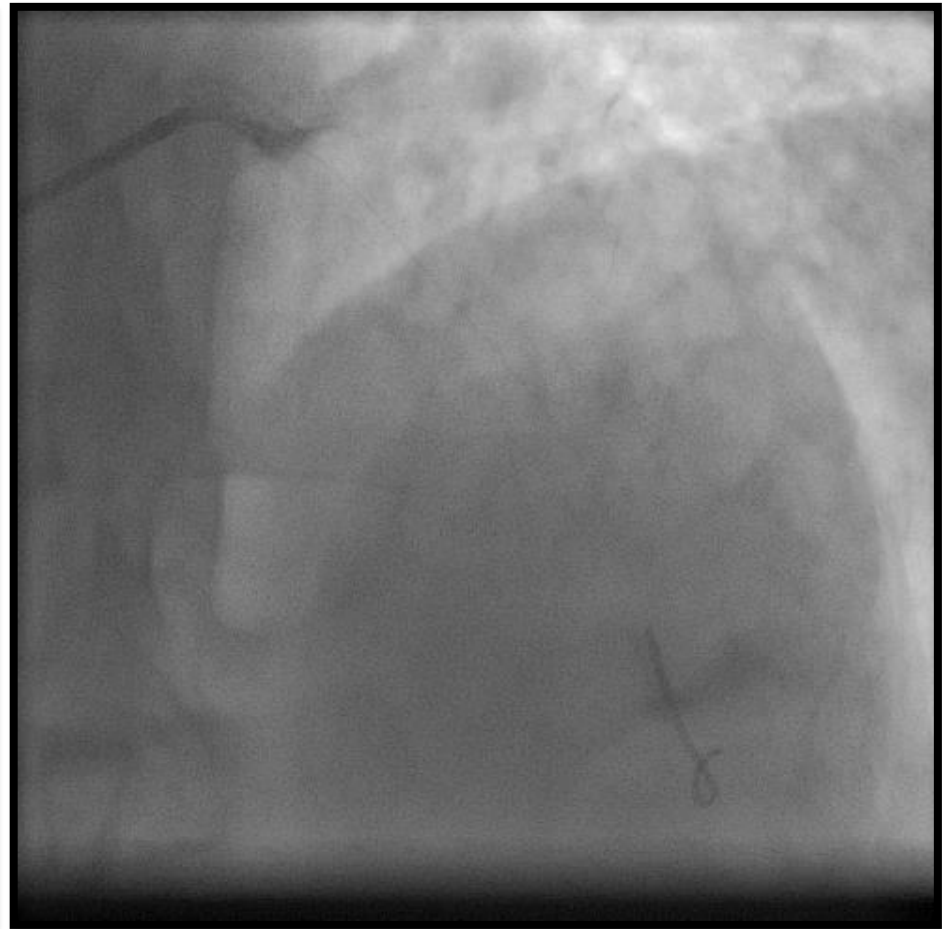
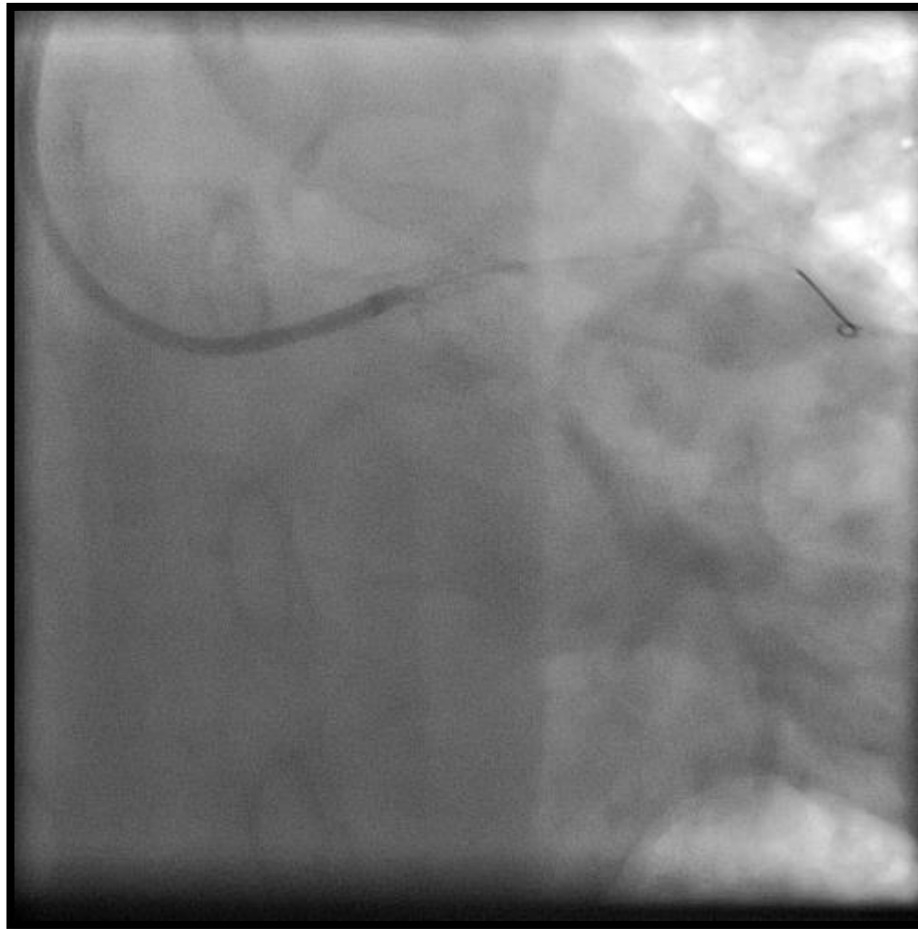
Implantation DES
4.5x18mm in ost LM



POT with NC 5.0x8mm
balloon



Final result

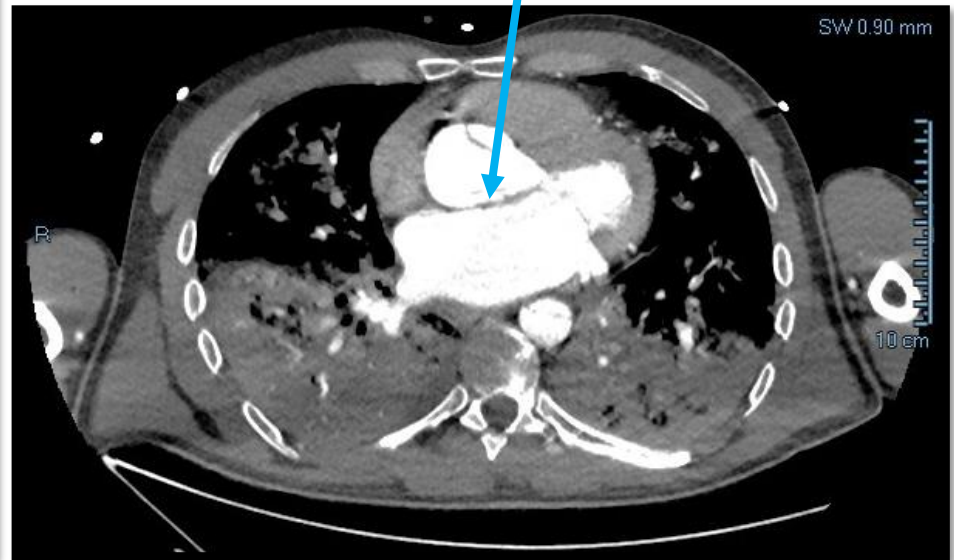
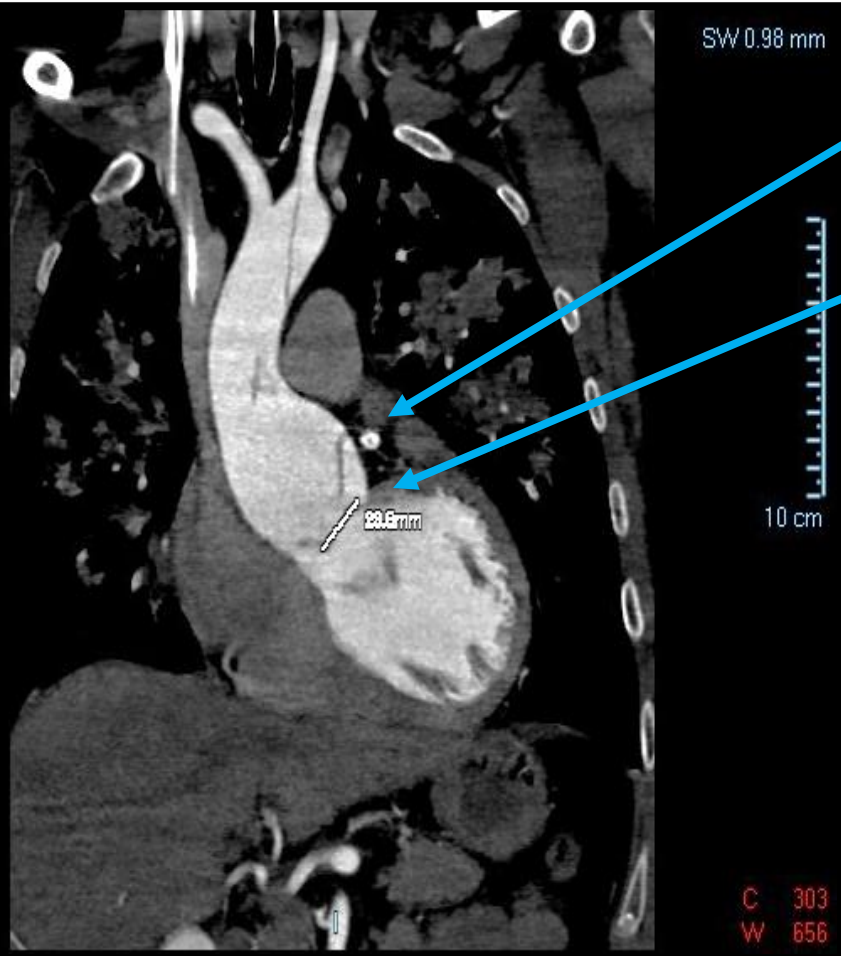


- Patient became hemodynamically unstable (inotropic stimulation required) with **divergent arterial pressure** (TA 110/35mmHg)
- Echocardiography showed small **pericardial effusion (5mm)** without compromised right ventricle, but dilatation of ascendant aorta (43mm) and intimal flap
- MDCT was performed

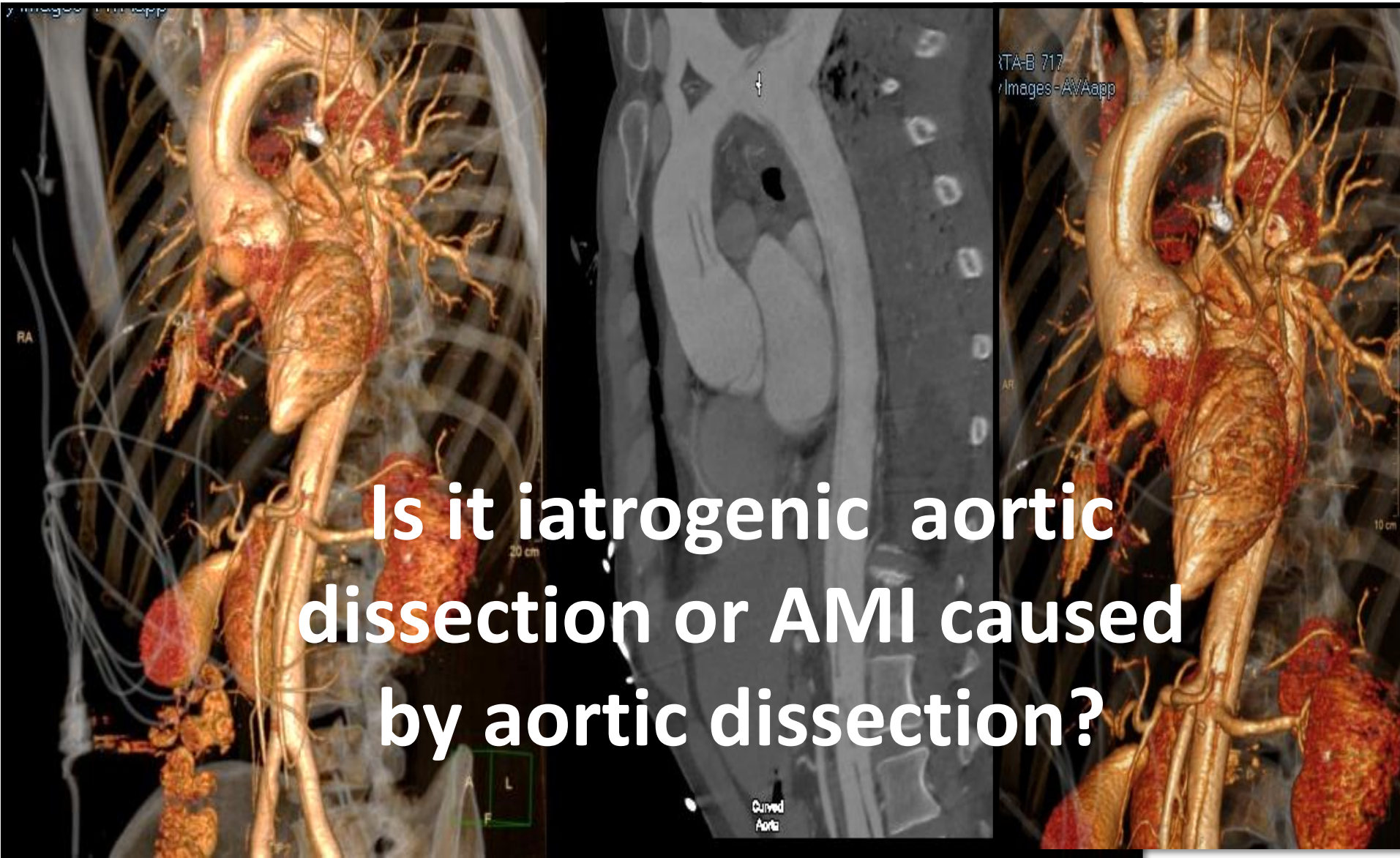
MDCT- Spiral dissection type A (Stanford)

Stent in the Left main

Origin of the dissection 1 cm from the aortic root



MDCT- Spiral dissection type A (Stanford)



- Resection of the ascending aorta and aortic valvular substitution (Bentall procedure), with reimplantation of the supraortic branches was performed.
- At 15-months follow-up, the patient was asymptomatic and has suffered no adverse events.

Acute aortic dissection should be taken into account in a young patient with an acute coronary syndrome and an isolated ostial LM stenosis