Acute myocardial infarction caused by severe muscular bridges of the left anterior descending artery and diagonal branch: a very unusual cause of myocardial infarction

A 50-year-old man with acute anterior myocardial infarction was referred to our hospital for primary percutaneous coronary angioplasty. He had had an aortic valve replacement operation 5 years ago. He had no coronary artery disease or myocardial infarction in his medical history. Electrocardiogram obtained in emergency department during the chest pain revealed ST segment elevations and inverted T waves in precordial leads. He was taking oral anticoagulation therapy and his INR was 2.8 at hospital admission. Coronary angiography showed non-atherosclerotic coronary arteries with almost completely systolic compression (Fig 1a, arrows) and diastolic normalization of the left anterior descending coronary artery (LAD) and first diagonal branch (Fig 1b).

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Tako-tsubo-like cardiomyopathy induced by pheochromocytoma crisis

Feokromasitoma krizinin tetiklediği Tako-tsubo benzeri kardiyomiopati

Pheochromocytomas are rare catecholamine producing neuroendocrine tumors typically located in the adrenal medulla or along the sympathetic ganglia. It can secrete excessive catecholamine and causes clinical problems. Takotsubo cardiomyopathy, also known as transient left ventricular (LV) apical ballooning syndrome, is an acute cardiac syndrome characterized by transient LV regional wall motion abnormalities, chest pain or dyspnea, ST-segment elevation at electrocardiography (ECG) and minor elevations of cardiac enzyme levels. A 64-year-old man was admitted to hospital because of severe non radiating central chest pain and palpitation. He had labile blood pressure for 6 months, 12 kg weight loss for one year. He was referred to endocrinology clinic with these complaints 1 month ago and pheochromocytoma was diagnosed. On presentation, the patient’s high blood pressure values measured in the emergency department, laboratory, angiography, 210/130 mmHg, respectively. Dual heart sounds with no cardiac murmur, clear lung fields. ECG showed ST-segment elevation in leads II and aVF, V3-V6 (Fig. 1A, B). The patient underwent emergent cardiac catheterization for presumed acute myocardial infarction (MI). Coronary angiography showed patent epicardial coronary arteries with only minor atherosclerotic manifestations (Fig. 2A). LV angiography demonstrated the characteristic morphology of apical ballooning with hyperkinesis of the basal segments and hypokinesis of the mid-apical segments (Fig. 2B, 1C-F). Two week later, the patient underwent a laparoscopic surgery and excision of the right adrenal mass, with gross and microscopic pathology confirming pheochromocytoma (Fig. 2D-F).

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