Perkutane inotrevencije u bolesnika s anomalnim polazištima koronarnih arterija u akutnim koronarnim sindromima

Percutaneous interventions in patients with anomalous origin of coronary arteries presenting with acute coronary syndromes

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Uvod: Anomalna polazišta koronarnih arterija se pronalaze u oko 0,6 do 1,5% svih angiografskih nalaza¹. Ove aberantne arterije predstavljaju posebni izazov za dijagnostiku i za eventualno intervencijsko liječenje. Posebno zahtjevni su slučajevi kada su upravo te aberantne arterije odgovorne za akutne koronarne sindrome.

Prikazi slučajeva: Prikazujemo tri slučaja akutnih infarkta miokarda sa ST elevacijom koji su uključivali aberantne koronarne arterije. Prvi je slučaj trombotske okluzije dominantne desne koronarne arterije i trombotske subokluzije anomalne cirkumfleksne arterije koja polazi od ostijuma desne koronarne arterije. Drugi slučaj je primjer trombotske okluzije desne koronarne arterije koja polazi iz lijevog koronarnog sinusa. Treći je slučaj okluzije dominantne prednje silazne interventrikularne arterije u situaciji odsutnosti desne koronarne arterije ("single coronary artery"). Sva tri slučaja uz zahtjevne manipulacije vodećih katetera su uspješno intervencijski liječena.

Diskusija: Akutni infarkt miokarda kao posljedica okluzije aberantne koronarne arterije je rijedak slučaj te je tek nekoliko takvih slučajeva opisano do sada u literaturi. Tehnički problemi uključuju adekvatnu vizualizaciju arterija, balansiranje između vodećeg katetera koji daje dobru potporu i rizika eventualne disekcije ušća te ponekad ekstremni tortuoziteti koje koronarna žica i sav intervencijski materijal (balon, stent) moraju savladati.

Zaključak: Adekvatno znanje tijeka i odnosa koronarnih arterija te adekvatno poznavanje raspoloživog intervencijskog materijala svakako omogućuju inotrevencijsko liječenje i u slučaju kada je aberantna koronarna arterija odgovorna za akutni koronarni sindrom.

Introduction: Coronary artery anomalies are found in 0.6%-1.5% of patients undergoing diagnostic coronary angiogram or intervention.¹ These arteries present a challenge for diagnosis and intervention particularly in case of acute myocardial infarction presenting with occluded aberrant coronary artery.

Case reports: We report three cases on acute myocardial infarction with ST elevation presenting with "culprit" lesions in aberrant coronary arteries. First case is thrombosis occlusion of dominant right coronary artery and thrombosis sub occlusion of circumflex artery which originate from right coronary cusp. Second case is thrombotic occlusion of right coronary artery which originate from left coronary cusp. Third case is thrombotic occlusion of dominant left anterior descend artery in situation of absence right coronary artery ("single coronary artery"). All three cases were successfully treated.

Discussion: Acute myocardial infarction associated with anomalous origin of coronary artery is very unusual. Only few cases have been reported in literature. The technical difficulties associated with interventions include improper visualisation, managing the balance between adequate guiding support and risk of dissection, and casual extreme significant curves that have to be overcome with guide wires and all other interventional material.

Conclusion: Appropriate anatomical knowledge about the course of aberrant vessels and selecting appropriate hardware leads to safe selective engagement of anomalous coronary artery which is very important for finishing intervention in safe and reasonably quick manner.

LITERATURE

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