

## Medical Expertise

"Development of the European Network in Orphan Cardiovascular Diseases"  
„Rozszerzenie Europejskiej Sieci Współpracy ds Sierocych Chorób Kardiologicznych”

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#### **CASE SUMMARY**

57-year-old man with 3-year history of exertional angina pectoris, with documented congenital coronary artery anomaly was admitted to the hospital in January 2014 with symptoms of unstable angina. Elevated troponin level together with typical symptoms made possible the diagnosis of myocardial infarction (NSTEMI). The coronary angiography was unchanged in comparison to the examination performed in 2012. Exercise tests revealed provoked angina but without changes in ecg and with normal picture of perfusion in myocardial scintigraphy. Pharmacological treatment of NSTEMI was introduced. During follow-up patient demonstrated symptoms of stable angina in CCS II.

#### **DISCUSSION**

Diagnosis of NSTEMI was stated according to the ESC recommendation – definition of myocardial infarction (exaggerated typical angina + elevated troponin level). There is only one result of the troponin level. The ESC recommends in diagnostics of NSTEMI the second assessment of troponin level after 2-3 hours. The double-antiplatelets therapy was properly introduced according to the ESC guidelines.

#### **EXPERT'S OPINION**



Diagnostic and therapeutic management in patient with coronary artery anomaly and acute coronary syndrome was in accordance with guidelines. In follow-up patient has presented symptoms of stable angina pectoris. According to the actual ESC recommendations, the indication for coronary grafting would be reasonable in case of a documented large area of ischemia  $>10\%$  for SPECT or  $\geq 3$  dobutamine-induced dysfunctional segments of LV by stress echo. The repeat scintigraphic perfusion stress test may be useful by ineffective pharmacological therapy and increasing level of angina pectoris

## CONCLUSION

Patient with coronary artery anomaly without accompanied atherosclerotic changes in coronary circulation presenting symptoms of acute coronary syndrome was qualified for pharmacological strategy. Further management should depend on the level of angina symptoms and evidence for myocardial ischemia. Cardiosurgical revascularisation in the region of the anterior wall could be taken into account only in case of documented large grade ischemia in functional imaging examinations (cardiologist final decision)

## REFERENCES

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