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Coronary artery dissection as a complication of blunt chest trauma in a young male.

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Coronary artery (CA) dissection is uncommon condition that clinically may be indistinguishable from acute myocardial infarction (MI), especially in presence of typical retrosternal pain and characteristic features on the initial electrocardiogram (ECG). According to several retrospective studies, thrombolytic therapy should be avoided in this group of patients. A previously healthy 31-year old male was admitted to the National Research Center for Preventive Medicine (Moscow, Russia) due to severe interscapular pain radiating to the left arm, sweating and lightheadedness appeared after he got a blow to the chest by a rugby ball. During the pre-hospital management a 12-lead ECG was recorded that showed ST-segment elevation in the anterior leads (V1-V4) suggestive of MI. Before being delivered to the hospital, patient had received successful thrombolytic therapy with subsequent ST-segment resolution on ECG. Echocardiographic studies showed hypokinesis of the left ventricular (LV) apical segments and preserved LV ejection fraction. Coronary angiography revealed extensive narrowing of the left CA trunk with involvement of the proximal left anterior descending artery. At the site of lesion a single false radiolucent lumen was visualized pathognomonic for CA dissection. Percutaneous coronary intervention (PCI) was successfully attempted with initial balloon dilatation followed by bare metal stent insertion to the affected vessel area. Stent provided a good coverage for the lesion, and no more narrowing was observed. Patient was discharged home on dual-antiplatelet therapy along with small doses of beta-blocker and ACE inhibitor. 6 months following the patient discharge repeated examination revealed no residual symptoms and good exercise tolerance confirmed by stress-echocardiography.

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