Primary Percutaneous Coronary Intervention in Anomalous High Anterior Takeoff Right Coronary Artery

Yukarı-Ön Çıkışı Sağ Koroner Arter Anomalisinde Primer Perkütan Koroner Girişim

Özet
Primer perkütan koroner girişim (PCI) da kısa ve uzun dönem mortaliteye etki eden önemli parametrelerden biri de ‘door to balloon time’dir. Sorumlu lezyonun oldukça nadir görülen koroner arter çıkış anomalisinin olması ve koroner artere kanülasyon için uygun kateter bulunamaması bu sürenin uzamasına neden olabilir. Burada, literatürdeki ilk vaka olan, akut inferior miyokard enfarktüsü (MI) ile başvuran hastada sorumlu lezyon yüksek anterior çıkışlı sağ koroner arter (RCA)’nin olduğu nadir görülen koroner anomaliye modifiye edilmiş sol guiding kateter yardımıyla başarılı primer PCI uygulanan vaka sunuldu.

Anahtar Kelimeler
Guiding Kateter; Yukarı-Ön Çıkışı RCA; Primer PCI

Abstract
One of the important parameters that influence the short and long-term mortality in primary percutaneous coronary intervention (PCI) is door to balloon time. Because culprit lesion is extremely rare anomalous origin of coronary artery and there is no proper catheter for coronary artery cannulation, this period may take longer. Here; the case that is the first in the literature, in which the culprit lesion was high anterior takeoff right coronary artery (RCA) in the patient admitted to hospital with acute inferior myocardial infarction (MI), and in which a successful primary PCI was applied to a rare coronary anomaly with the help of a reshaped left guiding catheter was presented.

Keywords
Guiding Catheter, High Anterior Takeoff RCA, Primary PCI

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Introduction
ST elevation acute coronary syndrome (STE-ACS) is the major reason affecting morbidity and mortality in developed countries. The most effective way of reducing mortality in STE-ACS is initiation of interventional (primary PCI) or thrombolytic therapy as soon as possible. Door to balloon time has been shown to be an important parameter affecting short and long term mortality in STE-ACS, and morbidity and mortality of the patients with shorter door to balloon time is less than the others. The incidence of coronary artery anomalies (CAA) are between 0.3% and 1.3% in general population and these patients who are usually asymptomatic may be admitted to the hospital with a variety of clinics, including sudden cardiac death [1]. One of the very rare subtypes of CAA is anomalous right coronary artery (RCA) with high anterior takeoff [2]. Various catheters are used for this anomaly which is quite difficult to cannulate in selective coronary angiography, but this increases the time and the cost of procedure. When patients with rare CAA are admitted to hospital with STE-ACS, because of these difficulties, door to balloon time may increase. However, this problem can be avoided with catheters providing adequate and appropriate back-up [3]. Here, we presented the case in which the culprit lesion was high anterior takeoff RCA and in which cannulation can not be achieved despite the use of numerous catheters, but cannulation and adequate back-up was provided after the use of a reshaped Judkins left guiding catheter.

Case Report
55 year old male patient with typical anginal pain in last 6 hours was admitted to our hospital. There were no risk factors for coronary artery disease except smoking. There were 2/6 systolic murmur on mitral valve area in cardiac auscultation, and ST elevation in the inferior leads and reciprocal ST depression in leads V1-V3 on admission electrocardiography. The patient with wall motion abnormalities on echocardiography was taken to the catheter laboratory for primary PCI with the diagnosis of acute inferior MI. In left coronary angiography via the femoral artery, cannulation of the left main coronary artery was achieved with Judkins left 6-F catheter and no significant lesions in the left coronary system was determined (Figure 1). RCA could not be displayed with Judkins guiding catheters of different sizes and then aortography was performed. In aortography RCA was observed as ghost-like image (Figure 2), and despite the use of, respectively, Amplatz left and right (AR-AL), right coronary bypass (RCB) and multipurpose guiding catheters, cannulation still was not achieved. Finally, Judkins left 6-F guiding catheter was reshaped manually by increasing the primary and secondary slopes up to 100-110 degrees, and quite good back-up was provided. In the imaging, high anterior takeoff of RCA and in the mid-region of RCA thrombosed lesion causing 99% stenosis was determined (Figure 3). RCA lesion was passed through by 0.014 inch AsahiTM floppy guide wire (Asahi Intecc, Aichi, Japan) and after predilatation by 2.0 mm*20 mm Alvimedica Invader® balloon (Alvimedica, Istanbul, Turkey), 2.75 mm*24 mm BiomimeTM sirolimus eluting stent (Meril Life Sciences, Vapi, India) was implanted and the lesion had <10% residual stenosis at the end of the procedure (Figure 4). There was no complication during the procedure and two days later the patient was discharged uneventfully.

Discussion
In STE-ACS cases which account for approximately 30% of all cases of ACS, reperfusion therapy plays a key role in reducing morbidity and mortality and reperfusion therapy can be performed by primary PCI which is an invasive way or by thrombolytic therapy. One of the most important factors influencing the decision of primary PCI is door to balloon time and this time is recommended to be under 90 minutes in patients with STE-ACS for effective benefits and every minute over 90 minutes increases mortality. But unfortunately, in some patients taken to the catheter laboratory for primary PCI, complexity of the culprit lesion and presence of CAA restricting cannulation or adequate back-up may increase this time. The frequency of CAA in the general population has been re-
ported to be between 0.3% - 1.3%, and these patients who are usually asymptomatic may present with a variety of clinics including sudden cardiac death [1]. High anterior takeoff RCA anomaly is an extremely rare subtype of all CAA [2]. Therefore, no case has been reported so far in which this extremely rare anomaly is culprit lesion for acute STE-ACS. Hence, only one high anterior takeoff RCA in 49 patients in which cannulation of the RCA could not be achieved and selective cannulation may be achieved by reshaping the left Judkins catheter [6]. For providing adequate back-up in RCA anomalies arising from the left sinus valsalva, Cohen et al. showed in two cases that Judkins left guiding catheter can be used and Caliskan et al. showed that multipurpose Hockey Stick guiding catheter can be used [7,8].

As a result, when rare seen high anterior takeoff RCA is the culprit lesion in STE-ACS, to provide adequate support for selective cannulation and primary PCI, manually reshaped Judkins left guiding catheter can be used as we did in our case. Also, this method can contribute to the reduction of morbidity and mortality by reducing procedure time and the amount of opaque.

Competing interests
The authors declare that they have no competing interests.

References

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Figure 3. Coronary angiogram of the high anterior takeoff right coronary artery (RCA) engaged with reshaped Judkins left 6-F guiding catheter and showing critical stenosis in the mid-RCA.

Figure 4. Angiogram showing good flow in the high anterior takeoff righ coronary artery after primary percutaneous coronary intervention.