A LUCKY COINCIDENCE

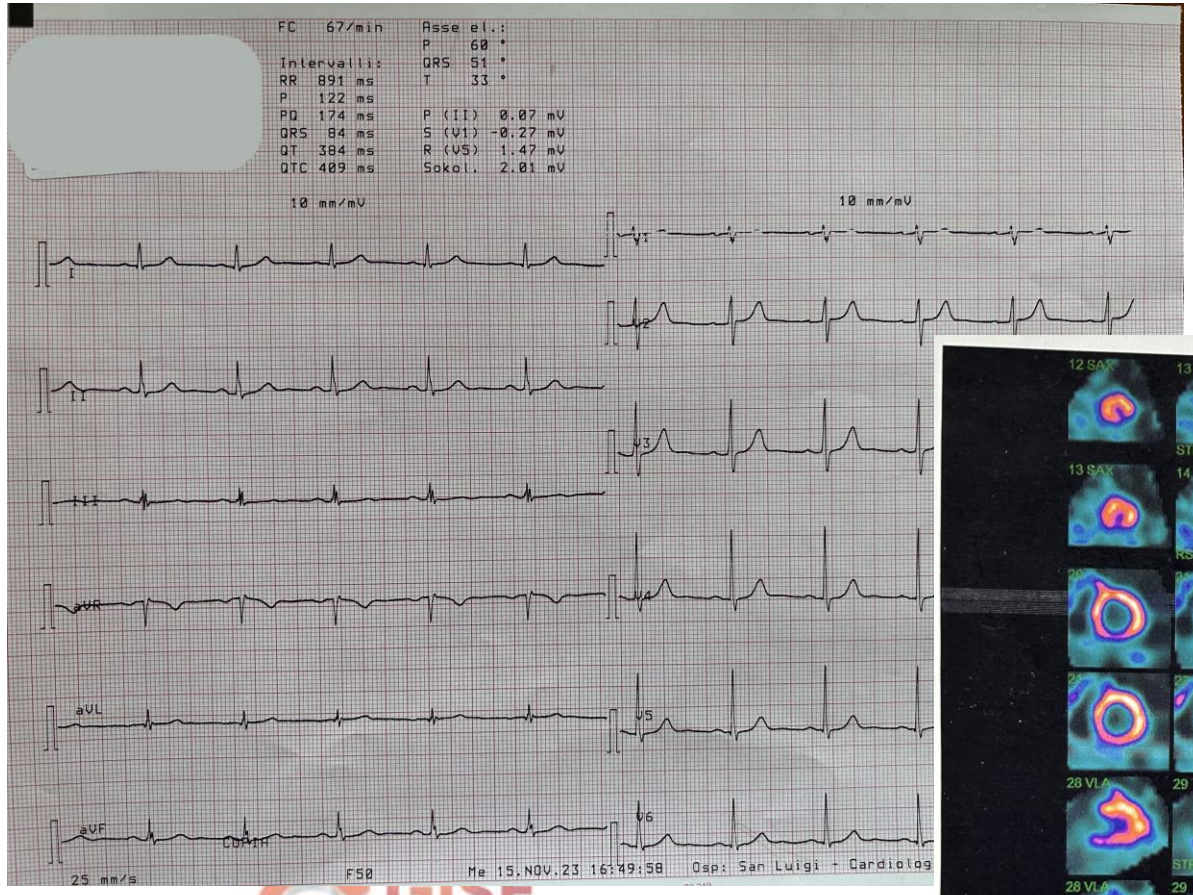
P.G. , man, 68 y.o.

PAST MEDICAL HISTORY:
Active smoker

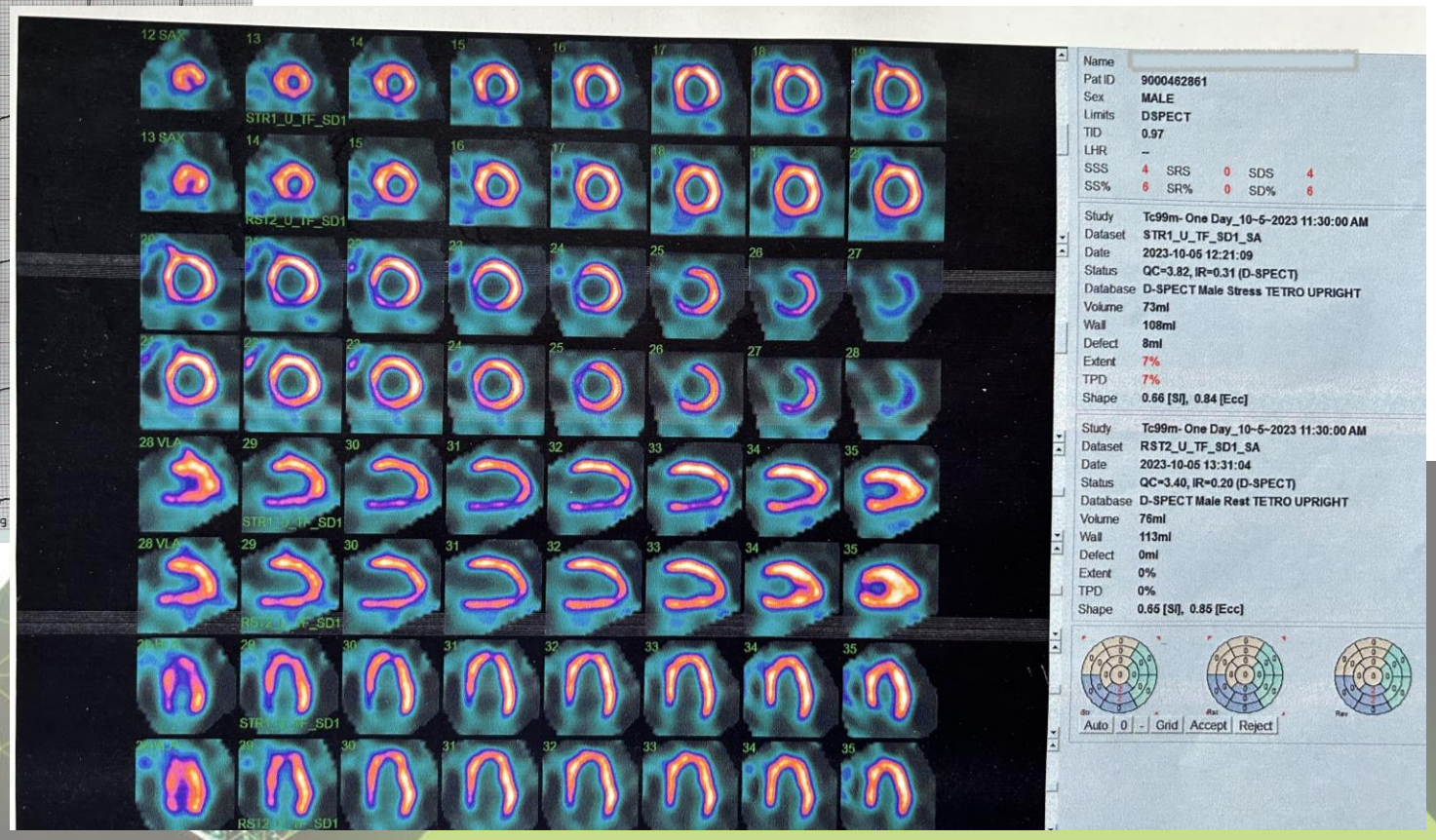
RECENT HISTORY
ER admission due to multiple episodes of typical angina even at rest
Cardiovascular examination was unremarkable with normal HS-Tn, ECG and echocardiography

Subsequently due to angina recurrences he underwent:
- Coronary CT: negative
- Stress myocardial scintigraphy: moderate inducible ischemia in the inferior wall (SSS 4)

Baseline ECG



Myocardial scintigraphy



GISE
Società Italiana di Cardiologia Interventistica
+JIM 2024
JOINT INTERVENTIONAL MEETING

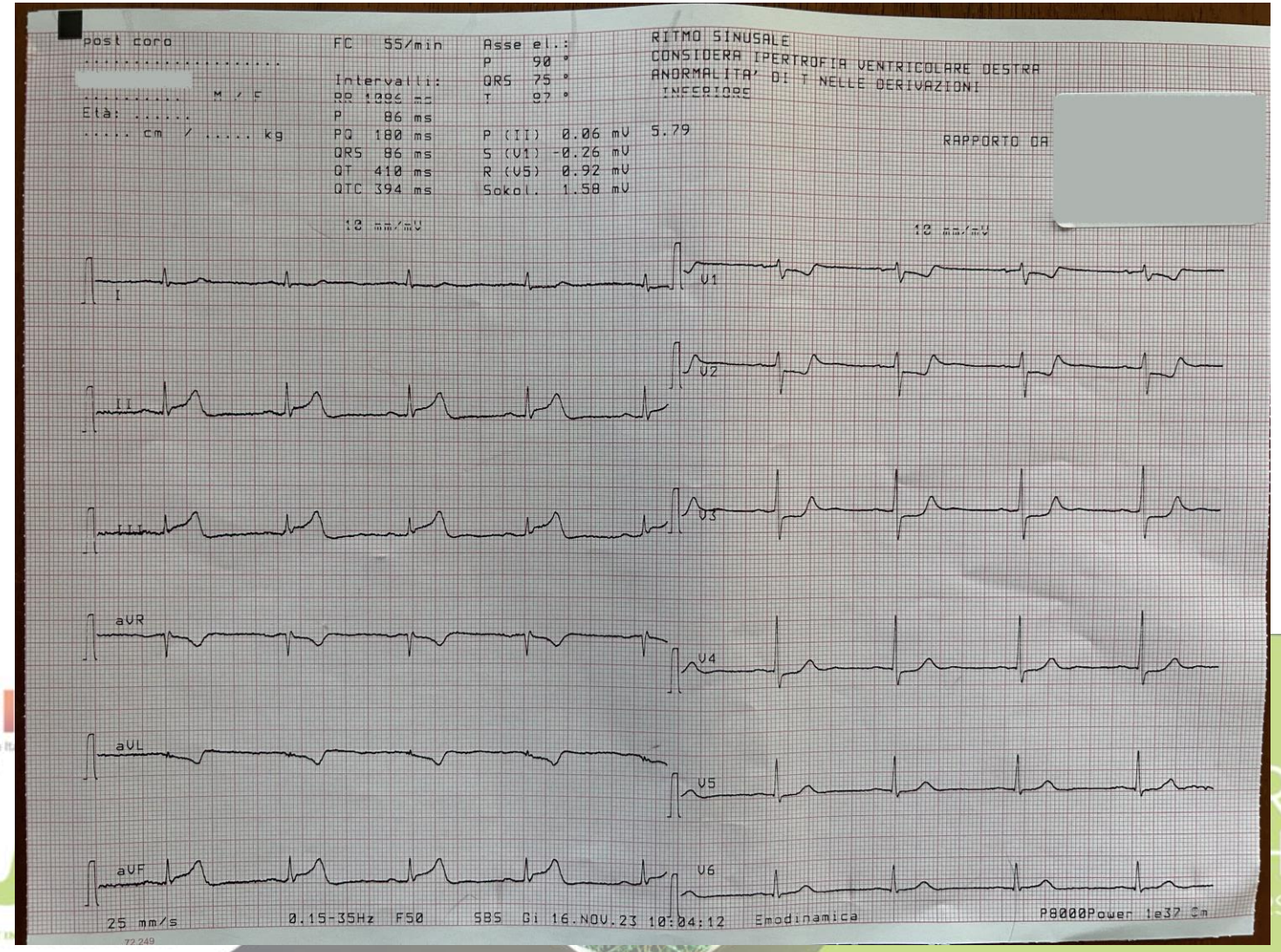
Patient was finally referred to our cath lab to perform a coronary angiography

Left coronary artery (LCA) was normal

Intermediate tubular stenosis was identified in mid-distal right coronary artery (RCA)

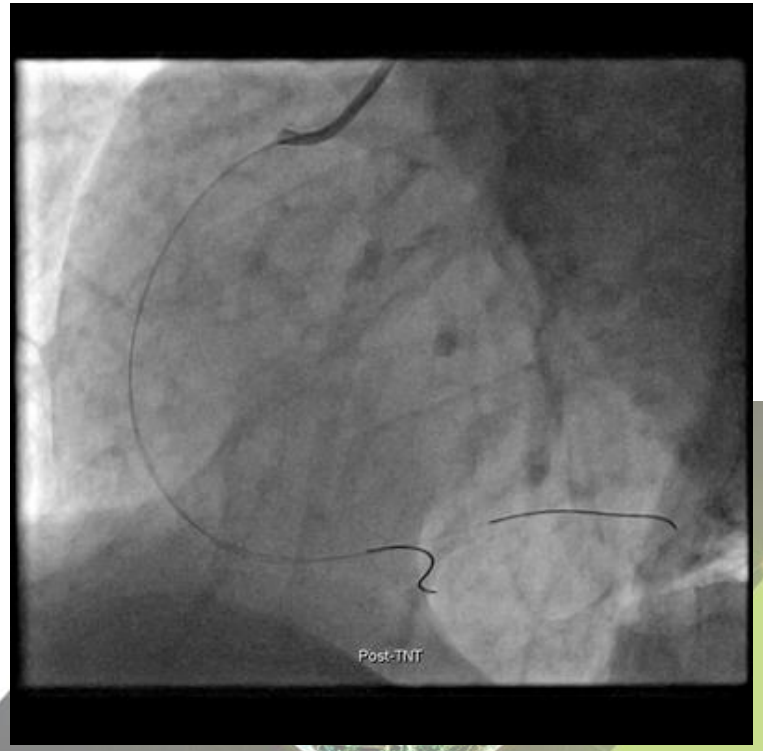
Epicardial intracoronary physiological indexes were negative
Full-physiology assessment was not available at the time of the procedure

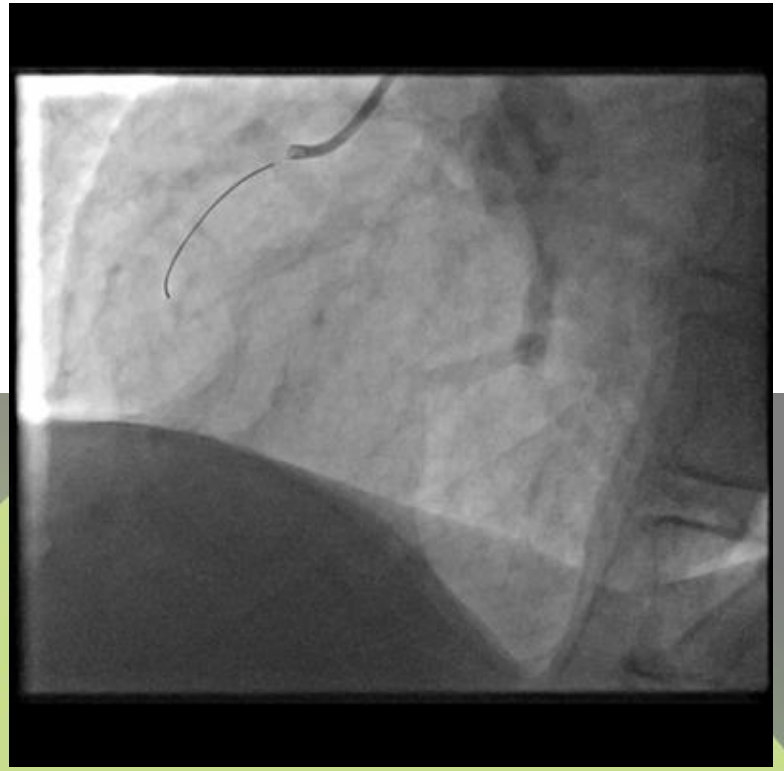
Few minutes after the end of the procedure, moving to cardiology ward, patient complained new onset of angina with ST-T elevation in inferior leads



An urgent angiography was performed showing acute occlusive vasospasm in mid RCA in the segment with intermediate stenosis
Intracoronary nitroglycerin was administered with promptly restoration of TIMI 3 flow and complete regression of angina and ST-T changing.

Operator decided to perform PCI to fix the stenosis





LEARNING POINTS

- Non invasive anatomical and functional tests were not able in identifying vaso-spastic angina

- The sole epicardial physiological assessment was not helpful to reach a diagnosis

- Acetylcholine test and full physiology assessment may be used in such cases even being aware of current limitation (risk of transient bradyarrythmias)

- PCI and stenting should be arguable vs. optimal medical therapy with calcium channel blockers