Complete Resolution of Iatrogenic Aortic Dissection

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Case Summary

- 58 Yrs old Female
- C/C  Effort induced chest pain (CCS III)
- Risk Factor - DM (-), HTN (+) for 10Yr non-Smoker
TTE

No RWMA
Preserved LV systolic function
EF 60%
CAG  Trans-radial, 6fr
My Plan
PCI

- Trans-radial approach
- Guiding Cath; Ikari 6Fr SH(-)
- Fielder XT with OTW balloon
PCI

POBA

1.2mm Sapphire (OrbusNeich)
2.5mm Trek (Abbott)
Oh My God ~ !!

A. Check Vital Sign
B. Keep The Wire
C. Call Other Cardiologists & Surgeon, ASAP
✓ No Chest Pain
✓ Vital was stable
✓ no ECG change
PCI

Xience Prime 3.5 x 33mm
$FL = False Lumen$
PCI

Xience Prime 4.0 x 15mm
Final Result
Chest CT
Iatrogenic Bidirectional Dissection of the RCA and the Ascending Aorta

How to Manage ??
Emergency Operation
(Hemiarch Replacement & LIMA to midLAD)

Stanford Type A
Pericardial Effusion

Entry Point was Sealed
Asymptomatic
Denial of Surgery

Close Observation & Surgical back-up
Close Observation & Surgical back-up

1. Check bed-side TTE for hourly
2. Keep the Low BP (< Sys 100 mmHg, < Mean 60 mmHg)
3. Keep the Low HR using IV labetalol (< 60 bpm)
Post-PCI

48 hr After
Post-PCI

48 hr After
3month FU CT
Clinical Course

- FU CT showed regression of hematoma (max; 7mm)
- Patient discharged at 18 days after PCI
- Effort chest pain was relieved
- 3 months FU CT revealed complete resolution
- Stable in outpatient department for 6 months
- Additional LAD stent is considered... Not Yet,
Summary

1. Be Careful of bidirectional dissection when treat Proximal Lesion.

2. In Coronary Dissection, covering of the entry point was important to limit progression of false lumen.

3. Most of Aortic Dissection needed surgery, but in selected cases conservative management can be effective.
Thank you for your attention.