中文題目：罕見的嚴重主動脈剝離併雙側頸動脈剝離個案

英文題目：Stanford type A aortic dissection with bilateral carotid arteries dissection: a case report.

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Background:

Aortic dissection (AD) is a life-threatening condition. The incidence of AD is 2.6 to 3.5 per 100,000 person-years. 10-15% of AD involved a carotid or subclavian artery were reported. Without accurate diagnosis, mortality rates were up to 2% per hour for type A of AD. Patients with AD classically presented with sharp or tearing chest pain with radiated to the back. Other clinical manifestations of the AD include acute aortic valve regurgitation resulted in a newly diastolic decrescendo murmur, hypotension, heart failure, acute myocardial ischemia, myocardial infarction, cardiac tamponade, sudden death, hemothorax, a considerable variation (>20 mmHg) in systolic blood pressure between the arms and neurologic deficits. Neurologic deficits were reported to occur in 18–30% of patients with AD. Differentiating between the acute neurologic deficits due to stroke and AD is central to patient care because thrombolytic therapy can be helpful in patients with stroke but be contraindicated in patients with AD.

We report an unusual Stanford type A AD patient with involvement of bilateral carotid arteries presented as loss of consciousness.

Case Report:

A 71-year-old male with old cerebral infarcts and hypertension was admitted due to a scheduled surgery for bilateral inguinal hernia. The chest radiography showed grossly normal in the pre-operation survey. Sudden onset of chest tightness and then loss of consciousness were noted when he was walking in the day before operation. The blood pressure was 73/49 mmHg, the electrocardiogram was atrial fibrillation and the biochemistry lab data were all within normal range. The brain computed tomography was performed for acute stroke survey and no new lesion could be detected. Widening of the mediastinum with calcium sign was found in the chest radiography (Panel B). The cardioechogram revealed impaired LV systolic function (EF: 47.47%), dilated aortic root (5.76cm), and a

dissected flap in the ascending aorta with severe acute aortic regurgitation (Panel C and D). Under impression of aortic dissection, the computed tomography angiography was performed. The computed tomography angiography revealed Stanford type A of AD involving from aortic root to bilateral common iliac arteries (Panel E,F,G) Surprisingly, unusual dissection of bilateral common carotid arteries were also found (Panel H). Due to old age and poor prognosis in patients with type A of AD with involvement of bilateral carotid arteries, family refused further aggressive management. Finally, the patient expired on the same day.

Conclusion:

We presented an unusual patient with extensive Stanford type A of AD involving both common iliac arteries, the entire length of the aorta, and the bilateral common carotid arteries. AD with involvement of carotid arteries should be considered in patients presented as loss of consciousness. The prognosis is poor in patients with AD and involvement of bilateral carotid arteries.