Type A Aortic Dissection Lasting More than 2 Years

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A 65 year-old man with a history of smoking and hypertension complaint of intense chest pain irradiated to back 25 months ago. An echocardiogram was then performed which diagnosed an aortic dissection, but the patient refused to undergo other complementary studies. He is currently treated with beta blockers, chlorothiazide and angiotensin converting enzyme inhibitors. The patient gave up smoking and his blood pressure is well controlled. He remains in NYHA functional class II. A grade II/VI diastolic murmur is audible in the aortic area. The echocardiogram corroborates the presence of aortic dissection and mild aortic regurgitation. His family physician prescribed a multislice computed tomography of the thoracic aorta to assess the possibility of surgical treatment (Siemens Somaton Sensation Cardiac 64 computed tomography scanner). A type A aortic dissection was diagnosed according to Stanford classification (DeBakey type I), with extension to the renal arteries (not seen in the figure). The patient refused surgical treatment.

Fig. 1. Coronal plane with maximum intensity reconstruction. The head of the arrow shows the aortic wall portion between the enhanced false lumen (FL) and the true lumen (VL). Left coronary artery with calcifications (arrow). AA: Ascending aorta. LV: Left ventricle. T: Mural thrombus. ST: Supra-aortic trunks originating in the true lumen.

Fig. 2. Axial plane with maximum intensity reconstruction. Calcifications in the aortic wall between the FL and VL. Arrows: as mentioned in Figure 1. T: Mural thrombus. FL: False lumen. VL: True lumen. DA: Descendant aorta.

Fig. 3. Volumetric reconstruction. RCA: Right coronary artery displaced by the FL. ST: Supra-aortic trunks. FL: False lumen. VL: True lumen.

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