Po-Chen Chou, MD; Shih-Chieh Chien, MD

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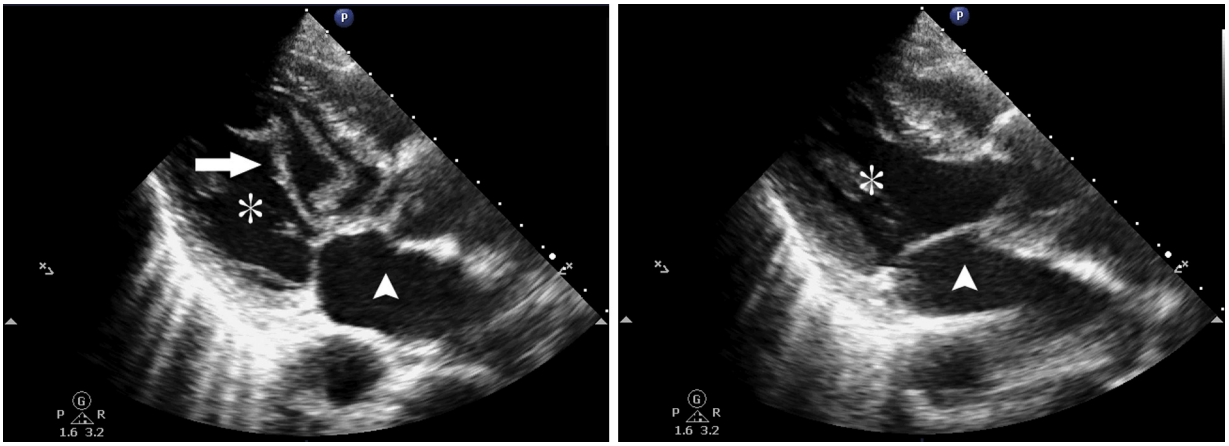

Figure 1. Echocardiography with left parasternal long-axis view demonstrating the left ventricle (asterisk) and left atrium (left panel, arrowhead). The intimal flap (arrow) is prolapsed into the left ventricle during systole. The identical view during diastole shows lack of an intimal flap in the left ventricle (right panel).

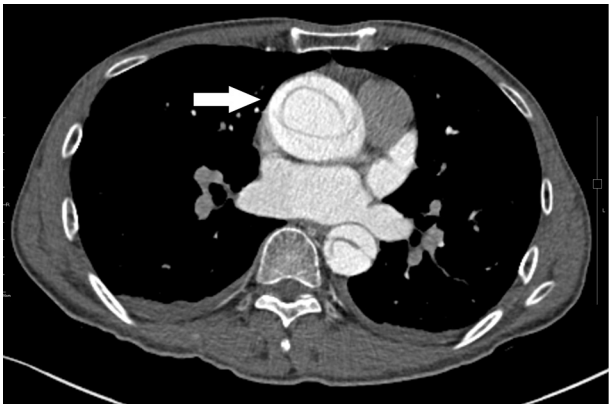

Figure 2. CT showing the circumferential aortic flap in the aortic root (arrow), extending to the descending aorta.

[Ann Emerg Med. 2019;73:236.]

A previously healthy 55-year-old man presented to a regional hospital with epigastric pain and diaphoresis for 1 day, and a diagnosis of non–ST elevation myocardial infarction was made because of elevated cardiac enzyme levels. However, the interventional angiographer could identify only the right coronary artery (Video E1, available online at http://www.annemergmed.com) and the patient was transferred to our emergency department (ED) for further assessment. His pulse rate was 99 beats/min, his blood pressure was 113/51 mm Hg, and he had a grade 5 diastolic murmur over the left sternal border. We performed ED-based bedside echocardiography (Figure 1 and Video E2, available online at http://www.annemergmed.com) and confirmed the diagnosis with a computed tomography (CT) scan (Figure 2).

For the diagnosis and teaching points, see page 247.
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(continued from p. 236)

DIAGNOSIS:

Stanford type A acute aortic dissection with intimal flap prolapsing into the left ventricle. Echocardiography showed a dilatated aortic root and the intimal flap prolapsing into the left ventricle during diastole (Figure 1, left panel) but returning to the normal location in the aortic root during systole (Figure 1, right panel). Although dissection may present with a number of findings, including myocardial infarction,[1] circumferential detachment of the intima[2] with resulting complete obstruction of the coronary ostia[3] is an uncommon finding.

Our patient underwent surgical repair and was discharged uneventfully 1 month later.

Author affiliations: From Emergency Medicine (Chou) and Critical Care Medicine (Chien), Mackay Memorial Hospital, Taipei, Taiwan.

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