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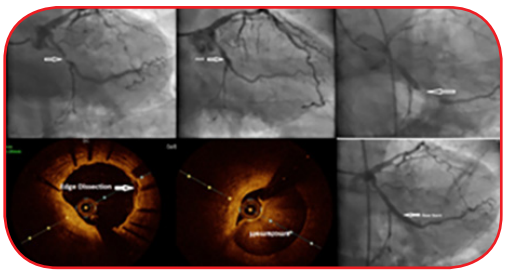
Post PCI coronary intramural hematoma causing NSTEMI and short runs of VT

The optimal management of coronary intramural hematoma has not been well defined. Their occurrence can be a diagnostic challenge to the interventionist. Ischemia and hemodynamic compromise are possible complications, if not managed promptly. Conventional coronary angiography alone is often insufficient to identify an intramural hematoma without intimal dissection and a visible flap. Intra Vascular Ultrasound (IVUS) and Optical Coherence Tomography (OCT) are helpful modalities for diagnosis and evaluation of its extension. We present a case in which coronary occlusion developed due to an intramural hematoma after an elective Percutaneous Coronary Intervention (PCI) to the mid left circumflex artery. The patient was clinically asymptomatic after the angioplasty, but his highly sensitive troponins were trending very high and had two short runs of ventricular tachycardia. We did a relook angiography the next day and it showed new hazy 80% stenosis from the distal end of the newly implanted stent. In view of likely dissection, we decided to do OCT to identify the etiology of the new lesion. We choose OCT as it offers clear, high resolution images, compared to grainy, lower resolution IVUS images. Moreover, OCT provides a complete vessel wall assessment and can reveal more insight into the mechanisms of intramural hematomas like the entry point of the dissection, propagation direction, underlying arterial plaque, severity of the intramural hematoma and luminal compromise. OCT confirmed an edge dissection at the distal end of the stent, which created a big intramural hematoma compressing the true lumen. We decided to perform angioplasty, as the patient had two short runs of ventricular tachycardia and high sensitive troponin T was highly elevated. Direct stenting was performed using drug eluting stent overlapped with distal end of the previous stent covering the edge dissection. The inflation pressure was kept low at 10 atm for 17 seconds. Post dilation was performed only at the stent overlapped area using a Quantum 3.5 x 8 mm non-compliant balloon at a pressure of 16 atm for 16 seconds. Following the intervention there was 0% stenosis with TIMI 3 flow. Post stenting OCT (Optical Coherence Tomography) showed complete resolution of the intra mural hematoma and edge dissection, with well apposed stents. The patient was discharged after few days in a very good condition and his clinical outcomes were excellent at one month after intervention.



Biography

Muhammed Jameesh Moidy is a currently 3rd year Cardiology ACGMI accredited Fellowship program scholar at the Heart Hospital, Qatar. His research interest is in coronary artery disease root cause analysis, prevention and better long-term patient outcome. He has her expertise in evaluation and passion in improving the health and well-being by introducing innovative technologies in the field of intervention cardiology.

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