

ostium should be covered by slightly protruding the stent towards the aorta. There is no doubt that the use of drug-eluting stents is advisable as well as the selection of stents with a scaffold with significant over-dilatation capabilities to adjust to the size of the vessel and into the LMCA. Checking the results on the IVUS is of paramount importance.

Regarding the circumflex branch that would be jailed by the stent, given the unstable clinical context, I wouldn't prescribe any treatment unless flow or the vessel lumen were compromised. In a different procedure, treatment could be optimized by opening the stent mesh towards the circumflex branch through the simultaneous inflation of 2 kissing balloons.

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CONFLICTS OF INTEREST

No conflicts of interest related to this work.

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Spontaneous left main coronary artery dissection complicated with vasospasm. Case resolution



Disecção coronária espontânea en el tronco común izquierdo complicada con vasoespasmo. Resolución

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CASE RESOLUTION

We decided to end the procedure because the patient (informed consent obtained) became asymptomatic and the ST-segment elevation resolved. After the procedure, the blood test performed revealed a new increase of troponin I levels (4.4 ng/mL). The patient started therapy with dihydropyridine calcium channel blockers due to the observed vasospasm. While in observation, the patient remained asymptomatic. Five days later, she was discharged on dual antiplatelet therapy. One month later, the patient was readmitted to undergo an elective coronary angiography to reassess the lesion. The coronary angiography only revealed the presence of irregularities without further lesions ([videos 1 and 2 of the supplementary data](#)). Therefore, the most probable diagnosis was a spontaneous coronary artery

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dissection (SCAD). The management of SCAD is still a matter of great discussion especially regarding left main coronary artery lesions and situations of hemodynamic instability as it is well-known that SCADs can heal spontaneously after 1 month.¹⁻³ In this case, we decided not to proceed with the percutaneous coronary intervention because the patient became asymptomatic and the electrocardiographic alterations resolved after the administration of intracoronary nitrates and because we were not sure about the etiology of the severe vasospasm (SCAD vs atherosclerotic lesion). The reassessment coronary angiography performed appeared normal and confirmed the most likely diagnosis of SCAD. The patient had multiple risk factors for SCAD: multiparity, a recent delivery, and use of hormonal contraceptives.^{1,2} Therefore, after discussion with the gynecology team, the patient was administered lactation suppression medication and hormonal contraception was withdrawn. Autoimmune diseases and fibromuscular dysplasia were excluded. The reassessment transthoracic echocardiogram did not show any alterations. To date, a year has gone by without recurrence.

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AUTHORS' CONTRIBUTIONS

C. Costa Oliveira was responsible for the analysis of the clinical case and the writing of the article. C. Galvão Braga was the responsible for patient coronary intervention and for revising the article. C. Quina, J. Costa and J. Marques participate in the case resolution and were also responsible for revising the article.

CONFLICTS OF INTEREST

Nothing to declare.

SUPPLEMENTARY DATA



Supplementary data associated with this article can be found in the online version available at <https://doi.org/10.24875/RECICE.M20000195>.

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