Management of an Iatrogenic Intramural Coronary Haematoma

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71 year old gentleman

Cardiovascular Risk Factors

- HTN
- Dyslipidemia
- T2 Diabetes Mellitus
- Current Smoker, 50 Pk years

Cardiovascular History

- 2013 - Unstable angina PCI to proximal LCx performed at another centre, stent type and size unknown

Current presentation

November 2019 at outpatient clinic review:

-One month history of progressive exertional angina

December 2019 - Angiogram

-Severe calcific disease in the mid and distal RCA.

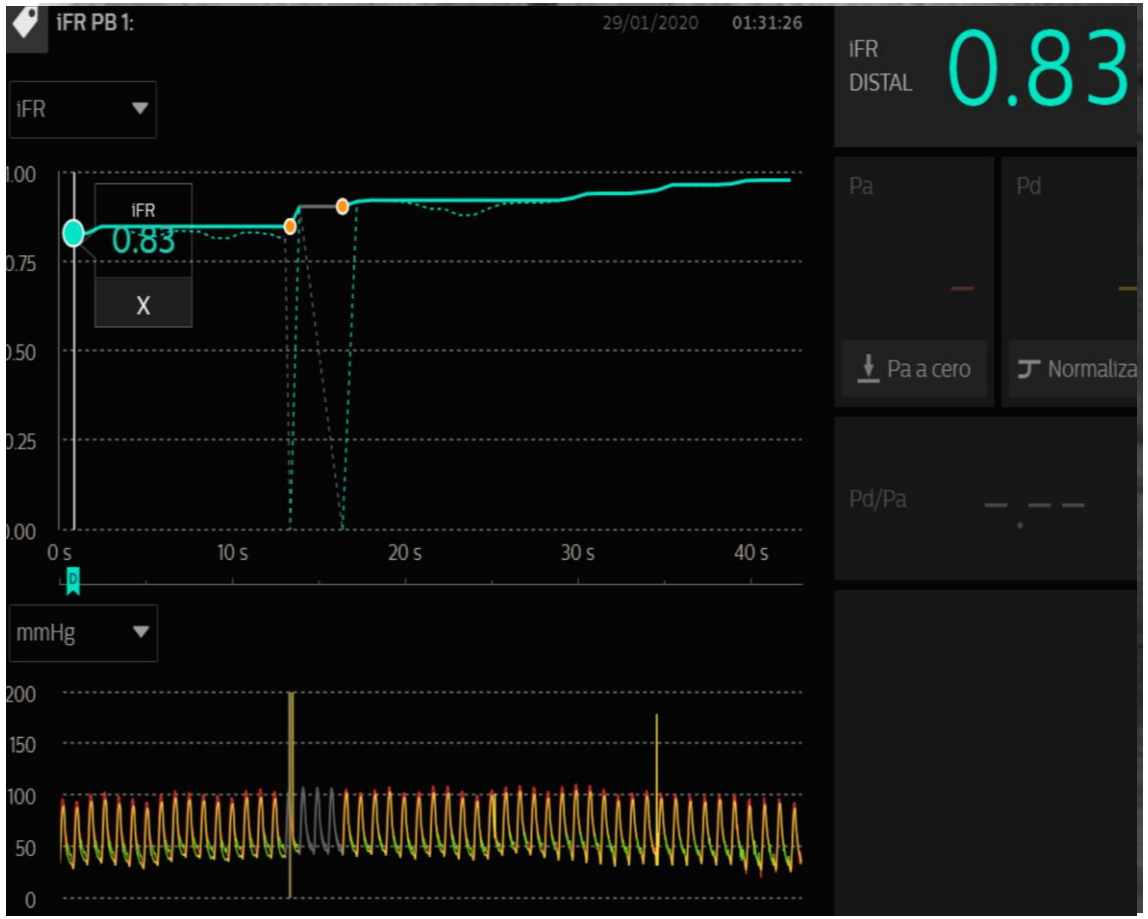
Investigations

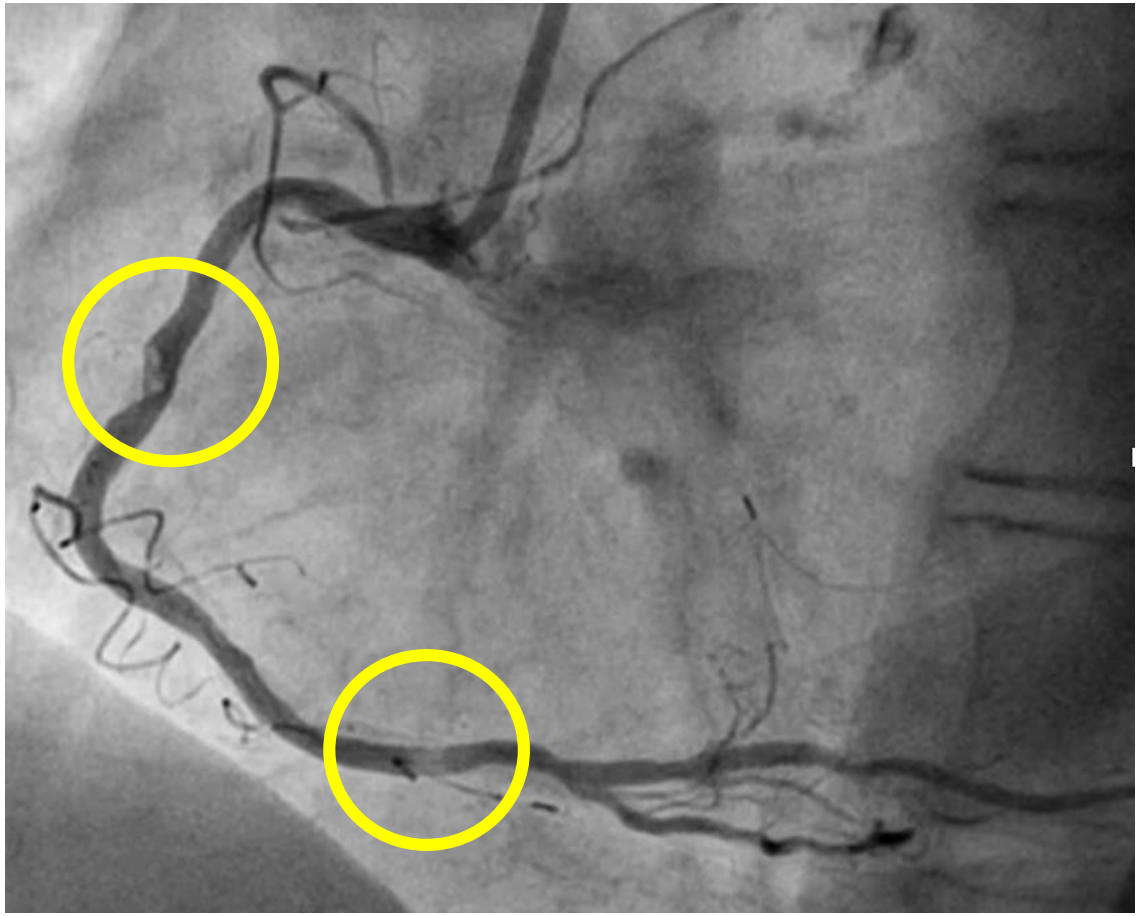
Laboratory: Hb 16.0 g/dl, Plts 199*10^3/uL, Cr 0.84 mg/dL (eGFR 91.2 ml/min)

ECG: Sinus Rhythm 62bpm, no ischaemic changes.

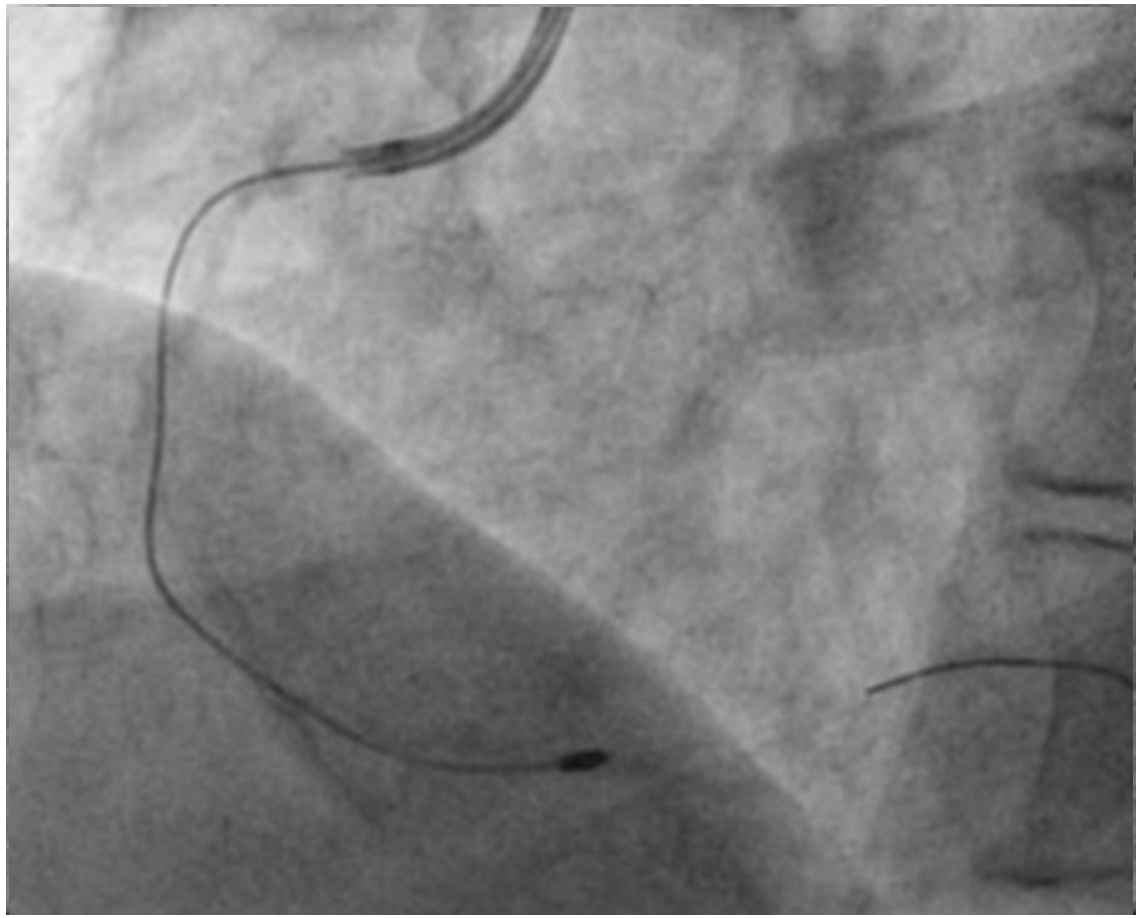
Echocardiogram: Normal left ventricular size and function with no regional wall motion abnormalities or significant valvular lesions.

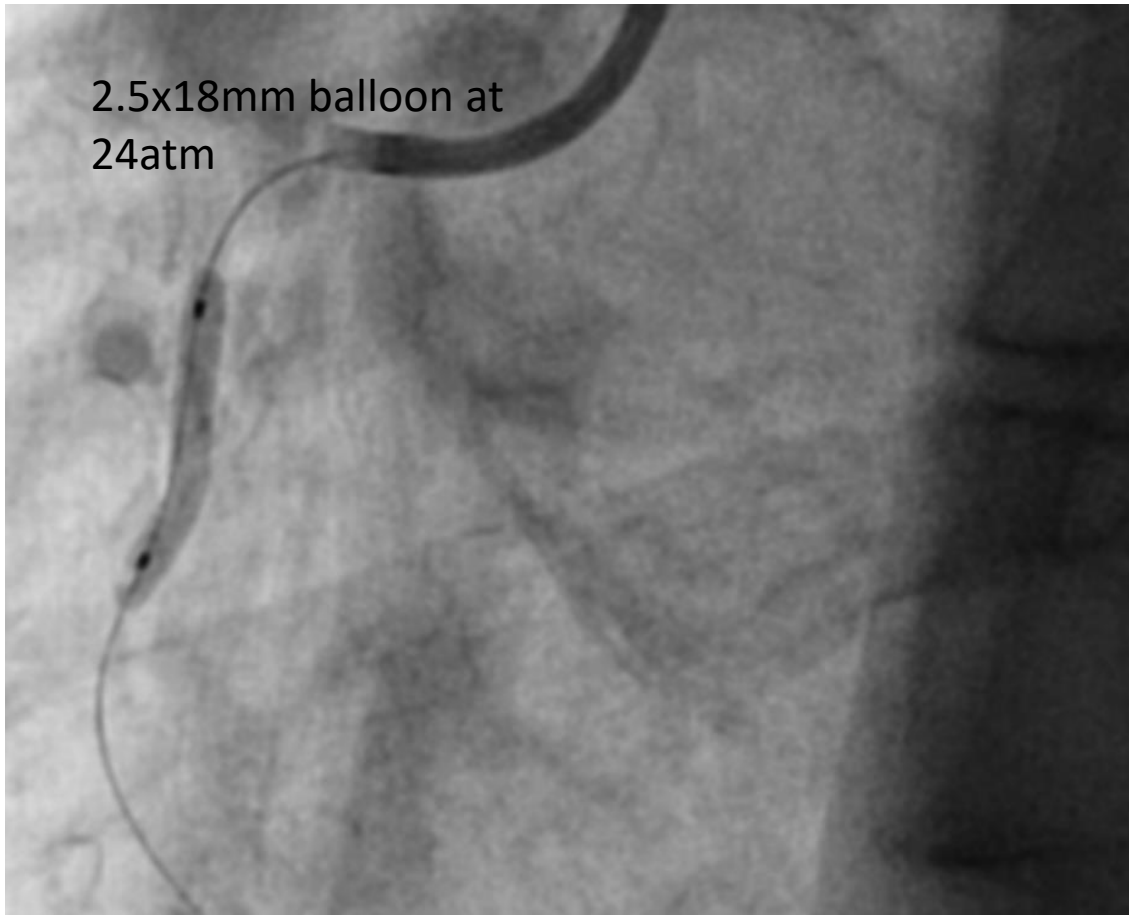
Procedural Planning





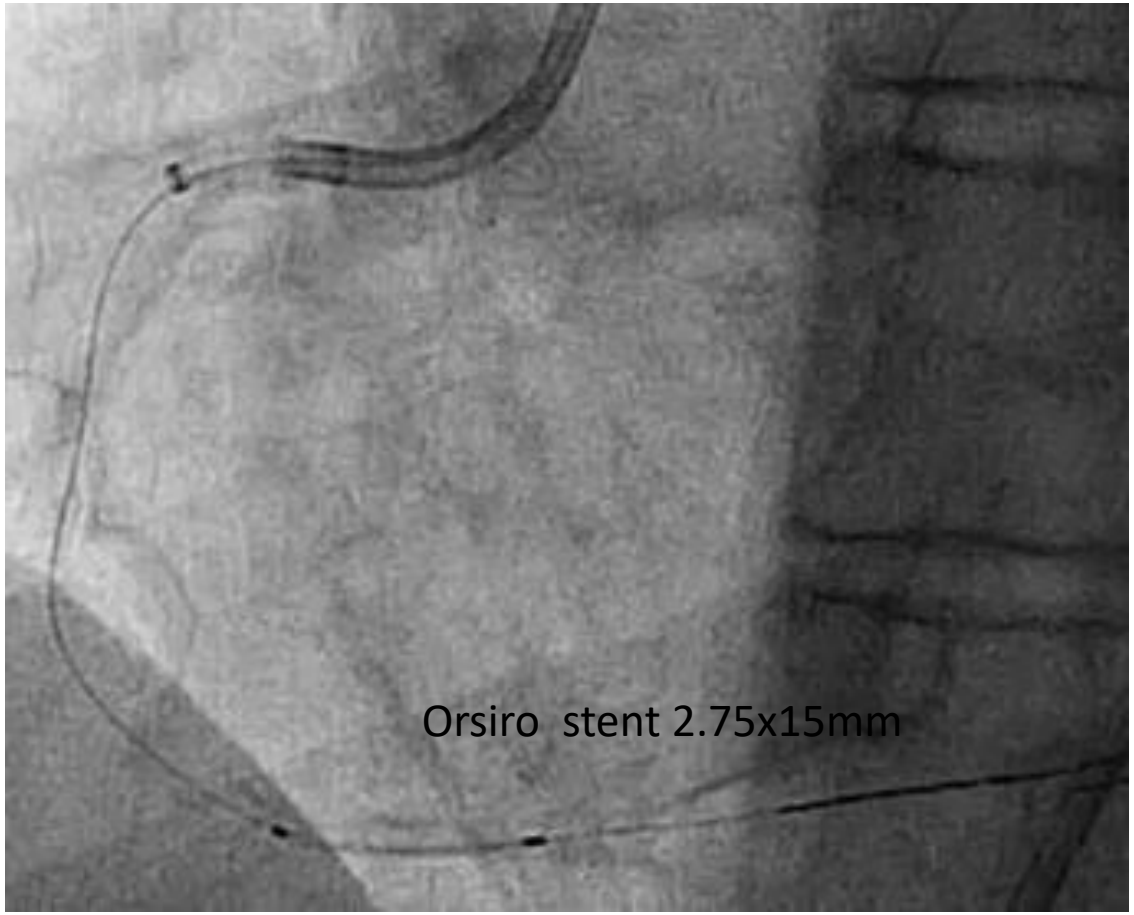
Lesion Preparation

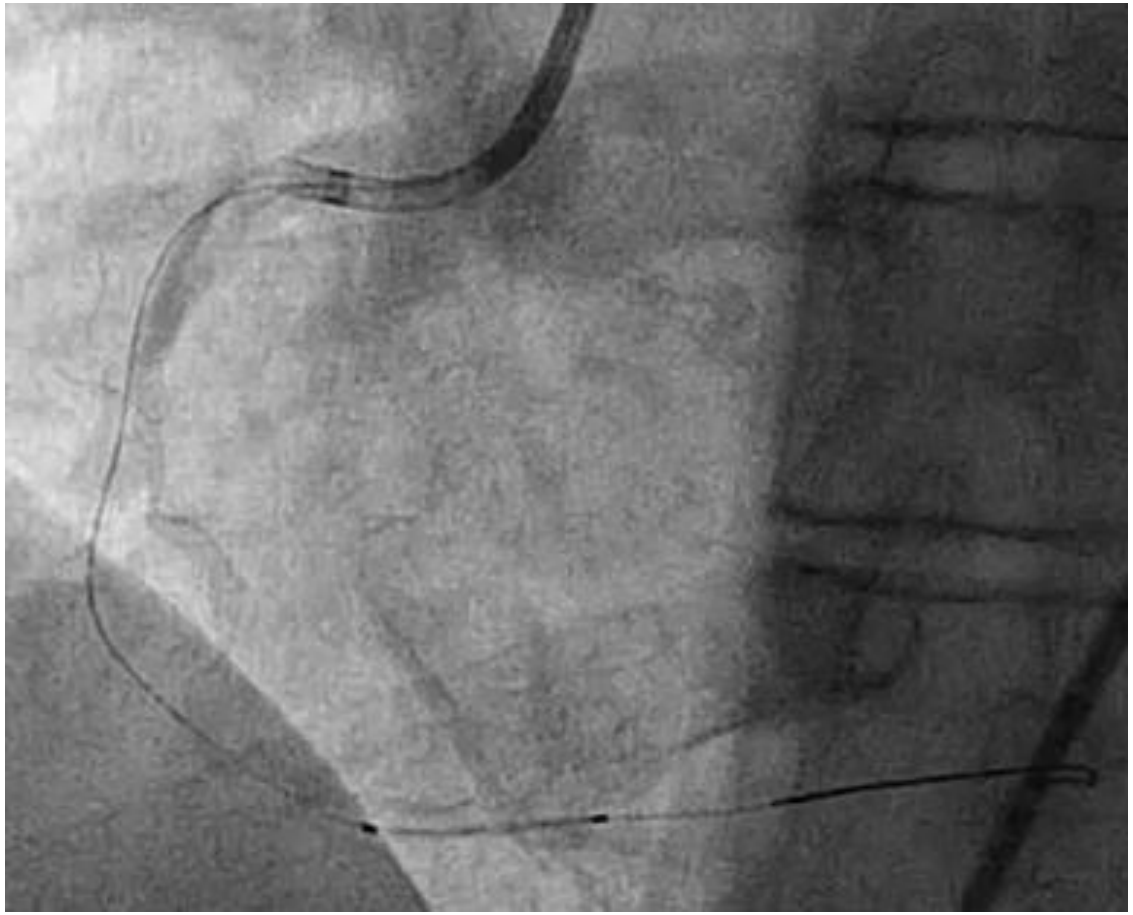




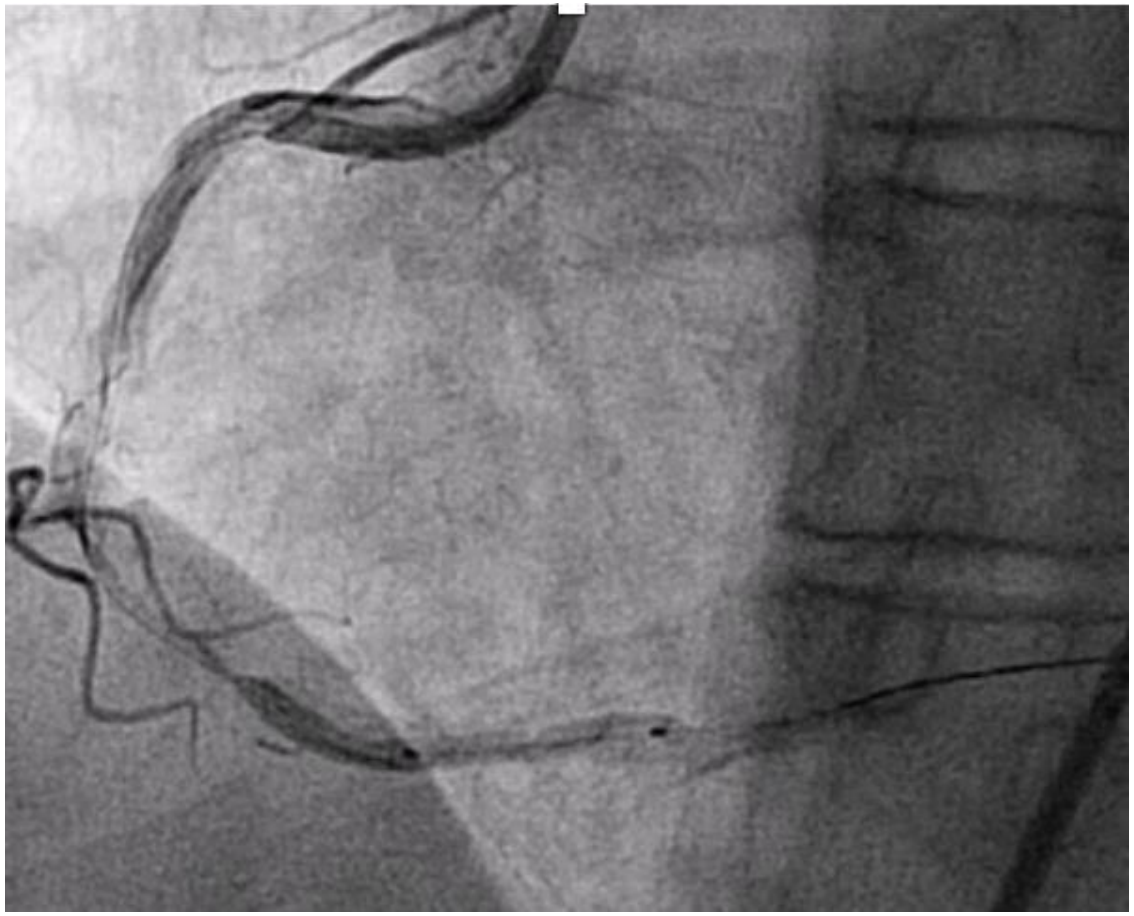
PCI to the distal RCA

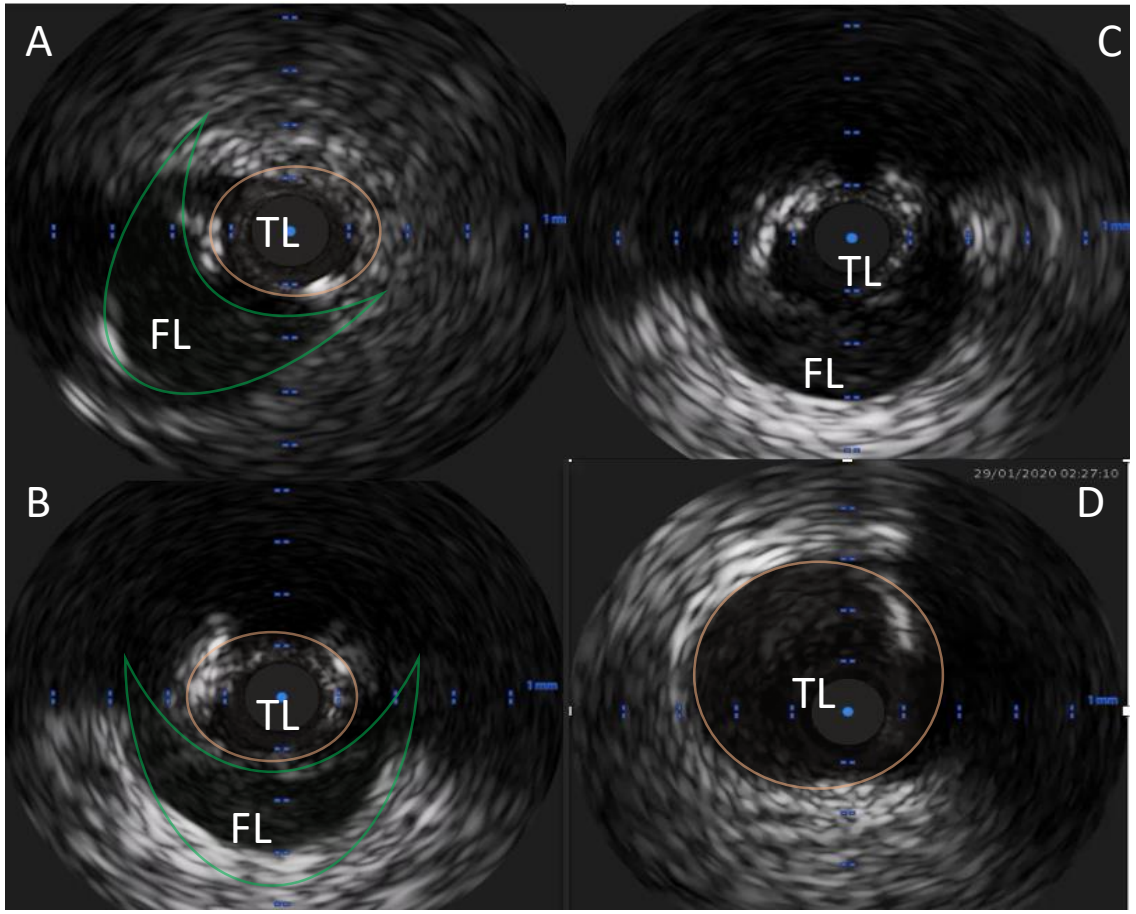
Chest pain, Inferior ST elevation on ECG



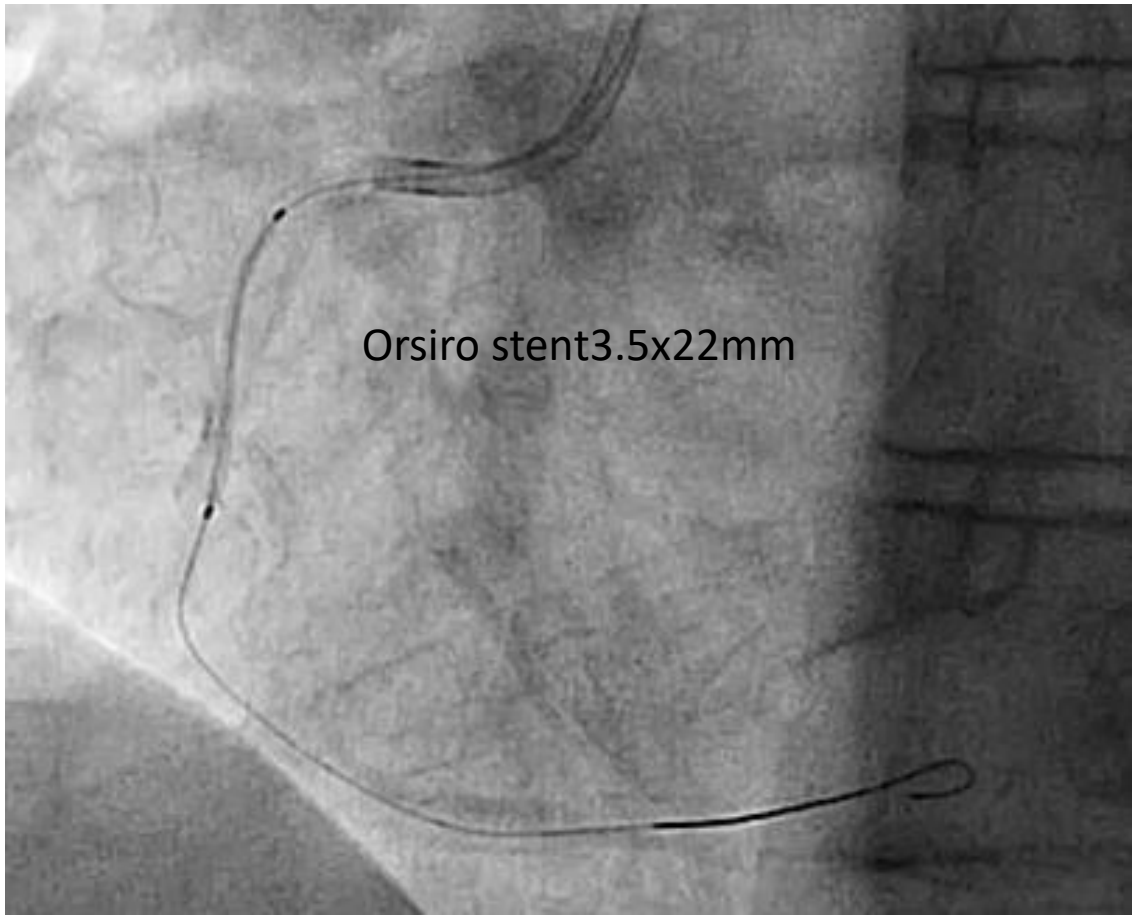


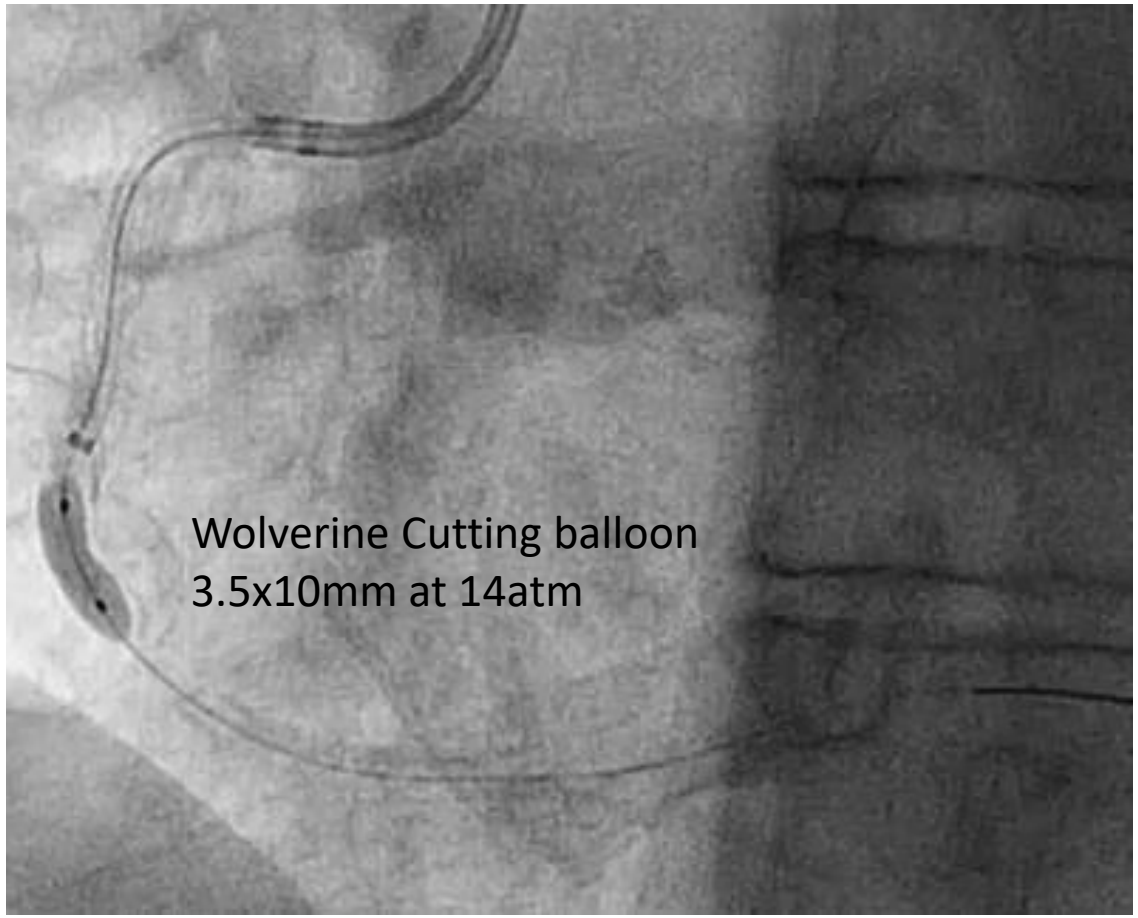
Assessment with IVUS





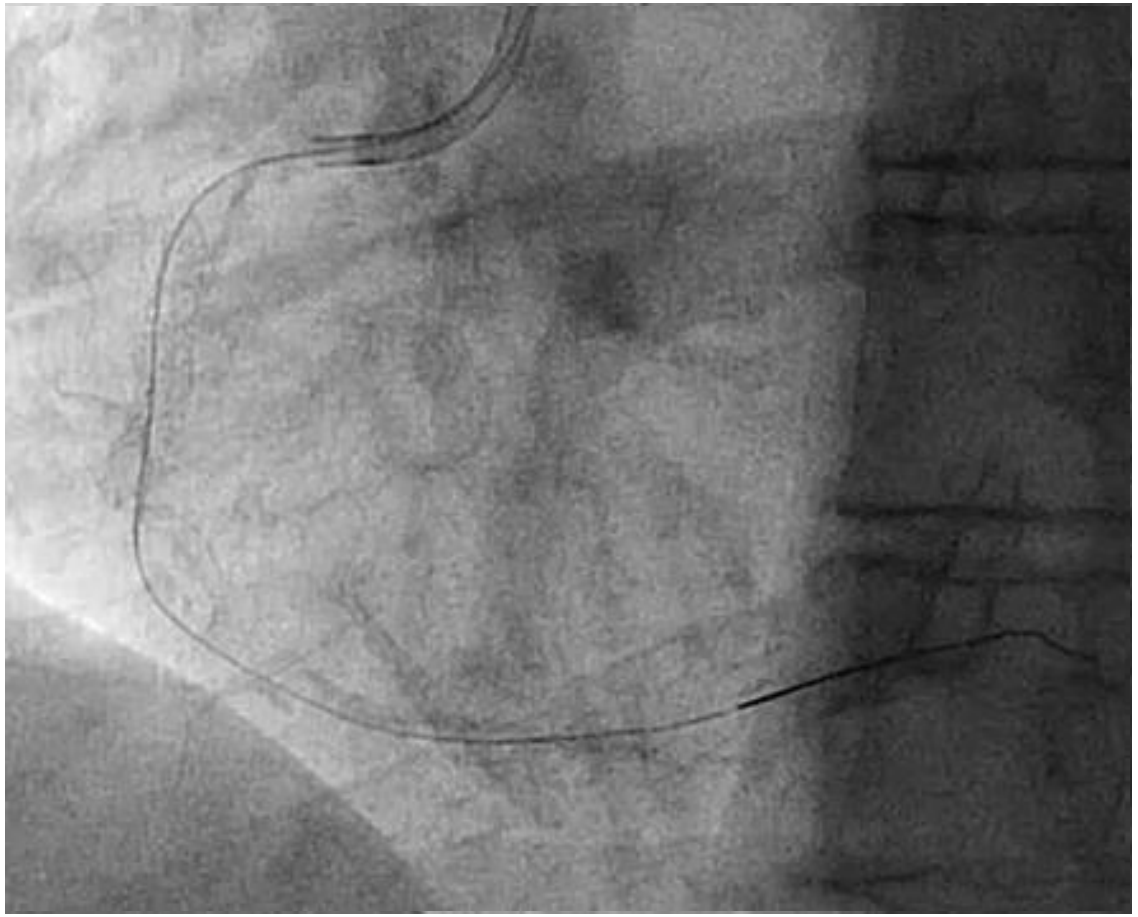
Management of dissection and intramural haematoma





Final Results

Result after fenestration



Final result

Key Learning Points

- Appropriate assessment of calcification – choice of calcium modification technique
- Intracoronary assessment to understand aetiology of complication
- Controlling a dissection by stenting proximal and distal edge
- Fenestration of an occlusive intramural hematoma to relieve myocardial ischeamia and avoid unnecessary additional stenting