

CASE OUR EXPERIENCE SIMULTANEOUS STENTING OF THE RIGHT CORONARY ARTERY AND THE RIGHT CAROTID

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HISTORY AND PHYSICAL

Patient B., 58 years old, was admitted to the Department of endovascular surgery with the diagnosis of ischemic heart disease. Angina 3rd functional class. Myocardial infarction from 2010. Hypertensive disease stage 3, the degree of hypertension-1 risk -IV.

On admission the patient complained of burning, squeezing chest pain that occur during exercise lasting longer than 20 min., Stopped taking nitroglycerin. In the history of high blood pressure (BP) during the years with the highest levels of 200/100 mmHg, inadequate antihypertensive therapy with unsatisfactory control of blood pressure. In 2010 he underwent the myocardial infarction of posterior wall of left ventricular with tooth Q.

On examination: height 172 cm, weight 91 kg. The skin of normal color. Auscultation of the lungs the weakened vesicular breathing. Area of heart are not visually changed. Heart sounds are muffled, regular rhythm, no abnormal noise. BP 130/80 mm Hg, heart rate 80 beats / min. In analyzes - without peculiarities (w / p), except for the the lipid spectrum, where it showed a reduction in the level of high density lipoprotein cholesterol to 29 (the norm > 40 mg / dL), dyslipidemia, type - II of beta, hypo-alpha.

On radiographs of lung fields without fresh focal and infiltrative shadows. The roots of the lungs enlarged, condensed. Sinuses free. Heart - border dilated, due to the ventricles. Aorta w / p.

On ECG were cicatrices changes in myocardial on the back and the basal localization.

On echocardiography, global systolic function is normal (ejection fraction 60.2%) revealed moderate dilation of the left chambers of the heart, signs of significant valvular disease have been identified.

On dopplerography brachiocephalic arteries revealed signs of atherosclerosis. The thickness of the intima medial layer higher than the norm, intima-media complex of homogeneous structure, with irregular contours. In the transition zone of the common carotid artery (CCA) at the mouth of the internal carotid artery (ICA) on the right is determined by the heterogeneous plaque, component 65-75% stenosis of the ICA. Left in the mouth of ICA stenosis of 40%.

IMAGING

For diagnosis specification and to determine further treatment strategy performed coronary angiography and brachiocephalic arteries (Figure1), which revealed:



Figure 1. An angiogram of the right common carotid artery.

INDICATION FOR INTERVENTION

The right type of blood supply to the myocardium. Stenosis (Type C), 70-80% in the proximal third of the transition in the middle part of the right coronary artery (RCA). The trunk of the left coronary artery (LCA), the anterior descending artery (LAD) and circumflex artery (OA) without pronounced restrictions. Risk PTCA scale Syntax - low (<22 points). Stenosis of the right internal carotid artery 70-75% (by NASCET criteria) at the level of the bifurcation.

Conservative therapy: TromboAss 75 mg / day, Plavix 75 mg / day, Concor 2.5 mg / day, Diroton 2.5 mg / day, Ldnil 20 mg / day, Thiotriazoline 4 ml / day.

INTERVENTION

Taking into account the clinical picture and the results of the study of invasive patient was recommended to stenting of RCA and the right ICA. The patient after consultation (involving cardiology, neurology and interventional) performed endovascular revascularization access via the right femoral artery and stenting of the RCA. two stents were implanted with drug-coated Biomatrix (Biosensors international) 4 * 28mm and Biomatrix 4 * 28mm, with good angiographic result.

The next step performed stenting of the right ICA. Self-extracting implanted stent Acculink (Abbott) 8 * 40mm. The stent is positioned in the BCA in ampoules transition OSA (the mouth of the external carotid artery is blocked). Stent post dilated balloon catheter 6 * 20mm, the pressure of 8 bar. with good angiographic result (Figure 2).



Figure 2. An angiogram of the right common carotid artery, the final result.

During dilation stent marked the temporary bradycardia and hypotension, hemodynamics was stabilized with medication. The intervention is completed with a good angiographic result.

The patient was discharged 3 days after surgery with recommendations: Concor 2.5 mg / day, Cardiomagnyl 75 mg / day, Plavix 75mg / day, Ldnil 20 mg / day, Diroton 2.5 mg / day, as well as control of blood pressure and heart rate ECG dynamics, lipid-lowering diet, physical activity in the form of a walking distance (2-3 km per day with good tolerability), the control Doppler brachiocephalic arteries in 3 months, coronary angiography after 1 year. The patient noted significant improvement, no recurrence of angina attacks during exercise.

LEARNING POINTS OF THE PROCEDURE

Thus, in practice, widely streaming Center for Cardiovascular Surgery will always be a cohort of patients who need to perform revascularization of coronary and carotid. Question about tactics and stages of the treatment of these patients remains debatable because of the scarcity of the evidence base.