Case presentation

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Medical History

Female patient
53 years old
Obese
Diabetic, hypertensive
Dyslipidemic
Unstable angina since September 2014
PCI to LAD at January 2015
Complaint

- Recurrent attacks of chest pain increasing in frequency and duration.
- ECG: sinus rhythm with no evidence of active ischemia.
- Echo: Normal LV function with no resting wall motion abnormality.
Resting vital data:
HR: 92 beat/minute
Bl.pr: 140/80

Physical stress study
Bruce protocol
Time: 4 : 13 min
HR achieved: 142 b/min
Termination reason: chest pain
Peak Bl/pr: 200/100
RECOVERY ECG
MYOCARDIAL PERFUSION SCAN

Positive Tc99m sesta MIBI Gated SPECT showing combination of severe ischemia and small sized scar at LAD / ischemia in LCX territory with stress induced LV dilatation.

Myocardial perfusion scan pointed to possible LAD and LCx ischemia with need for coronary angiography for anatomic delineation
Coronary Angiography showed

- Patent stent in the LAD with diffuse distal disease without angiographic significant lesion and CTO of diagonal branch
- An intermediate lesion in the LCX.
Decision:

- In view of recurrence of chest pain and physiologic evaluation of the lesion by MPI, IVUS was warranted for anatomic evaluation of both LAD and LCx lesions.

IVUS TO LAD
IVUS TO LCX

IVUS FINDINGS:

IVUS findings supported angiographic findings with non-significant LAD instent restenosis and a significant LCx lesion with need for intervention
Patient became symptoms free for the last 2 years and she is on regular follow-up till current period.
Conclusion

Respect patient complaint.

MPI is essential for diagnosis of ischemia in angiographically borderline / insignificant stenoses.

IVUS is useful in localizing exact site for coronary intervention.