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Image Focus

A giant right coronary artery aneurysm as an incidental finding

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We present the case of a 63-year-old asymptomatic man, with a diastolic murmur who was submitted for echocardiographic assessment. He was hypertensive and smoker. Two-dimensional transthoracic echocardiogram revealed a moderate aortic insufficiency and an abnormal extra-cardiac shadow on the right cardiac border (Figures A and B, arrows). There were no other abnormalities. In order to complete the diagnosis, he was referred for non-invasive coronaryography, which was performed with a 64-multidetectector computed tomography. It revealed a giant atherosclerotic right coronary artery (RCA) aneurysm with a maximal diameter of 45 mm, which was compressing the right chambers (Figures D and E), distal RCA was also aneurysmatic. A giant intramural thrombus was present surrounding the coronary lumen. In order to complete diagnosis and thinking in a possible surgical treatment, invasive coronaryography was practised confirming the finding (Figures C and F). Afterwards, the patient refused any invasive treatment.

Aneurysmal coronary artery disease is an uncommon disease (1.5–5%) defined as a coronary dilatation that exceeds the diameter of normal adjacent segments or the diameter of the patient’s largest coronary vessel by 1.5 times. The RCA seems to be the most commonly involved.

The most frequent aetiology is atherosclerosis followed by Kawasaki disease. Other less common causes include connective tissue diseases, Takayasu arteritis, trauma, or dissection.

In asymptomatic patients, diagnosis is usually incidental; cardiac computed tomography, cardiac-magnetic resonance imaging and cardiac catheterization are useful to make a definitive diagnosis. Ischaemia detection tests should also be performed to determine the significance of the aneurysm or stenoses and the best therapeutic options.

Conflict of interest: none declared.

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