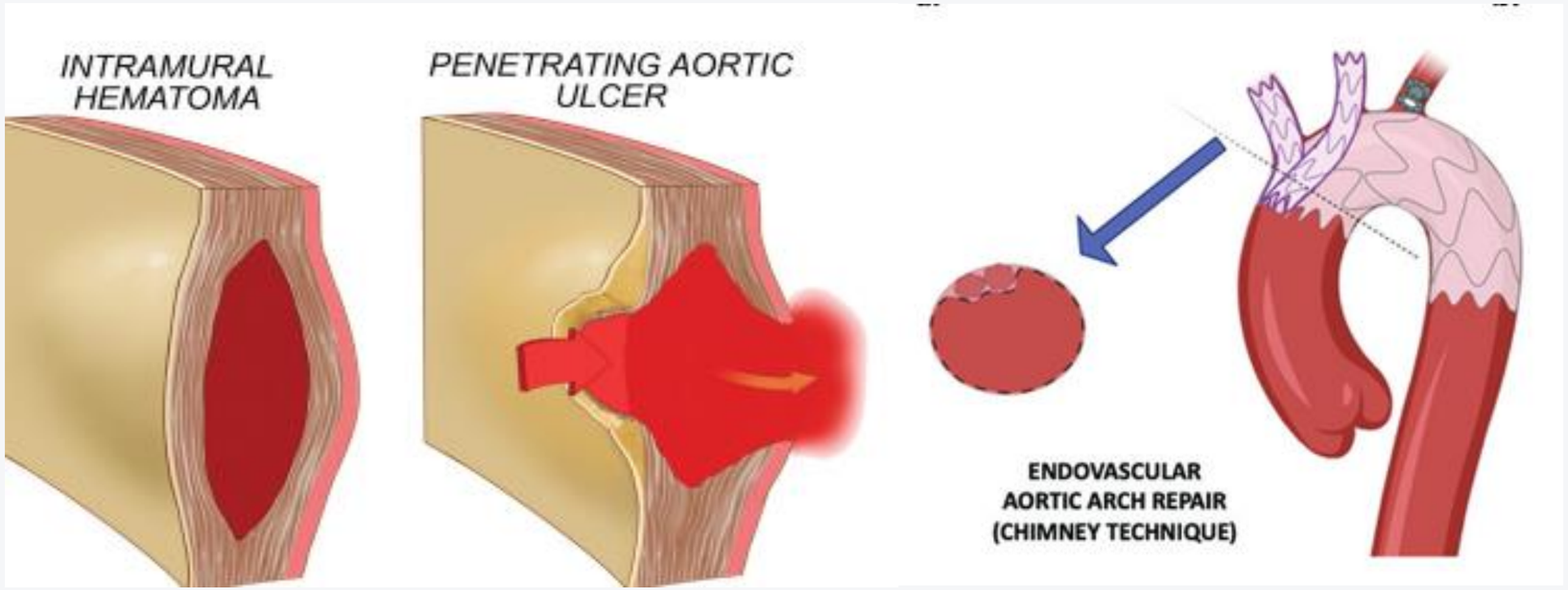


CASO CLÍNICO: ABORDAJE PERCUTÁNEO DE SAA

EXPOSITORA: XIMENA PAREDES GONZALES
RESIDENTE DE 3° AÑO DE CARDIOLOGÍA

PRESENTACIÓN:

- Nombre: Ximena Stephany Paredes Gonzales.
- Correo electrónico: ximena_1216@hotmail.com
- Teléfono: 051-998944959
- Título del caso: Abordaje percutáneo de Síndrome Aórtico Agudo.
- Permanencia académica: Residente de Cardiología del Hospital Central de la Fuerza Aérea del Perú.
- Servicio de Hemodinámica del HCFAP.
- Tercer ayudante.

DATOS CLÍNICOS:

- Varón 52 años.
- Antecedente: LINFOMA no HODKING, región torácica.
- Tratamiento: Radioterapia (25 sesiones) hace 35 años.
- Niega HTA, Niega DM2, Niega Tabaco.
- Dislipidemia mixta.
- Medicación habitual: Acido Acetil Salicílico 100 mg c/24 h, Bisoprolol 5 mg c/24 h, Atorvastatina 20 mg c/24h.

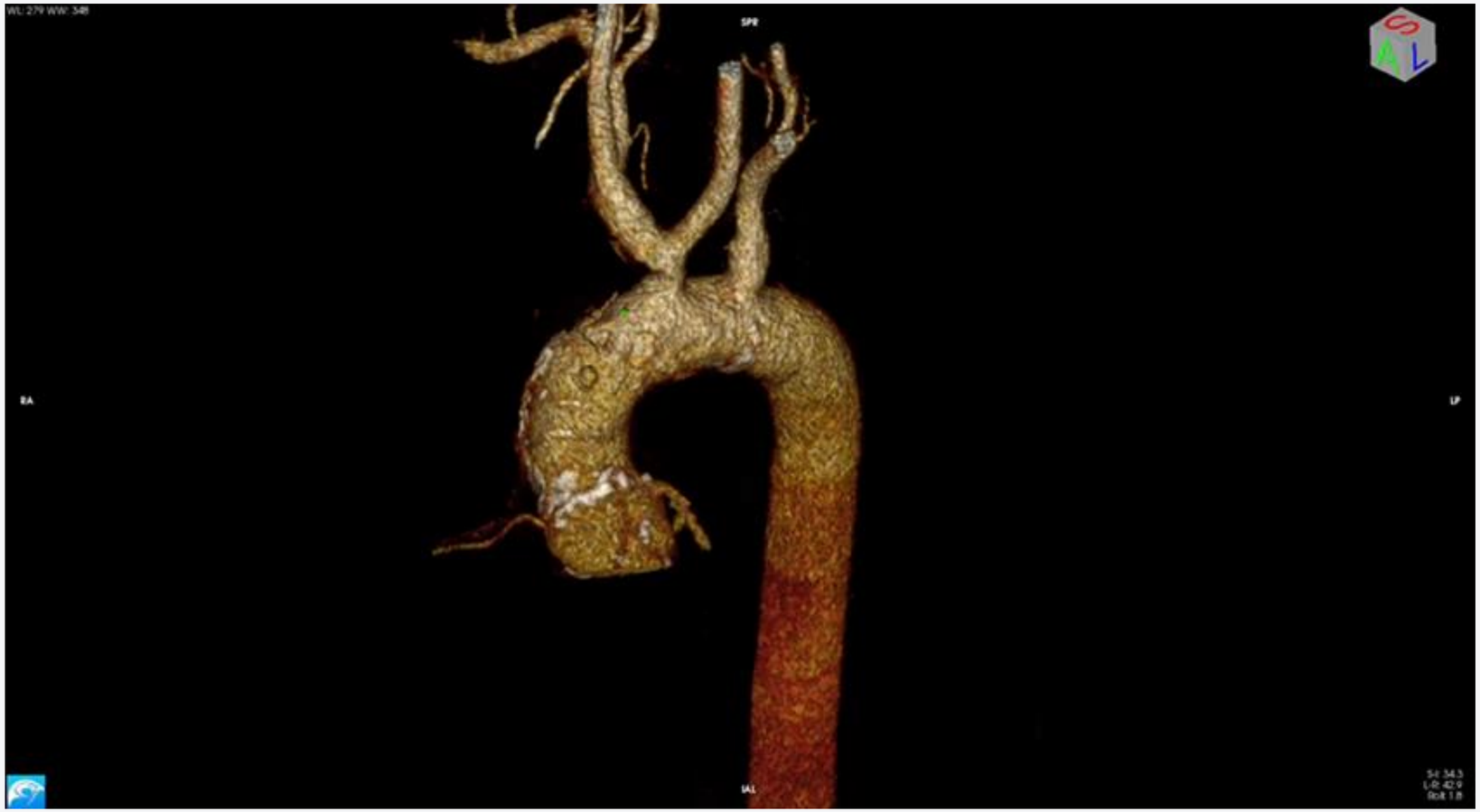
Relato Cronológico:

- T. Enf: 3 meses
- Evaluación por consultorio externo:
- Dolor precordial intensidad 7/10. Sin relación al esfuerzo. Niega otros síntomas.
- FV: PA 110/60 mmHg, FC: 50 lpm

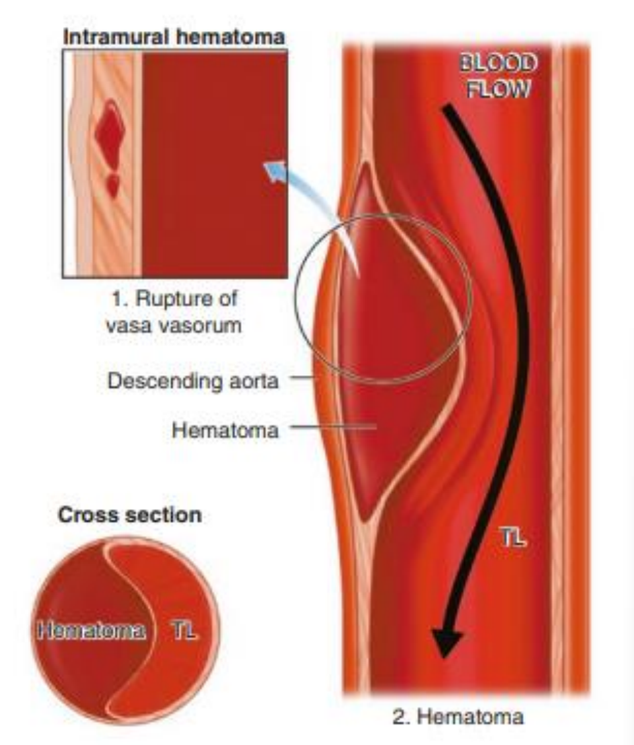
Exámenes auxiliares:

- ECG: Ritmo Sinusal, FC: 55 lpm. Sin otras alteraciones.
- P. De Esfuerzo: Negativa para isquemia miocárdica.
- Ecocardiografía: FEVI 68%, HVI leve, no hay trastorno de motilidad. No Valvulopatías significativas.

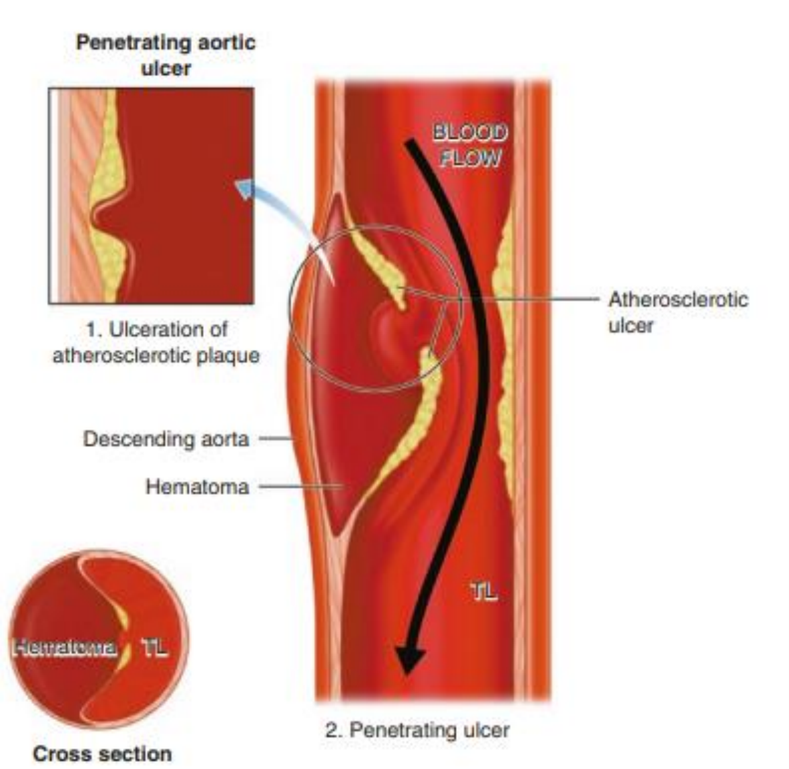
ANGIOTOMOGRAFÍA AORTO-CORONARIO:



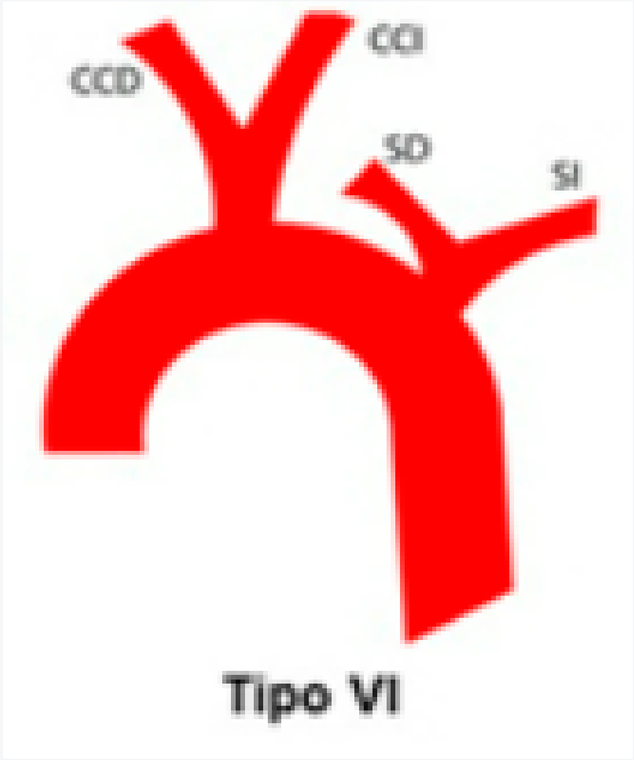
- Engrosamiento difuso de la pared de la aorta, con calcificaciones concéntricas de raíz de aorta, aorta ascendente y cayado aórtico.
- **Presencia de múltiples ulceras penetrantes en curvatura mayor de aorta ascendente y arco aórtico.**
- **HIM que compromete el tercio distal de la aorta ascendente.**
- **Arco bovino con tronco único dilatado y ambas arterias carótidas con origen común.**
- Art. Coronarias: sin lesiones.
- Se discute caso con HEART TEAM.



- 10%-40%: DAA → Mortalidad: 1–2% c/hora sin intervención
- 54%: Disrupción intimal
- **Tipo A: Mortalidad Qx: 20%**



- Afectación de Aorta ascendente complicada con HIM: Riesgo de ruptura de 33%-75% y de progresión a DAA.
- **Tratamiento Qx: Mortalidad 20%**



ESC European Society of Cardiology
European Heart Journal (2024) 00, 1–163
https://doi.org/10.1093/eurheartj/ehae179
ESC GUIDELINES

2024 ESC Guidelines for the management of peripheral arterial and aortic diseases

Recommendation Table 51 — Recommendations for the management of intramural haematoma

Recommendations	Class[a]	Level[b]
In patients with IMH, medical therapy including pain relief and blood pressure control is recommended.[24,172]	I	C
In type A IMH, urgent surgery is recommended.[172,1175,1192]	I	C
In type B IMH, initial medical therapy under careful surveillance is recommended.[1175,1192,1347,1350,1353]	I	C
In uncomplicated[c] type B IMH, repetitive imaging (CCT or CMR) is indicated.[1175,1192,1347,1350,1353]	I	C
In complicated[c] type B IMH, TEVAR is recommended.[1175,1192,1347,1350,1353]	I	C
In uncomplicated[c] type B IMH but with high-risk imaging features[d], TEVAR should be considered.[1347,1350]	IIa	C
In complicated[c] type B IMH, surgery may be considered in patients with anatomy unfavourable for TEVAR.[1175,1192,1347,1350,1353]	IIb	C
In selected patients with increased operative risk and uncomplicated[c] type A IMH without high-risk imaging features[d], a 'wait and see' strategy may be considered.[1348,1354–1356]	IIb	C

CCT, cardiovascular computed tomography; CMR, cardiovascular magnetic resonance; IMH, intramural haematoma; TEVAR, thoracic endovascular aortic repair.
[a]Class of recommendation.

Recommendation Table 52 — Recommendations for the management of penetrating atherosclerotic ulcer

Recommendations	Class[a]	Level[b]
In all patients with PAU, medical therapy including pain relief and blood pressure control is recommended.[24,172]	I	C
In cases of type A PAU, surgery is recommended.[172]	I	C
In cases of type B PAU, initial medical therapy under careful surveillance is recommended.[1347,1350]	I	C
In uncomplicated type B PAU, repetitive imaging (CMR, CCT, or TOE) is recommended.[1347,1350]	I	C
In complicated type B PAU, endovascular treatment (TEVAR) is recommended.[1347,1350,1357]	I	C
In uncomplicated type B PAU with high-risk imaging features,[c] endovascular treatment should be considered.[1347,1350]	IIa	C
In selected patients with increased operative risk and uncomplicated type A PAU without high-risk imaging features,[c] a 'wait-and-see' strategy may be considered.[1367]	IIb	C
In complicated type B PAU, surgery may be considered based on anatomy and medical comorbidities.[1347,1350]	IIb	C
In isolated, asymptomatic, small PAUs with no high-risk features,[c] conservative management with regular surveillance and medical treatment may be considered.[24,1361]	IIb	C

IMPRESIÓN DIAGNÓSTICA:

SINDROME AORTICO AGUDO:

1.- HEMATOMA INTRAMURAL TIPO A

2.- ULCERAS PENETRÁNTES DE AÓRTA ASCENDENTE.

QX EMG

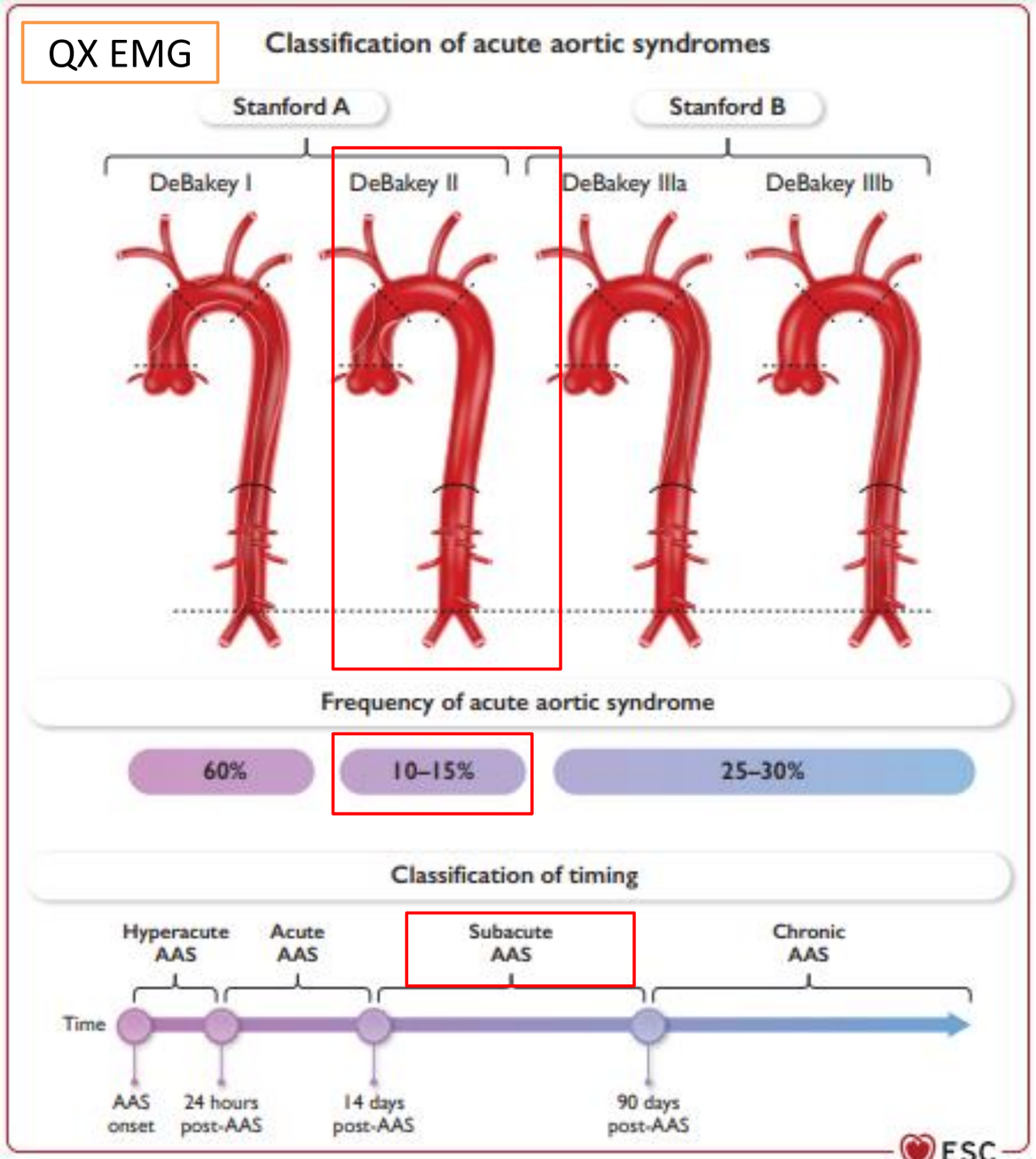


Figure 28 Anatomical and temporal classification of acute aortic syndrome. AAS, acute aortic syndrome.

Mortalidad 20%

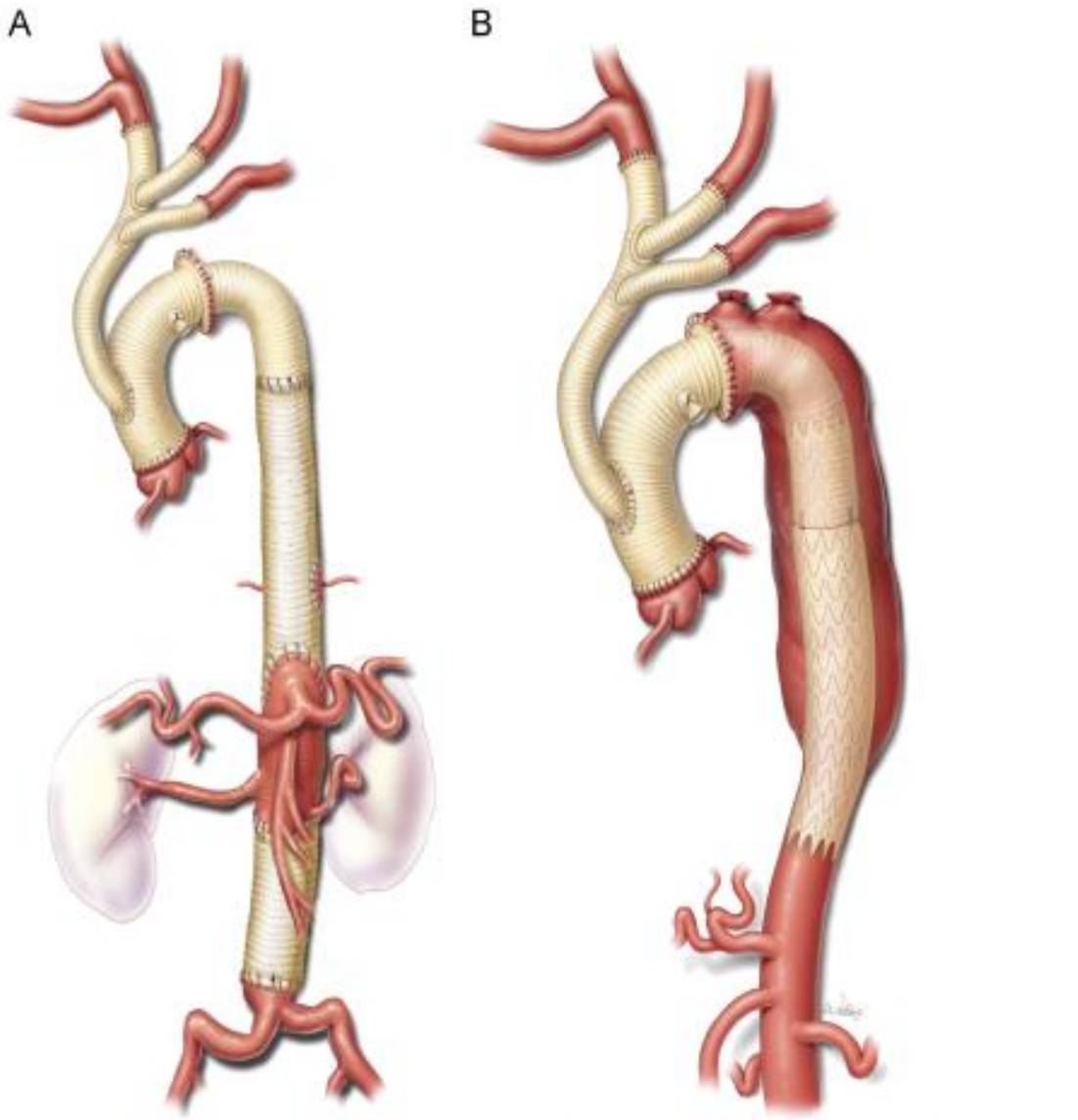
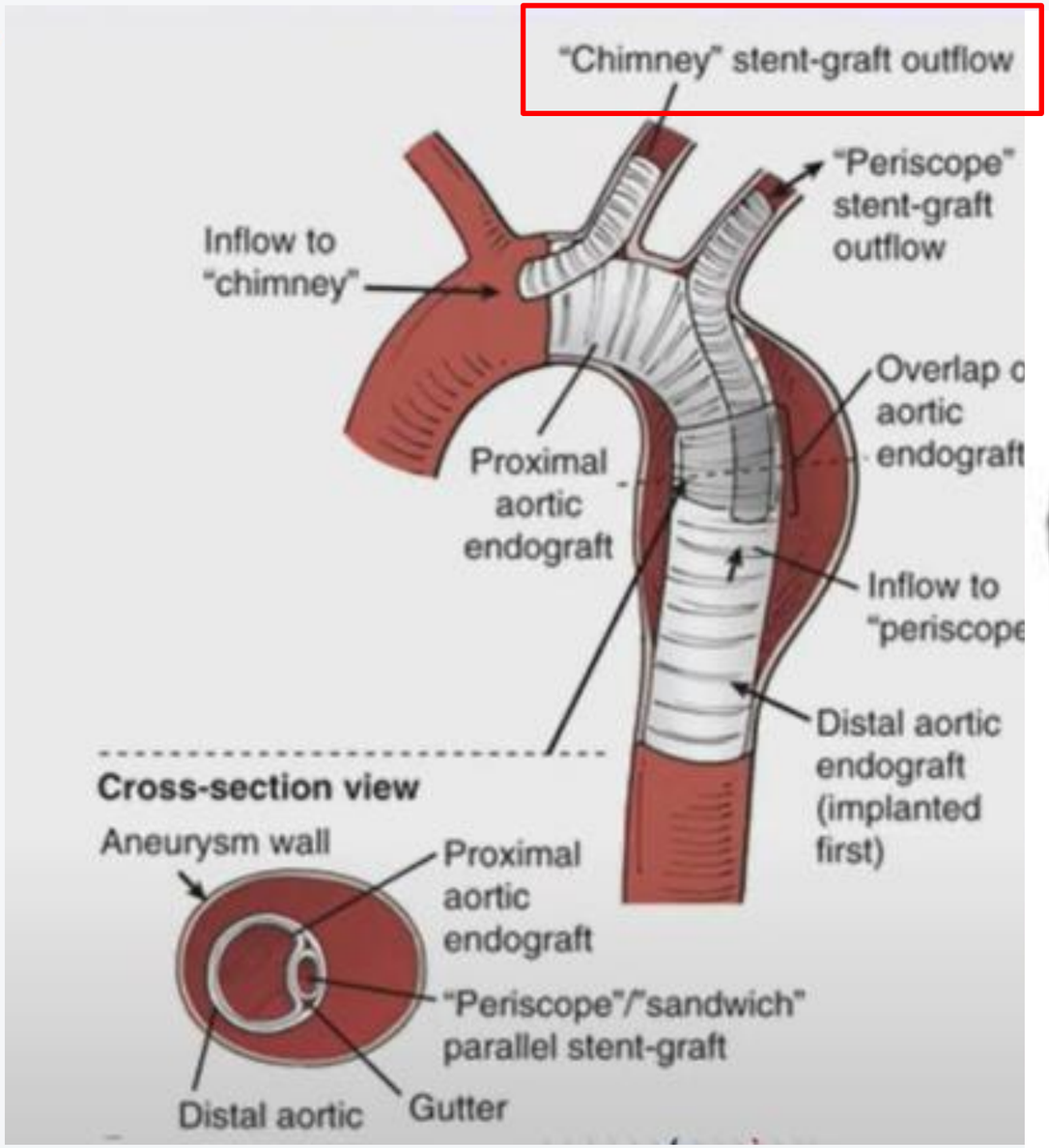
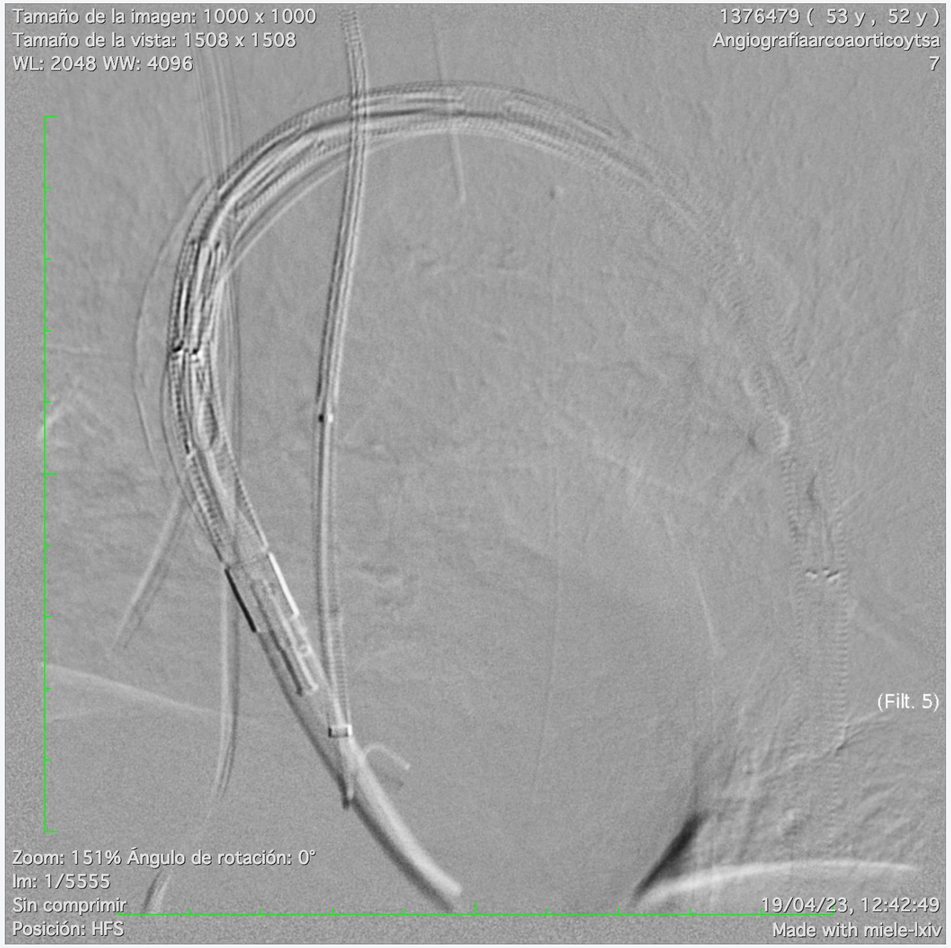


Figure 4. Completed (A) open and (B) endovascular second-stage repairs in patients who underwent first-stage elephant trunk repair of the aortic arch by the Y-graft technique. (Reproduced with permission from LeMaire et al.[2]) (Color version of figure is available online at http://www.semthorcardiovascsurg.com)

TÉCNICA ENDOVASCULAR

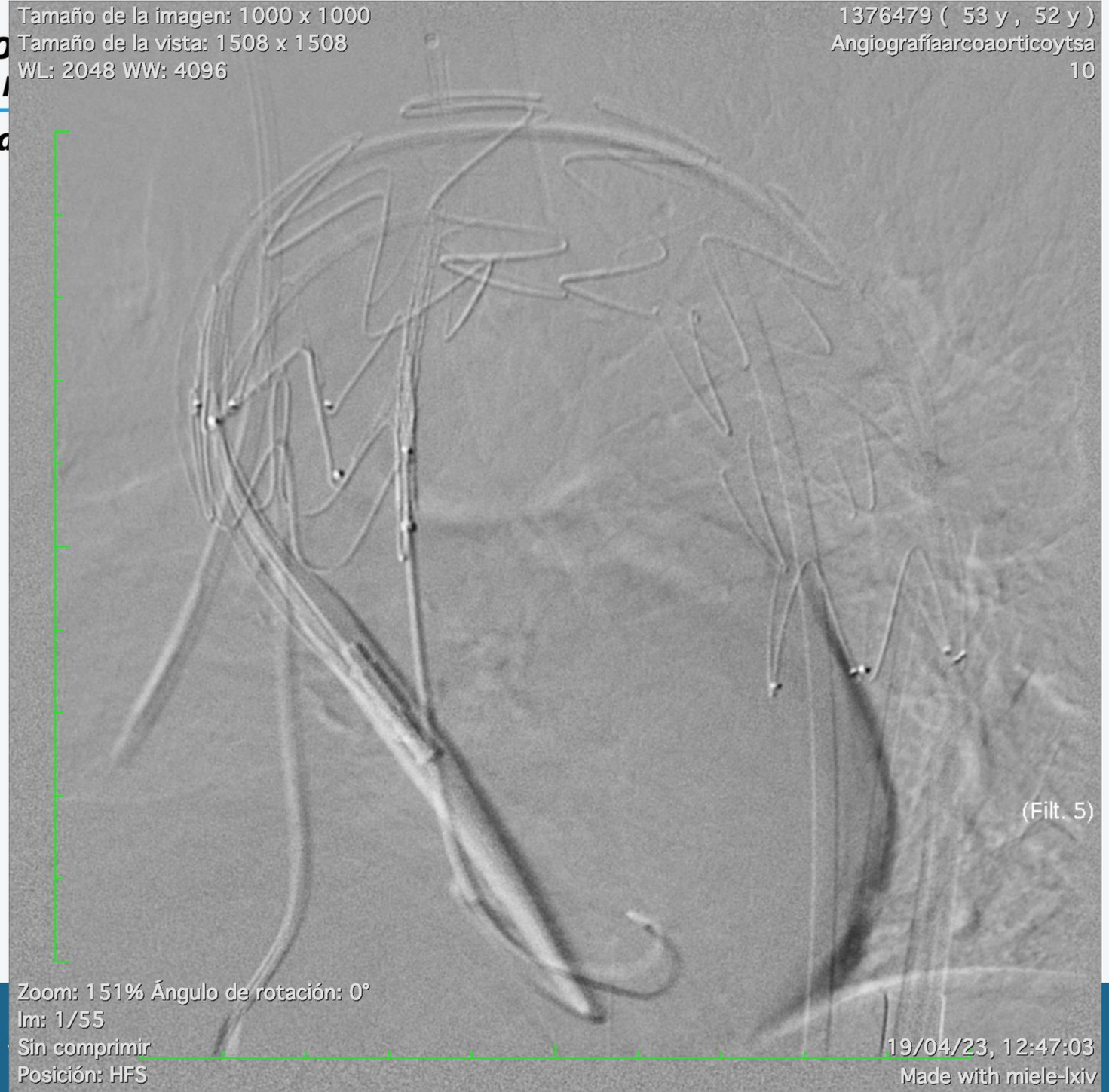


Punción arteria braquial D → TC
Art.Femoral D → Endoprótesis
Femoral I → SC
Vena Yugular D → MCP T.



Cateterización de TCC Y ASI
Introductor largo y colocación de Stent BEGRAFT 10mmx57 mm (TC)

FD: Prótesis endovascular de aorta torácica de 34 mm x 160 mm (Ao Asc a 1 cm de Art. Coronarias).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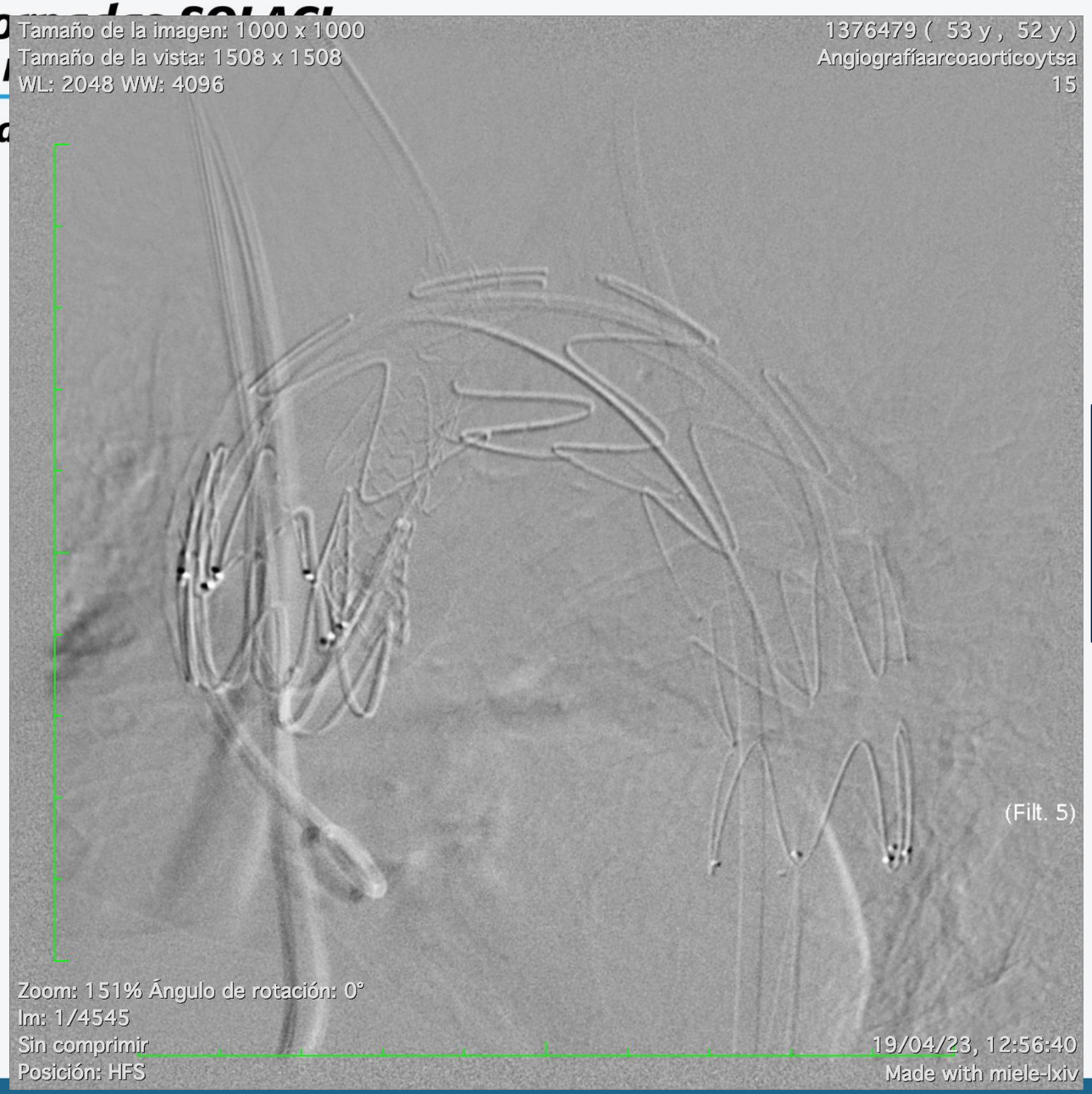
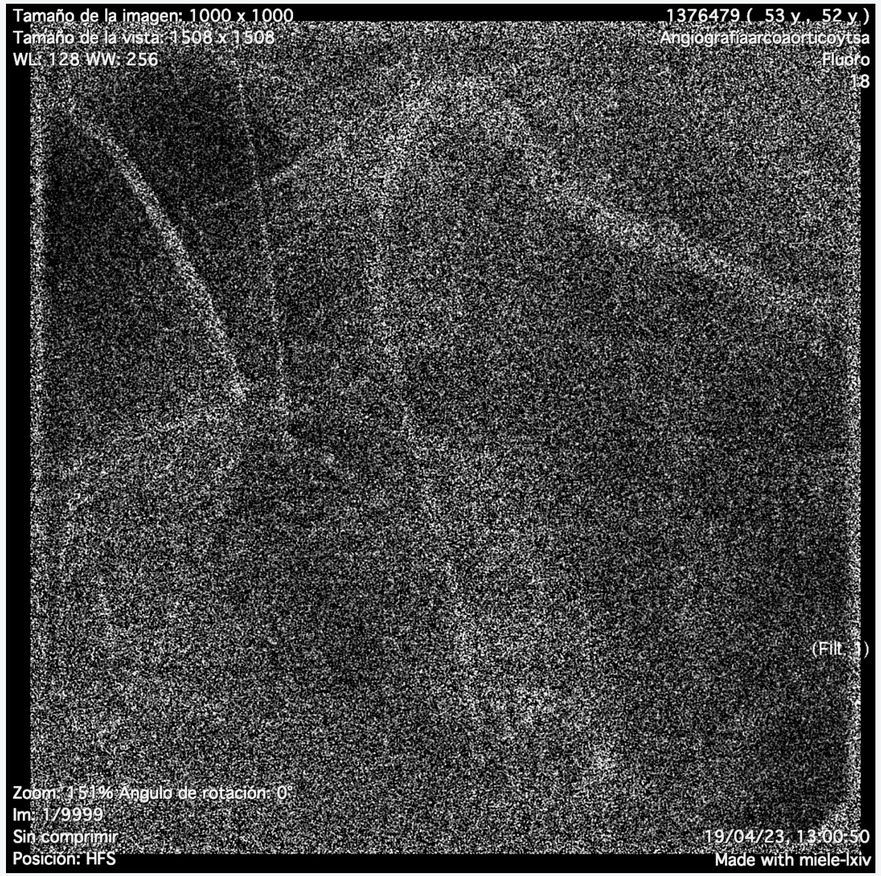
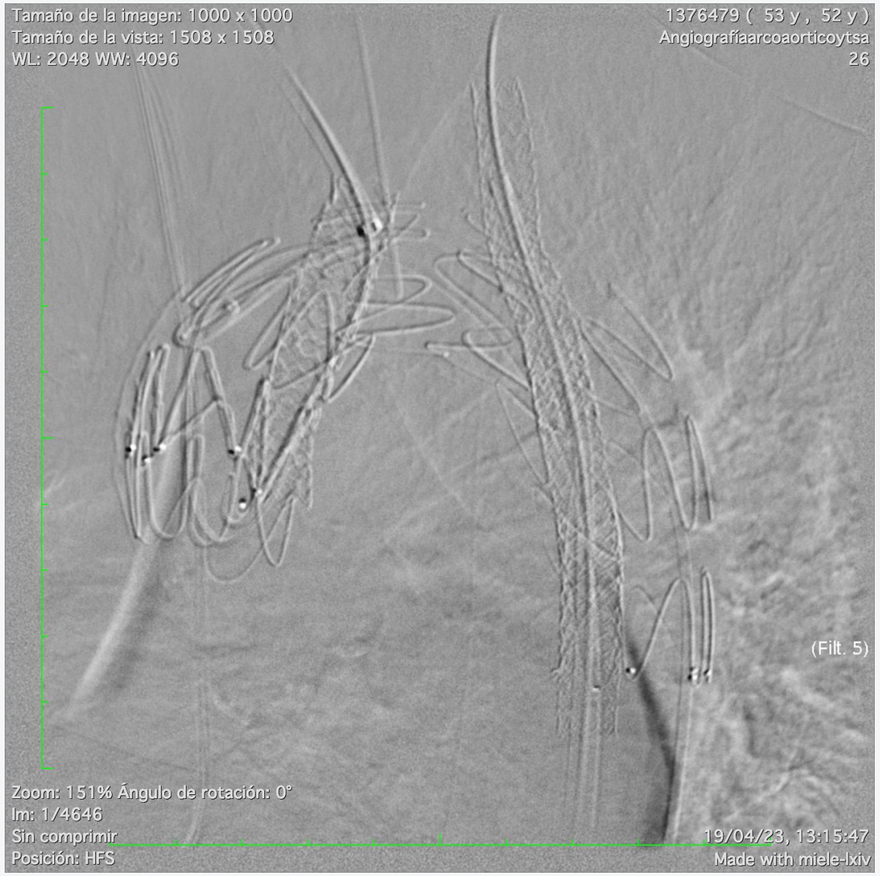
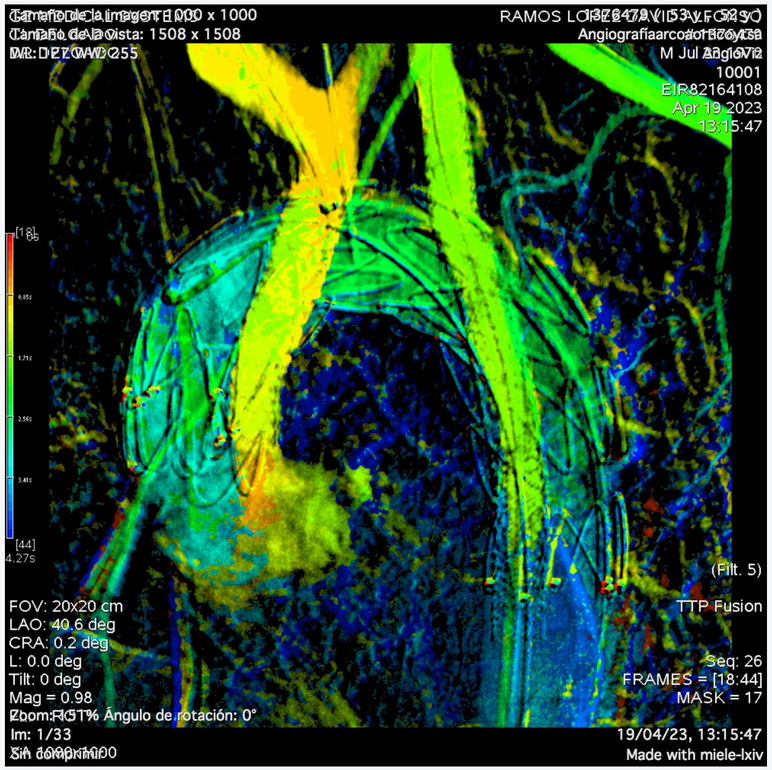


Angioplastía con Stent recubierto BELGRAFT 10 mm x 57 mm (Chimenea)





Angioplastía con STENT RECUBIERTO SNORKEL de 8.57, 7x57, 7x37 y Post dilatación con balón de 10 mm


Tamaño de la imagen: 1000 x 1000
Tamaño de la vista: 1508 x 1508
RAMOS LOPEZ
Angiografía arco aórtico
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[44]
4.27s
(Filt. 5)
TTP Fusion
FOV: 20x20 cm
LAO: 40.6 deg
CRA: 0.2 deg
L: 0.0 deg
Tilt: 0 deg
Mag = 0.98
Seq: 26
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MASK = 17
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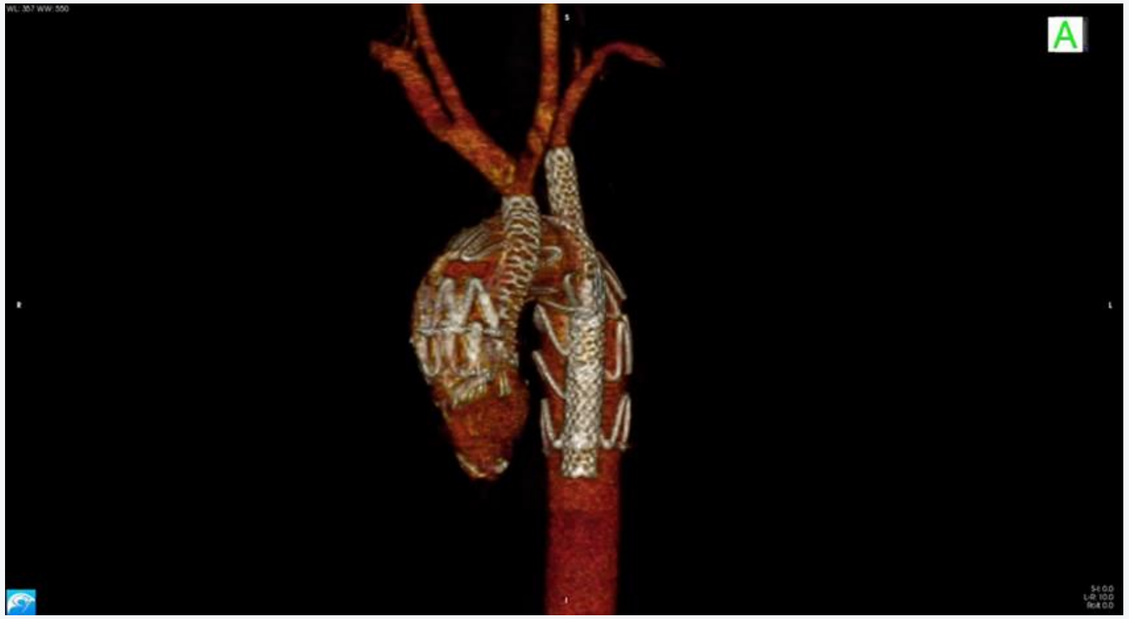
A

CONCLUSIONES:

INDICACION: I C TRATAMIENTO QUIRUGICO.

ALTERNATIVA TRATAMIENTO ENDOLUMINAL (MENOR MORTALIDAD).

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