Case Summary

• **Patient Demographics**
  Age: 76
  Gender: Female

• **Risk Factors**
  Diabetic
  Hypertension
  Dyslipidemic
  Mild CKD s.cr 1.8 mg/dl

• **Clinical presentation**
  Sever agonizing chest pain 2 h before admission associated with sweating and dizziness.

  • Pt shifted to CCU with ECG showing Ex AWMI.

  • Echo: showed preserved EF with Hypokinesia at LAD territory.
• **Loading**: ASA 300mg  
  Ticagrelor 180 mg.  
  Atorvastatin 80 mg.  
  Enoxaparin 40 mg IV.

• Pt shifted to cath lab

**What's the plan?**
Procedure Strategy

• Using Guiding JL4 6F (short LM).
• Wiring of the LAD using PT2 Ls.
• Pre Dilatation…. May I need aspiration ?!
• Reassessment of the lesion for the size of the stent.
• Stenting the lesion.

• PT started to be Hypotensive with sever chest pain
• Cardiac Arrest
FEAR IS AN ENERGY
**WHAT SHOULD I FIX FIRST??**

- The Osteal Dissected LAD

OR

- The Culprit Lesion
Do I have to stop?
Take Home message

- Coronary artery dissection is a rare but well-recognized complication of CA with high incidence of M&M if left untreated.

- The cause of dissection may be due to anatomical reasons or physician reasons.

- The best ttt of CA dissection is to prevent it from happening in the first.

- Conservative management should be recommended if there is no flow limitation with closely follow up.