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Successful coil embolization at acquired coronary artery to bronchial artery fistula presented by hemoptysis

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Congenital coronary arteriovenous fistula drains commonly to the right cardiac chambers or vessels. But, acquired coronary artery to bronchial artery fistula is very rare. We report a case of successful coil embolization at acquired coronary artery to bronchial artery fistula presented by hemoptysis. A 55-year-old man who had history of pulmonary tuberculosis was admitted to emergency department for evaluation of chest pain. The coronary angiography showed no definite coronary stenosis, but coronary artery fistula from left circumflex artery (LCX) to left bronchial artery and mediastinum. The Tc 99m sestamibi scintigraphy-single-photon emission computed tomography (99mTc-MIBI, SPECT) showed fixed defect at LCX territory. The chest computed tomography showed emphysematous and destructed lung. He refused further treatment and discharged without any evaluation. Two months later, the patient revisited at the ER due to hemoptysis and emergent bronchial artery embolization (BAE) was done. But, hemoptysis was continued for 3 days. Surgical treatment was not preferred because of both lung lesion (right upper lobe & Left lower lobe). The coil embolization (Tornado®, USA) was done successfully and the fistula was no more seen. After coil embolization, the hemoptysis was stopped and discharged without complication. We suggest that coil embolization at coronary artery to bronchial artery fistula is alternative modality if surgical treatment is not preferred. Keywords: coronary artery to bronchial artery fistula, coil embolization

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Spinal cord infarction as a disastrous complication of coronary intervention

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The incidence of spinal cord infarction (SCI) is low and difficulty in diagnosis. Although cases of SCI have been reported as complicating angiographic procedures, it rarely occurs nowadays. We report a case of SCI following coronary intervention. The 59 year-old woman was admitted to our hospital due to resting chest pain and decreased LV ejection fraction, and her risk factor was diabetes mellitus. The angiography showed critical stenosis of right coronary (RCA) and proximal left anterior descending artery (LAD). After the study had been done, the patient complained of progressive upper back pain uncontrolled by analgesics. At first, we performed paclitaxel-eluting stents implantation on RCA lesion. She complained suddenly paraesthesia and progressive weakness of extremities, followed by loss of consciousness in the course of LAD intervention. Magnetic resonance of the spine was done and showed high density lesion in cervical cord from C2 to C6 levels, compatible with acute cord infarction. Because her ECG showed high-degree AV block, we inevitably re-performed coronary angiography. Right angiography showed patent stents and we performed stent implantation laboriously at heavily calcified proximal LAD lesion. Her vital sign became stable and neurologic deficit got better. Six months later, her shoulder weakness and urinary incontinence were unchanged. A SCI as a complication of invasive vascular studies is exceptional nowadays, but should be remembered as a possible adverse effect. It may be suspected in cases of acute lumbar pain with motor and sensory defects of the extremities. Keywords : spinal cord infarction, coronary angiography