Spital Zentrum Münsingen: Dr F Repond, Münsterlingen, Kantonsspital Münsterlingen: Dr F Widmer, Muri, Kreisspital für das Freiamt: Dr A Spillmann/Dr F Scheibe/Dr K Rudaz-Schwaller, Nyon, Group Hosp Ouest lémanique: Dr R Polikar, Rheinfelden, Gesundheitszentrum Fricktal Regionalspital Rheinfelden: Dr H-U Iselin, Rorschach, Kantonales Spital Rorschach: Dr M Pfister, Samedan, Spital Oberengadin: Dr P Egger, Sarnen, Kantonsspital Obwalden: Dr T Kaeslin, Schaffhausen, Kantonsspital Schaffhausen: Dr R Frey, Schlieren, Spital Limmattal: Dr B Risti/Dr V Stojanovic/Dr T Herren, Schwyz, Spital Schwyz: Dr P Eichhorn, Scuol, Ospital d'Engiadina Bassa: Dr G Flury/Dr C Neumeier, Solothurn, Bürgerspital Solothurn: Dr P Hilti, St Gallen, Kantonsspital St Gallen: Dr W Angehrn/Dr H Rickli, Thun, Spital Thun: Dr U

Stoller, Thusis, Krankenhaus Thusis: Dr U-P Veragut, Uster, Spital Uster: Dr D Maurer/PD Dr J Muntwyler, Uznach, Kantonales Spital Uznach: Dr A Weber, Wädenswil, Schwerpunktspital Zimmerberg-Horgen: Dr G Garzoli/Dr B Kälin, Wald, Spital Wald: Dr M Schneider, Walenstadt, Kantonales Spital Walenstadt: Dr H Matter/Dr D Schiesser, Wetzikon, GZO Spital Wetzikon: Dr M Graber, Winterthur, Kantonsspital Winterthur: Dr A Haller, Wolhusen, Kantonales Spital Sursee-Wolhusen: Dr M Peter, Zofingen, Spital Zofingen: Dr HJ Vonesch/Dr HJ Meier/Dr S Gasser, Zollikerberg, Spital Zollikerberg: Dr P Siegrist/Dr R Fatio, Zug, Zuger Kantonsspital: Prof M Vogt, Zürich, Universitätsspital Zürich: PD Dr F Eberli/ PD Dr M Maggiorini, Zürich, Stadtsipital Triemli: Prof O Bertel, Zürich, Stadtsipital Waid: Dr M Brabetz/Dr S Christen.

IMAGES IN CARDIOLOGY

doi: 10.1136/hrt.2006.104893

Giant coronary artery aneurysm in Behçet's disease

A 27-year-old man with Behçet's disease was admitted to hospital after two episodes of typical rest chest pain and numbness of the left arm in the past 24 hours. Past medical history showed no risk factors for coronary artery disease. Behçet's disease had been diagnosed 7 years ago, and he was currently treated with colchicine.

On first examination in the emergency room, blood pressure was 120/70 mm Hg and heart rate 75 bpm. Echocardiography showed sinus rhythm with normal repolarisation. Laboratory tests showed raised troponin at 1.6 IU/nl (normal <0.4). Based on these data, non-ST elevation myocardial infarction was diagnosed. An early coronary angiogram was performed, showing an isolated giant aneurysm of the mid left anterior descending artery (panel A). A left ventriculogram showed a normal ejection fraction. Intravascular ultrasound analysis of the mid left anterior

descending artery demonstrated at the site of aneurysm neither thrombus nor atherosclerotic lesion, but a mild thickening of the intima and media layers, suggesting an inflammatory process. This abnormal intravascular ultrasound finding was also seen close to the aneurysm despite a normal angiographic aspect (panel B). No other vascular localisations were detected, particularly in pulmonary arteries.

We did not attempt coronary intervention and decided on conservative

treatment with oral antithrombotic treatment. Ten days after this acute coronary syndrome, since the patient was symptom-free, he was discharged under aspirin 160 mg and clopidogrel 75 mg once a day. The patient has not had any further episodes of chest pain and complications during a 6-month follow-up period.

T Cuisset, J Quilici, J-L Bonnet
thomascuisset@voila.fr