Giant Coronary Artery Fistula Between the Left Main Coronary and the Superior Vena Cava Complicated by Coronary Artery Dissection

To the Editor,

Coronary fistulas are connections between the coronary arteries and another cavity. They are generally congenital and are due to a defect in the compacting of the myocardium during embryonic development. This persistent primitive vascular pattern can connect the coronary arteries with the ventricular cavities or other vascular structures. The most common type is that which originates in the right coronary artery and drains into the right-sided chambers, followed by fistulas between branches of the left coronary artery and the pulmonary artery.1

These conditions are rare and are mainly associated with a risk of myocardial ischemia (steal phenomenon), heart failure (volume overload, pulmonary hypertension), rupture or dissection, endocarditis and arrhythmias.2

The patient was a 41-year-old man with no known cardiovascular risk factors or family history of heart disease. He was admitted with tightness in the middle of his chest that appeared with moderate exertion, accompanied by other characteristic symptoms of physical discomfort affecting vegetative functions (pallor, perspiration, nausea/vomiting, etc). The electrocardiogram revealed an inferior subepicardial lesion with ST segment depression in right precordial leads and aVL. The administration of sublingual nitroglycerine relieved the pain. Emergency coronary angiography revealed a giant coronary fistula (12 mm in diameter) connecting the origin of the left main coronary artery (LMCA) with superior vena cava prior to its entry into the right atrium. There was highly developed dilation of the LMCA and circumflex artery, with a lesion of 60% in the distal obtuse marginal branch. The ejection fraction was 75%. The observation of a translucent

References

1. Sudarshan CD, Cochrane AD, Jun ZH, Soto R, Brizard CP. Emergency coronary angiography revealed a giant coronary fistula (12 mm in diameter) connecting the origin of the left main coronary artery (LMCA) with superior vena cava prior to its entry into the right atrium. There was highly developed dilation of the LMCA and circumflex artery, with a lesion of 60% in the distal obtuse marginal branch. The ejection fraction was 75%. The observation of a translucent

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image led us to suspect of dissection. The enzyme curve was positive, with a peak troponin I level of 25 U/L. Ultrasound confirmed the high flow rate (Figures 1 and 2). Preferential surgical treatment was performed and confirmed the presence of circumflex artery dissection. The fistula was ligated and aortocoronary bypass to the first marginal branch was carried out. Graft function was verified by means of perioperative Doppler ultrasound. The postoperative course was event-free and, nine months after surgery, the patient was asymptomatic.

In a series of 108 fistulas, most of them originated in right coronary artery, followed by anterior descending coronary artery. In the majority of the series, the fistula develops between the coronary arteries and the right side of the heart; the most common of all is the connection to the right ventricle, but it can also occur with the right atrium, pulmonary artery and coronary sinus. The functional significance of the fistulas depends on their number and the amount of blood flowing through them. Pulmonary hypertension can develop when they connect with the right ventricle.

In our case, the fistula produced no symptoms related to coronary steal or excessive flow. It presented as an acute coronary syndrome secondary to the dissection of the circumflex artery owing to the aneurysmal fistula.

There is no established medical treatment for asymptomatic patients. Closure is indicated in symptomatic patients with high-flow fistulas. Likewise, the closure of large-caliber fistulas would appear to be a reasonable approach. Surgery involving the ligation of the fistula is the treatment of choice in the case of multiple fistulas with large branches or of substantial diameter, in cases of concomitant surgery and when percutaneous access is impossible. This case illustrates the importance of correcting large, high-flow fistulas early, using the technique most suitable to avoiding undesirable complications, such as the dissection of an aneurysmal coronary artery reported in this case.

REFERENCES
Letters to the Editor


Rupture of a Left Sinus of Valsalva Aneurysm Into the Pericardial Cavity

To the Editor,

The sinus of Valsalva aneurysm is an uncommon cardiac anomaly that can be congenital or acquired. It generally affects the right sinus of Valsalva (94% of the cases) and noncoronary sinus (5%); it rarely affects the left coronary sinus (1%).

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The sinus of Valsalva aneurysm usually ruptures (in order of frequency) into right ventricle (60%), into right atrium (29%) or, less frequently, into left atrium (6%) or left ventricle (4%). The rupture into the pericardial cavity is exceptional (1%).

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We report a complex and uncommon case of aneurysm of the aortic root, of the left sinus of Valsalva and of the proximal ascending aorta, complicated by rupture in left sinus of Valsalva into the pericardial cavity.

The patient was a 54-year-old woman with a personal history of hypercholesterolemia who came to the emergency room complaining of intermittent tightness in the center of her chest that had begun four days earlier. It was not associated with exertion, increased when she breathed deeply and radiated toward her jaw and left arm.

She had developed an upper airway cold over the preceding week that she was treating with amoxicillin and ibuprofen.

Upon her arrival in the emergency room, she was afebrile, her arterial blood pressure was 148/60 mmHg and her heart rate was 104 beats/minute. She was conscious and oriented, and was in generally