

Case	(548) Acute aortic dissection. from the top to the bottom.
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CASE PRESENTATION

A 41-year-old patient was referred to the emergency department with sudden oppressive thoracic pain irradiated to the jaw and the interscapular and lumbar regions. Physical examination revealed pallor, profuse sweating, transient loss of consciousness and pulse asymmetry with TA of 166/71.

Computed tomography angiography (CTA) was performed to rule out acute aortic syndrome.

The CTA revealed an acute aortic dissection from the ascending aorta with distal extension along the entire descending thoracic aorta and abdominal aorta. This is a Stanford type-A dissection (Figure 1).

DISCUSSION

The aortic dissection constitutes the most frequent aortic syndrome and it usually requires surgery due to its high morbimortality rate.

Most of the dissections occur 1-2 cm distal from the sinotubular junction (Stanford type A) which is the most common type or distal to the subclavian artery (Stanford type B).

It is important to correctly identify the true lumen, which differs from the false lumen because the contrast arrives first to it and it is usually the smallest one. Besides, it is essential to learn if the arterial branches come from the false lumen as this may develop in ischemia of secondary organs. Our patient presented an aortic dissection from the aortic annulus with an extension of the intimal flap to the brachiocephalic trunk and left common carotid and extended to the abdominal aorta affecting both renal arteries and both common iliac arteries.

The most affected branch was the right renal artery, with a filiform pass of contrast through the true lumen because of compression from the false lumen.

Moreover, findings of renal infarct can be seen with a hypodense area in the superior pole of the kidney.

Finally, the dissection extended to the iliac arteries, identifying a mural thrombosis in the false lumen of the right common iliac artery.

Type A dissection is surgical due to its associated possible complications such as coronary occlusion, aortic insufficiency or cardiac tamponade among others.

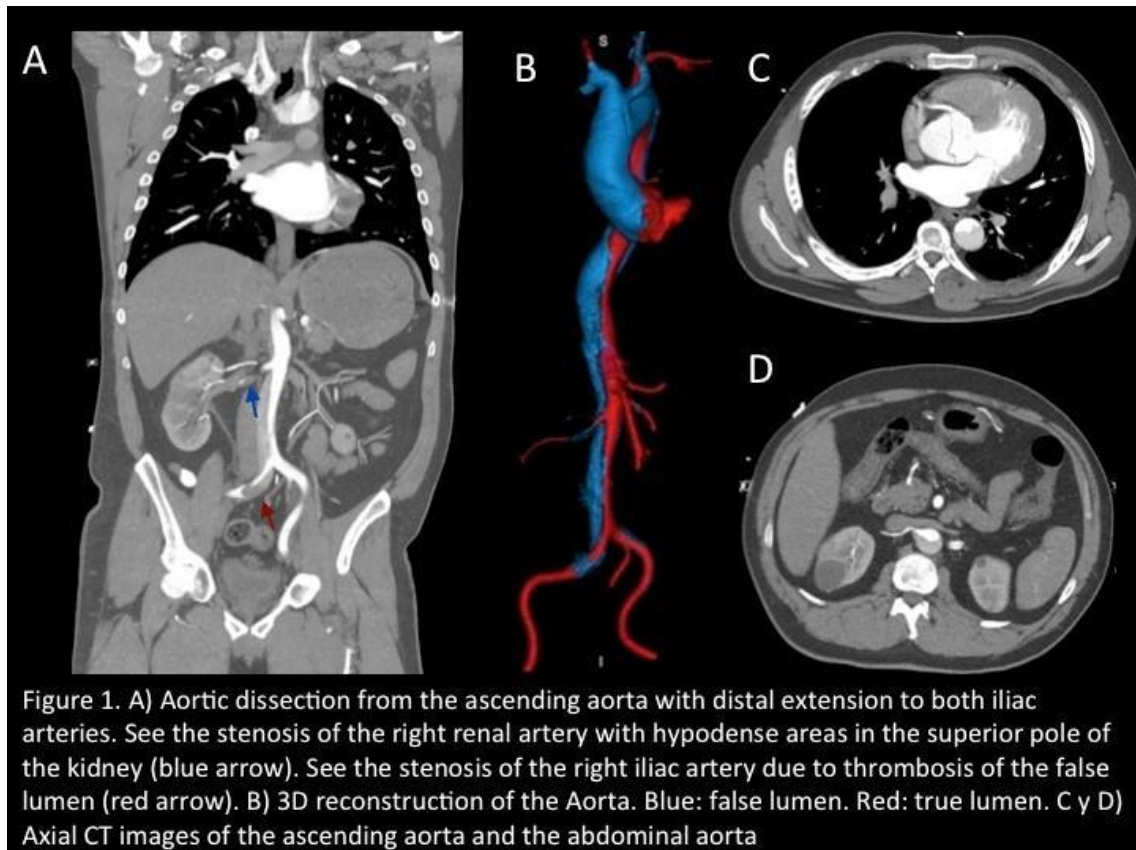
In this case, surgery was done with angioplasty and fenestration, but the patient died a week later.

CONCLUSION

Acute aortic dissection is one of the few emergency situations that require prompt diagnosis and rapid treatment due to its possible fatal outcomes.

The ACT differentiates a dissection involving the ascending aorta (Stanford type A) which needs surgical treatment, from a dissection distal to the left subclavian artery (Stanford type B), treated conservatively.

In addition, knowing the extension of the lesion helps to predict the possible involvement of secondary organs.



BIBLIOGRAPHY

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