A surprising appearance in an elective diagnostic angiogram

Richard G Bogle & Klio Konstantinou

Cardiology Clinical Academic Group

St George's University Hospitals NHS Foundation Trust, London, UK

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Potential conflicts of interest

Speaker's name: Richard Bogle

☑ I do not have any potential conflict of interest

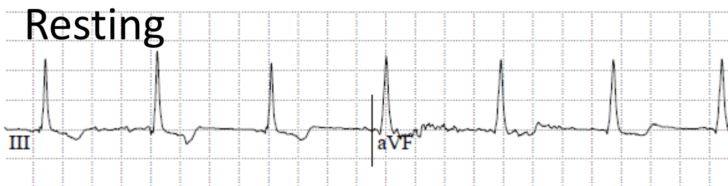
Background Case History

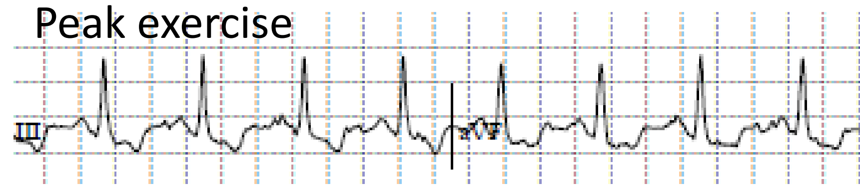
- 52 year old male; 4 week history of stable angina
- Hypertension, Non-smoker, LDL 1.6, HDL 1.0; No FH IHD
- Essential thrombocythaemia 2002 (JAK-2 negative)

- Aspirin 75mg od; Ramipril 5mg od; Indapamide 1.5mg od; Hydroxycarbamide 1.5g OD; Anagrelide 0.5mg BD

- Hb 120; WBC 3.5; Plt 314; eGFR>60; Glucose 5; TnI <17

- ECG: Sinus rhythm; T wave inversion - inferior leads
- Echo: LV apex akinetic, remaining regions normal; EF 56%
- Exercise ECG: 2.29 min chest pain and inferior ST depression





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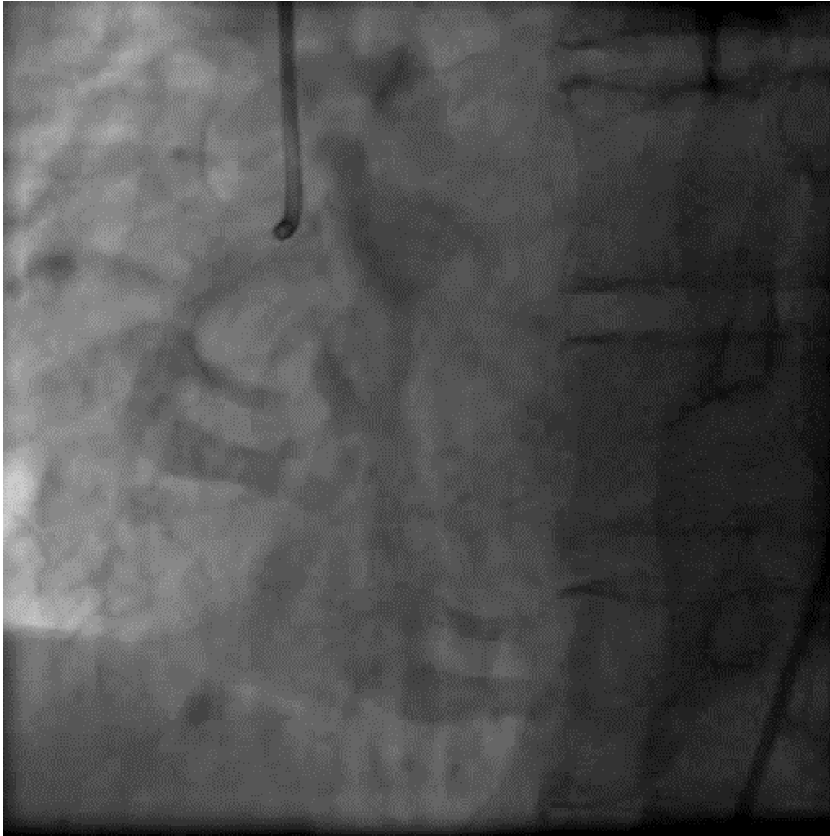
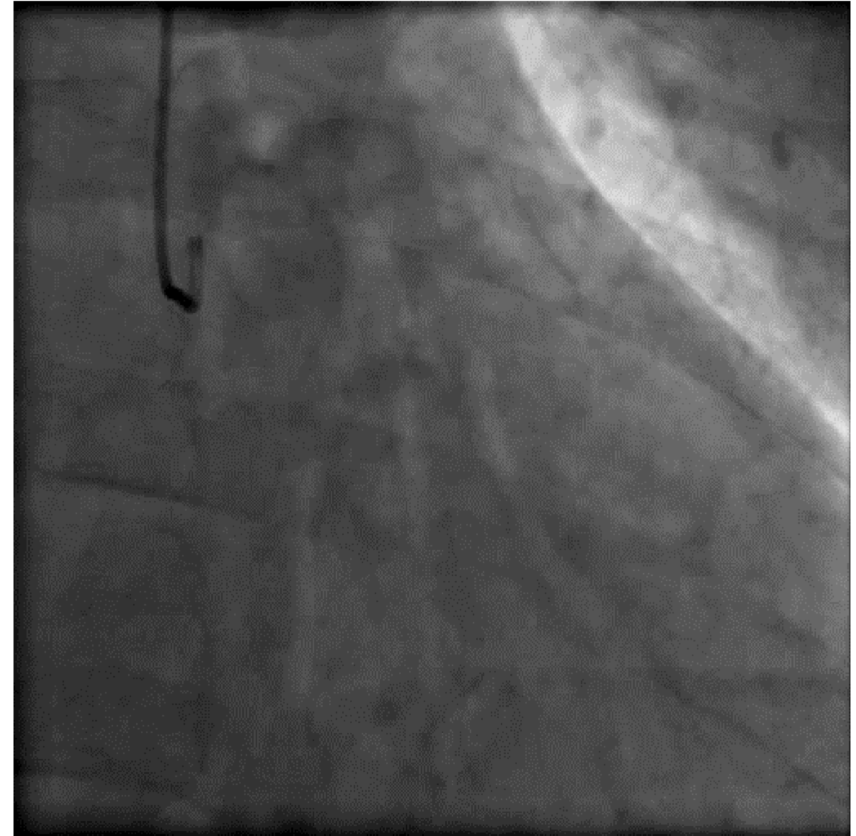
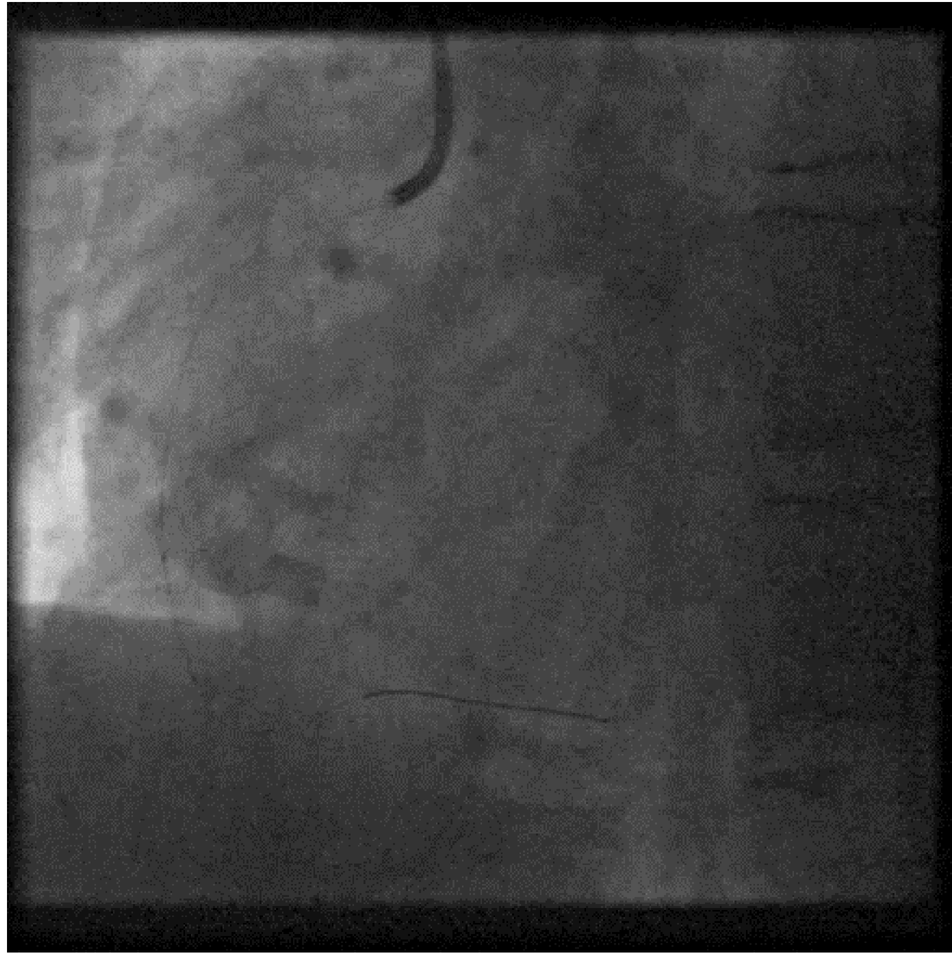
Coronary angiography

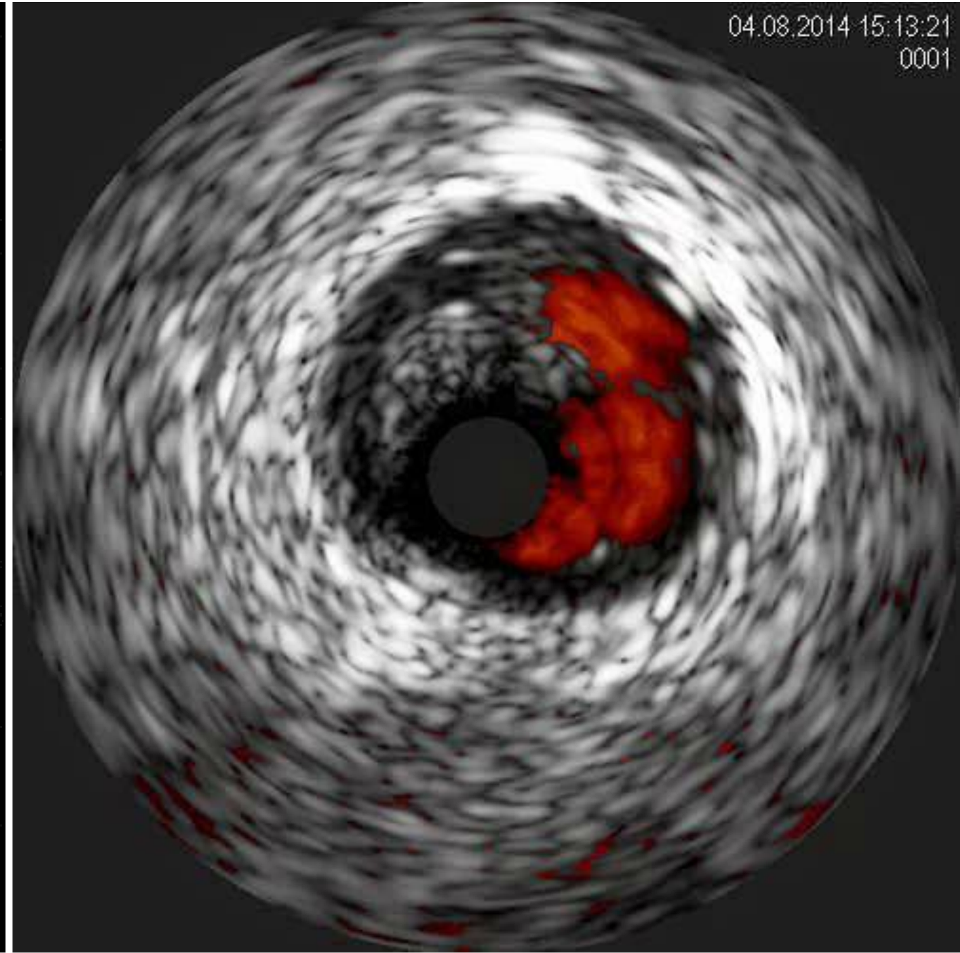




Intervention: JR4 guide. Ticagrelor 180mg po; Heparin 5000 units iv
BMW wire then Whisper MS wire – unable to advance to true lumen
No chest pain; TIMI3 flow; Given Abciximab/Fondaparinux for 48h
Plan for further attempt at PCI 1 week later

6F JR4 guide; Pilot 50 + Volcano™ Intravascular Ultrasound





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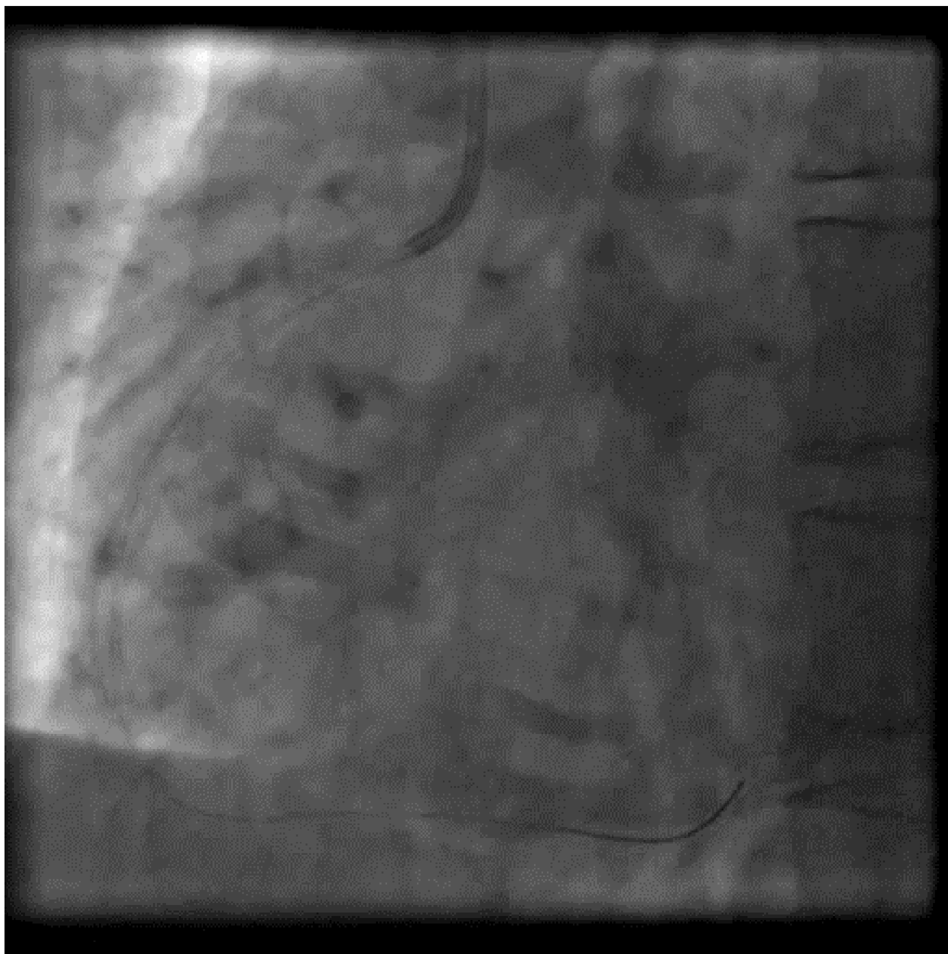
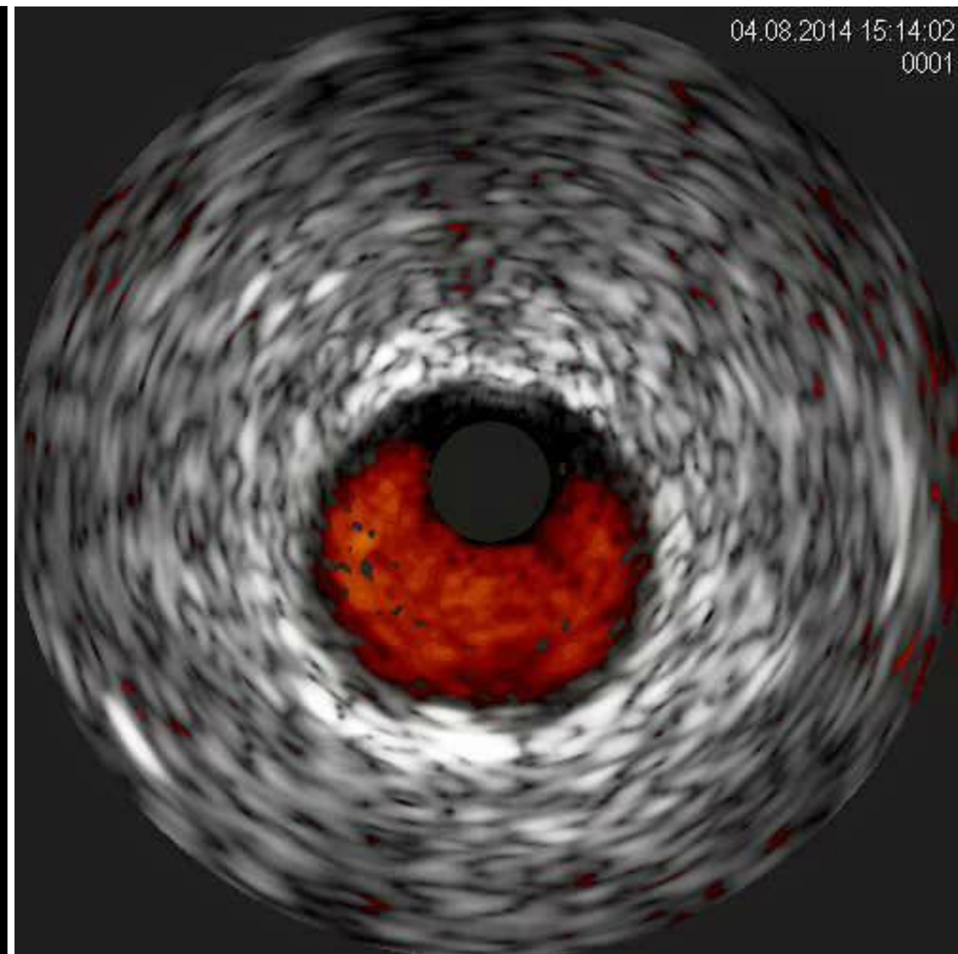
3.0×28 Resolute Integrity distal then 3.5×30 Resolute Integrity proximal





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Discussion

- Chronic spontaneous coronary dissection (SCAD) is rarely seen at routine diagnostic angiography (0.1-0.28%)
- Usually found in middle aged females with ACS presentation.
- Classification of SCAD:
  - Type 1: Pregnancy-associated (medial-adventitial disruption)
  - Type 2: Atherosclerotic plaque (intimal-medial disruption)
  - Type 3: Connective tissue diseases & FMD
  - Type 4: Vascular inflammation. e.g. SLE, PAN, drugs (5-FU, Cyclosporine, Cabergoline); myeloproliferative diseases, ET

- This is only the second reported case of SCAD in a patient with ET (Mali et al., 2015; WMJ; **114;** 26-29).