The case of a 71-year-old male patient, with symptoms of dizziness and atypical chest pain and a positive isotopic exercise stress test, is reported. Coronary angiography demonstrated an anomalous origin of the left circumflex coronary artery from right coronary ostium but no obstructive atherosclerotic coronary lesions. The possible relation between the congenital coronary anomaly and the clinical manifestations of the patient is discussed.

Key words: Catheterization. Congenital heart defects. Ischemia. Scintigraphy.

INTRODUCTION

The increasingly extended use of diagnostic coronaryography is discovering numerous congenital anomalies of the coronary arteries. At first they were considered simple coronariographic findings and there was a tendency to characterize them as benign. However, this attitude was undermined by reports of cases of sudden death, AMI, angina, and syncope associated with their presence. We now think that a new attitude is needed and, although not all coronary anomalies should be considered malignant, we must begin to consider them «potentially malignant.»

CLINICAL CASE

The patient was a 71 year-old male watchmaker with no family history of ischemic heart disease or known coronary risk factors. He was undergoing reha-

bilitation for left cervicobrachyalgia due to C6-C7 cervicobra- throsis. Occasionally and with no relation to effort, he referred dizziness without loss of consciousness and sweating followed by «chest discomfort.» Sublingual nitroglycerin resolved his dizziness and «discomfort.» He was admitted to our hospital with normal electrocardiograms and serial cardiac enzymes. Conventional stress testing following the Bruce protocol had to be interrupted for dizziness and emotional lability when 84% of theoretical maximum exercise heart rate (MEHR) was reached with no electrical changes being observed. A 24-h Holter study was normal. He was released with anxiolytic medication to complete studies on an outpatient basis.

In later follow-up visits he continued to have occasional dizziness and «chest discomfort» without losing consciousness «because he would lay down on the ground.» Several Holter studies were requested, but continued to be normal.

A tilt-test was negative. Given his reiterated symptoms a radionuclide myocardial perfusion test was made. After a conventional exercise stress test, according to the Bruce protocol, images at rest were obtained 3 h after intravenous administration of the radio-drug (Tc; 8 and 20-mCi doses). The conventional stress test was discontinued when dizziness appeared in 5 minutes, when the patient had reached 86% of
MEHR without angor, electrical changes, and with a good pressor response. The study of myocardial perfusion after the ergometric test and at rest revealed small subsegmental perfusion defects in the apical, inferior, and lower interventricular septal area and positive redistribution to the lower septum and inferior face (Figure 1). These disturbances suggested ischemic changes induced by the test. In view of these results, cardiac catheterization was requested, which revealed right dominance and coronary arteries free of angiographic lesions. The circumflex coronary artery arose from the ostium of the right coronary and had a retroaortic path (Figures 2 and 3); LVF was normal. At follow-up 3 months later the patient referred occasional dizziness.

**DISCUSSION**

The incidence of congenital anomalies of the coronary arteries in different series ranges from 0.3% to 8.3%. The origin of the circumflex artery (Cx) in the right coronary sinus (from an ostium common to the right coronary or an independent ostium) or right coronary artery (as a proximal branch of this artery) is the most common anomaly of the origin of the coronary arteries. Thus, Effler in 1970 recommended calling it a «normal variant» rather than an anomaly.

The disposition of the Cx from its anomalous origin is always the same. From its origin the Cx goes backward and to the left, circling the aorta from behind, then passing between the posterior aortic wall and first
the anterior right atrial wall, then the left atrial wall, until it reaches its location in the left part of the atrio-
ventricular sulcus, where it is covered by the left atrial appendage and has its usual disposition.

This anomaly has been and continues to be conside-
red benign. Nevertheless, cases of association with
sudden death, AMI, and angina pectoris in the absence
of atherosclerotic lesions have been reported. The fac-
tor responsible for this pathogenicity could be repea-
ted compression of this vessel by dilation of the aortic
root or angling as a result of its retroaortic position,
which would compress the coronary ostium into a
«slit» that obstructs blood flow. It seems reasonable to
carry out tests to detect possible myocardial ischemia
before considering a coronary anomaly as benign. One
of the tests most often used is the exercise stress test
with thallium. However, for Piovesana, et al. and
Molajo, et al. the test is not sensitive enough, as they
have demonstrated in published reports of patients
with Cx anomalies and positive conventional stress
tests with negative thallium stress tests. This finding
was attributed to a lack of sensitivity of this method in
characterizing myocardial perfusion defects in these
patients. In fact, Dunn, et al. questioned the sensitivity
of the thallium exercise stress test in demonstrating is-
chemia in the territory irrigated by the Cx.

Our patient did not have clear clinical manifesta-
tions of angor. He presented dizziness and chest discomfort
that remitted with occasional use of sublingual nita-

tes. His life was practically normal and in the last
month he had only one episode of dizziness without
loss of consciousness. We must also consider that his
dizziness could be due to cervicoarthrosis, or that the
«chest discomfort,» which could be caused by ische-
mia, could precipitate dizziness. We found no arrhyth-
mic cause of dizziness in Holter studies and the tilt-
test was negative. A finding suggesting a possible
ischemic cause was the positivity of the radionuclide
test was negative. A finding suggesting a possible
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In fact, an anomalous Cx artery, paradigm of the
«benignity» of coronary anomalies, can sometimes be
non-benign. Compression of the retroaortic segment of
the Cx, or angling at its origin, could narrow the os-

tium to a slit and cause ischemia.

In this case we decide not to take an aggressive the-
rapeutic approach for the moment. Taylor, et al. has
studied the main features of patients with coronary
anomalies that cause sudden death. Age under 35 ye-
ars and an interarterial path were the two factors most
commonly related with this fatal outcome. The age of
our patient and the fact that his clinical manifestations
did not interfere with a normal life motivated us to use
a conservative approach with anxiolytic drugs and su-
blingual nitrates.

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