



CASE REPORT – AORTIC DISSECTION – RARE PRESENTATION OF A RARE DISEASE .

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KEYWORDS :

A 21 year old male came to medicine OPD referred from outside hospital with complains of uncontrolled hypertension.

HOPI:

Patient was apparently alright until 19th April when he sustained a deaccelerating injury while travelling from Pune to Mumbai on the highway when he was sitting unrestrained on the passenger seat with the speed of the vehicle at 120km/hr. patient sustained a hip dislocation over the right hip which was reduced under local anaesthesia by Orthopedician. Since the incident, patient experienced high BP, all recordings were above 170mmhg. General medicine reference was taken and patient was started on Tab. Nicardia 20mg thrice daily and Tab Carvedilol 12.5mg twice despite which patient bp was chronically 170mmhg systolic. Patient was evaluated further. On examination patient had a pulse of 94/min, high bound, equal in all 4 limbs, bp was 170/80mmhg, spo2 99% room air, on systemic examination- RS- air entry equal, PA- soft, no bruit, CNS- conscious oriented, CVS- patient cvs findings were normal however there was a long diastolic murmur best heard in the aortic area.

Patient was evaluated further

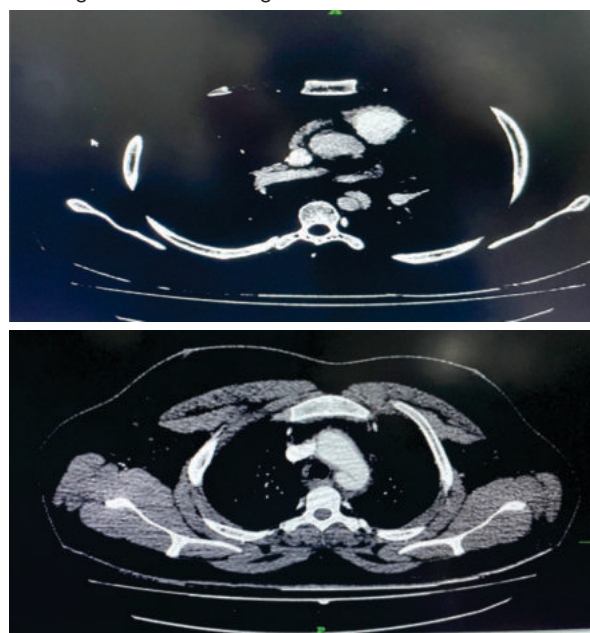
Hb – 14.5 , TLC- 15000, PLT 2.89, LFT- normal, RFT and electrolytes- normal, TSH- 2.65 , HbA1C- 6.0, Homocysteine- 22.4 (normal <20) urine rm- normal, UACR- normal, lipid profile- normal. Sr ANA- Negative, Urinary VMA- negative Patient 2d ECHO- normal, B/L renal artery doppler was done-normal, Patient right lower limb doppler was done- normal.

In order to evaluate for the cause of murmur and rule out any aneurysm, patient CT Pulmonary angio and CT Aortogram was done which was suggestive of – a 6cm intimal flap with true and false lumen seen in descending aorta distal to the origin of subclavian artery. Ascending aorta measuring- 33 mm and descending aorta 28mm The CT findings were in favour of Aortic dissection with Stanford Classification- B and De Bakey classification- De Bakey IIIA.

Patient urgent CVTS opinion was taken and medical line of management was advised to target HR 60/MIN, SBP – 120MMHG. Patient bp was regularly monitored with Arterial line insertion. Patient was initially on Labetolol infusion which was tapered over 24 hrs and patient was escalated to- Tab. Telma CT (80/12.5) OD, Tab Prazosin 10mg BD, Tab Diltiazem 90MG TDS, Tab. Carvedilol 25mg BD, tab Moxivas 0.2 mg was eventually added at night despite which Hr was 80/min, SBP 150mmhg.

Intervention radiology opinion was taken and patient was advised – Stenting with fenestration or Bypass grafting followed by graft surgery with later option being better for the patient considering the age of the patient was discussed as well however as per guidelines and available literature, patient was conservatively managed. Repeat scan was done after 2 months which did not show any deterioration of the

condition and oral anti hypertensives were continued. Currently patient is doing well with systolic blood pressure in the range of 130-140 managed on oral medications.



CT Aortogram of the patient showing false lumen .

Aortic dissection-

aortic dissection is an acute, potentially life threatening condition that warrants urgent evaluation and management. Usually patients present with "tearing" or "ripping" type of pain when acute. Pain is usually severe particularly radiating to the back between the shoulder blades and it reaches its peak intensity immediately following the event. A history of connective tissue disorder like marfans syndrome should be sought in such cases. Vital signs- Usually they present with severe hypertension but may be associated with profound hypotension when there is coronary arterial compromise or dissection into the pericardium. A murmur of aortic insufficiency may be a complication of proximal aortic dissection

A chest radiograph may reveal mediastinal widening in some patients with aortic dissection. Transthoracic echocardiography is poorly sensitive for aortic dissection although an intimal flap may sometimes be detected in the ascending aorta.

Coronary CT Angio is a good tool to detect aortic aneurysm. MRI also permits highly accurate assessment of aortic dissection but is seldom used as the first modality as CT and Echocardiography are usually performed first and are accurate.

Treatment options :

Acute aortic dissection can be treated surgically or medically. In surgical treatment, the area of the aorta with the intimal tear is usually resected and replaced with a Dacron graft.

Emergency surgical correction is the preferred treatment for Stanford type A (DeBakey type I and II) ascending aortic dissection. It is also preferred for complicated Stanford type B (DeBakey type III) aortic dissections with clinical or radiologic evidence of the following conditions:

- Propagation (increasing aortic diameter)
- Increasing size of hematoma
- Impending rupture
- Compromise of major branch of aorta
- Persistent pain
- Bleeding into pleural cavity
- Development of saccular aneurysm

Caution and relative contraindication to surgery include:

- Cerebrovascular accident (CVA)
- Severe left ventricular dysfunction
- Coagulopathy
- Pregnancy
- Previous myocardial infarction (<6months)
- Significant arrhythmias
- Advanced age
- Severe valvular disease

Medical management remains the treatment of choice for descending aortic dissections unless they are leaking or ruptured. With the progress in stenting technology, descending dissections can be approached with this modality in selected cases.

Medical management consists of decreasing the blood pressure and the shearing forces of myocardial contractility in order to decrease the intimal tear and propagation of the dissection. Medical management with antihypertensive therapy, including beta blockers, is the treatment of choice for all stable chronic aortic dissections.

