CASE REPORT

Acute Myocardial Infarction – An Unusual Presentation of Non-Specific Aortoarteritis

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Abstract:
A 42 year old man presented with classical presentation of Acute ST elevation MI of 2 hours duration. His CAG revealed a spared LMCA with a totally occluded LAD in proximal segment, for which he underwent a successful PAMI and CAG showed total occlusion of the proximal LAD (Figure 1), while other coronaries were normal. Thrombosis followed by stenting with a 2.75 x 28 mm DES was done. 48 hours later he developed continuous high grade fever with rigors. His WBC, cultures and chest X-ray were normal. No source of infection was identified. His ESR was 140 mm/hr and C - reactive protein was 236 mg/l. All antibody titers for connective tissue disorders were negative. His CT aortogram showed significant thickening of bilateral common carotid arteries, left subclavian artery and the arch of aorta (Figure 2) which suggested a diagnosis of acute onset Non-Specific Aortoarteritis. After 6 week of oral steroids, he was asymptomatic with an ESR of 4 mm/hr and a negative CRP.

Non-specific aortoarteritis is a disease of young females in 2nd to 3rd decade. Common presentations include absent pulses, hypertension, renal artery stenosis, AR and pulmonary artery involvement. Coronary involvement is reported in 10-12 % of patients and can be divided into 3 distinct types: stenosis or occlusion of ostia, diffuse or focal arteritis, and aneurysm formation.

Our case was unique as he had presented with hyperacute myocardial infarction, resulting from isolated proximal LAD lesion and later diagnosed as acute onset non-specific aortoarteritis.

A 42 year old male presented with acute ST segment elevation anterior myocardial infarction for 2 hours. Echocardiography showed anteroseptal hypokinesia with LVEF of 45%. He underwent PAMI and CAG showed total occlusion of the proximal LAD (Figure 1), while other coronaries were normal. Thrombosis followed by stenting with a 2.75 x 28 mm DES was done. 48 hours later he developed continuous high grade fever with rigors. His WBC, cultures and chest X-ray were normal. No source of infection was identified. His ESR was 140 mm/hr and C - reactive protein was 236 mg/l. All antibody titers for connective tissue disorders were negative. His CT aortogram showed significant thickening of bilateral common carotid arteries, left subclavian artery and the arch of aorta (Figure 2) which suggested a diagnosis of acute onset non-specific aortoarteritis. After 6 week of oral steroids, he was asymptomatic with an ESR of 4 mm/hr and a negative CRP.

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Fig. 1: (A) Angiography showing total occlusion of the proximal LAD. (B) final result after thrombosisuction and stenting.
Acute myocardial infarction as an initial and isolated presentation is rare.

References


Fig. 2: CT aortogram showing thickening of the arch of aorta (A) and the three branches (B)