

# Ektatična krvna žila i akutni infarkt miokarda

## Coronary artery ectasia and acute myocardial infarction

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**KLJUČNE RIJEČI:** ektazija koronarne arterije, infarkt miokarda, tromboliza.

**KEYWORDS:** ectatic coronary vessels, myocardial infarction, thrombolysis.

**CITATION:** *Cardiol Croat.* 2014;9(9-10):401-402.

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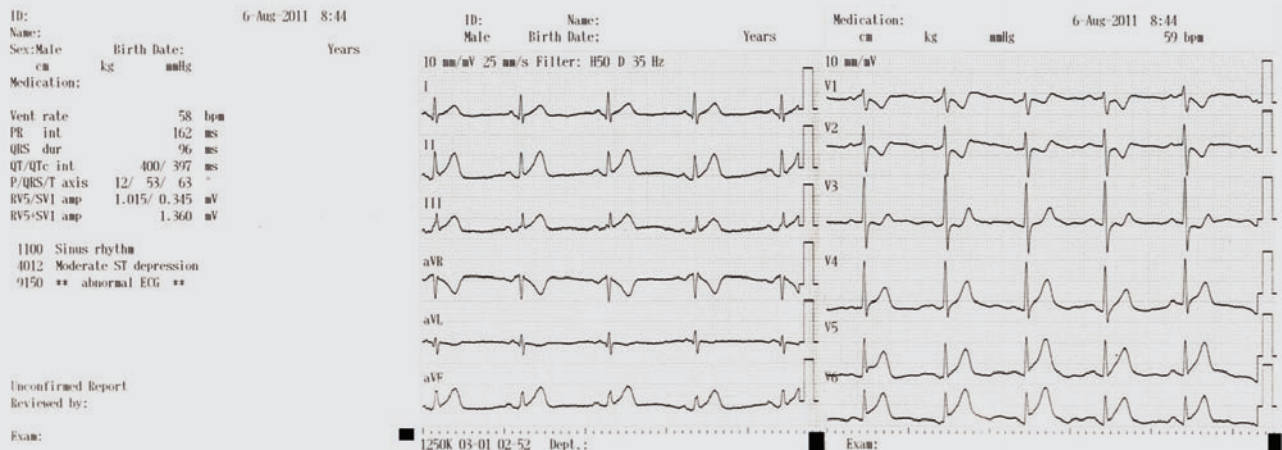
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**UVOD:** Ektatične krvne žile se pojavljuju u 3-8% populacije koja se podvrgava koronarografiji. Po prihvaćenim mjerilima ektazijom se smatra proširenje za 1,5 puta referentnog dijametra krvne žile. Etiološki se radi o upalnim bolestima arterija, autoimunim bolestima, nasljednim bolestima vezivnog tkiva, ali najčešće (50%) se radi o ektatičnom obliku aterosklerotske bolesti koronarne krvne žile.

**PRIKAZ SLUČAJA:** Prikazujemo slučaj muškarca, starog 59 godina, bivšem pušaču s poznatom neliječenom

**INTRODUCTION:** Coronary artery ectasia occur in 3-8% of the population which undergoes coronary angiography. By the accepted standards ectasia is considered as dilatation that was 1.5 times greater than the reference diameter of blood vessels. Etiological, ectasia is the result of inflammatory diseases of the arteries, autoimmune diseases, hereditary connective tissue diseases, but the most commonly (50%) involve ectatic form of atherosclerosis.

FIGURE 1.



12-lead electrocardiogram of the patient recorded at emergency department.

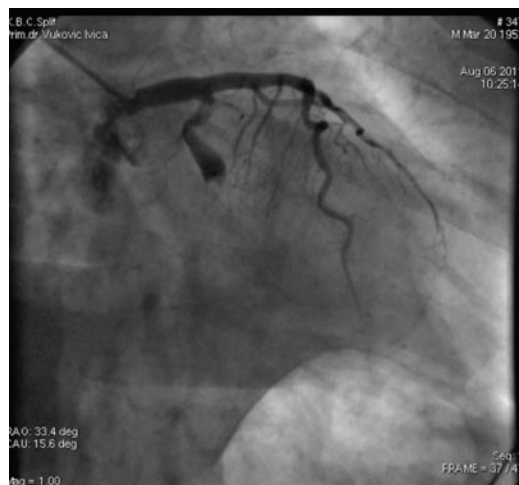


FIGURE 2.

Urgent coronary angiogram was performed, showing coronary artery ectasia and thrombotic occlusion of circumflex branch of left coronary artery.

RECEIVED:  
September 22, 2014

hiperlipidemijom koji je hospitaliziran radi protrahirane prsne boli i elektrokardiografskih znakova infarkta miokarda s elevacijom ST spojnice u inferolateralnim odvodima (slika 1). Radijalnim pristupom uradi se koronarografija, kojom se prikazu RCA i LAD bez značajnih angiografskih suženja, dok je u proksimalnom segmentu Cx aneurizmataska vreća promjera 7 mm (slika 2), distalno od koje se ne prikazuju krvne žile. Pristupi se intervenciji, uspije se plasirati žica u distalni segment Cx. Prikazu se trombotske mase u aneurizmi uz nesrazmjer aneurizmatске vreće i srednjeg segmenta Cx, kao i OM. Prilikom intervencije kod bolesnika je dva puta nastupila ventrikularna fibrilacija (slika 3) s prestankom disanja, koja je liječena defibrilacijom vanjskim elektrodama. Procijenili smo da dostupnim mehaničkim intervencijskim materijalom nismo u mogućnosti aspirirati velike trombotske mase, a da se eventualnim pokušajem aspiracije tromba može dogoditi i embolizacija u LAD. Stoga se odustane se od daljnje intervencije. Kako se radilo o radijalnom pristupu sistemski fibrinolize nam je bila dostupna opcija. Bolesnik je vraćen u Koronarnu jedinicu, gdje je po shemi primio sistemski alteplazu uz nefrakcionirani heparin.

**ZAKLJUČAK:** Primjenom sistemske fibrinolize, koja nije kontraindicirana u slučaju radijalnog pristupa, postigli smo dobar klinički odgovor. Bolesnik je otpušten iz bolnice. Rekoronarografijom nakon tri mjeseca prikazu se uredno prohodne Cx i OM (slika 4).

**CASE REPORT:** We present a case of 59-years old ex-smoker with known untreated hyperlipidemia. He was hospitalized due to protracted severe pain in the chest accompanied by electrocardiographic signs of ST elevation myocardial infarction in the inferolateral leads (Figure 1). Urgent radial access coronary angiography was performed, which visualized normal RCA and LAD, while in the proximal segment of Cx aneurysmatic sac, 7 mm in diameter, was shown (Figure 2). Distal segments bellow aneurysm did not visualize. The wire was successfully placed in the distal segment of the Cx showing extensive thrombotic masses in the aneurysm, and the discrepancy between the diameters of aneurysm sack and middle segments of the Cx and OM. During the intervention in two occasions patient developed ventricular fibrillation with cardiac arrest (Figure 3), and was successfully treated with defibrillation. We estimated that interventional material available to us was unable to aspirate such large thrombotic masses, and that any attempt to aspirate the thrombus can result in embolization of LAD. As a result, we discontinued further intervention. Since we used radial access, systemic fibrinolysis was available option. The patient was returned to the coronary care unit, where he received alteplase with unfractionated heparin.

**CONCLUSIONS:** By applying the systemic fibrinolysis we achieved a good clinical response. The patient was discharged. Three months later, reoronarography was performed which showed normal blood flow trough Cx and OM (Figure 4).

FIGURE 3.

During the interventional procedure the patient developed a cardiorespiratory arrest due to ventricular fibrillation which was successfully resolved by defibrillation.

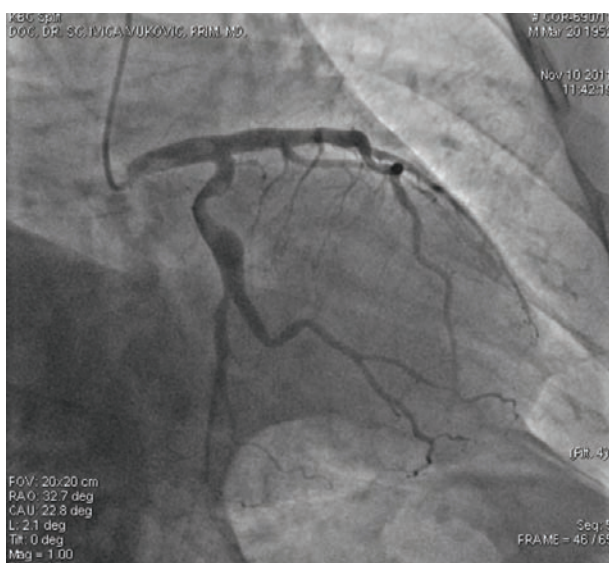
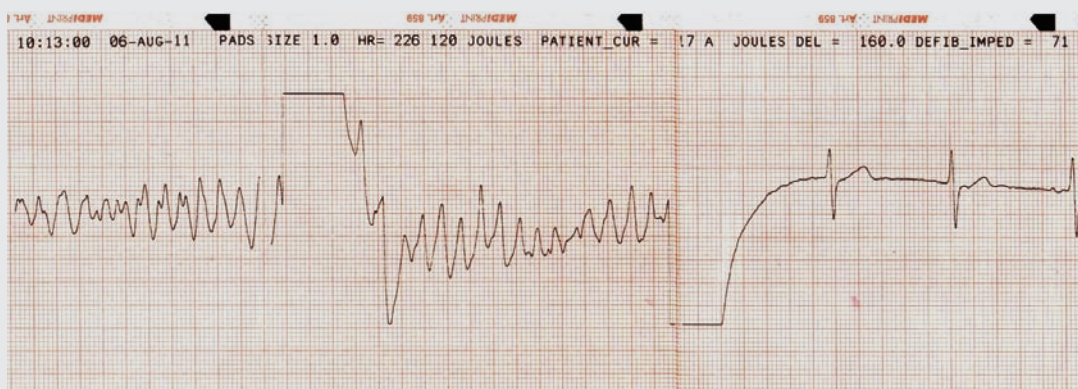


FIGURE 4.

Before discharge a control coronary angiogram was performed, still showing ectasia of left coronary artery. However successful thrombus dissolution and good revascularization within circumflex artery can be seen.

LITERATURE

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