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Recalcitrant angina in a young woman: The conundrum in atherosclerosis

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A 33 year old Asian woman, non-smoker with prior coronary artery bypass graft presented on the 10/1/2017 with central chest pain and shortness of breath. ECG showed anterior ST elevation myocardial infarction. An emergency cath showed native triple vessel disease, atretic left internal mammary artery graft, ostial SVG-OM (saphenous venous graft-obtuse marginal) 60% stenosis and SVG-RCA (right coronary artery) graft was patent. The native left main (LM), proximal left anterior descending (LAD) and the ramus intermedius (RI) was stented. On the 16/2/2017, she complained of chest pain and a repeat cath showed edge stenosis 70% of the proximal LAD stent with mid-distal LAD showing diffuse 60-70% disease and fractional flow reserve was 0.62 on hyperemia. The LM and RI stents were patent. The ostial SVG-RCA graft was occluded. She underwent balloon angioplasty (POBA) of the LAD and stenting of the SVG-RCA lesion. She complained of frequent episodes of chest pain and a nuclear myocardial perfusion scan showed significant ischemia in the left circumflex (LCx) artery territory. On the 3/8/2017, she underwent a POBA to a 100% in-stent restenosis to the RI. Computed tomography of the thoracic aorta showed eccentric wall thickening and moderate-severe narrowing in the proximal left subclavian artery suggestive of Takayasu's arteritis. She was referred to the rheumatologist and commenced on oral prednisolone and methotrexate. This case illustrates a rare cause of recurrent angina in a young woman, albeit an LDL of 1.1 mmol/l. An early index of suspicion may have prevented the multiple coronary interventions.

Biography

Punitha Arasaratnam became Member of the Royal College of Physicians in United Kingdom in 2008 and is a certified Cardiologist practicing in Singapore. She has completed a 2 year Fellowship in Advanced Multimodality Cardiac Imaging in Nuclear/PET, CT and MRI in Canada.

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