patients? Are there other treatments that might improve outcome? We should no longer neglect the majority of patients with heart failure, particularly the silent majority.

Conflict of interest: none declared.

References

Clinical vignette
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Unstable single coronary artery

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A 78-year-old male presented for elective cardiac catheterisation following a 1-week history of crescendo angina on a background of longstanding hypertension, hypercholesterolaemia, and transient ischaemic attacks.

Cardiac catheterisation revealed a single coronary artery (SCA) anomaly, with the right coronary artery (RCA) arising from the right coronary sinus continuing on to sequentially form the anatomical circumflex (CX) and the left anterior descending (LAD) artery. A 90% lesion was apparent in the anatomical mid-CX coronary artery isolating the LAD, which filled slowly antegradely. No left main coronary artery was discernable on angiography, aortography, or in an ECG-gated 64-slice cardiac CT, which corroborated the coronary course depicted by the angiogram.

SCA anomalies are uncommon (0.02–0.04%) and the variant we describe is exceedingly rare. To the best of our knowledge, this is the first reported case of this variant with evidence of a significant atherosclerotic lesion.

Panel A. The RCA arises normally in the right coronary sinus and continues to sequentially form the CX in the AV groove and continues on to form the LAD.

Panel B. A 90% lesion (L) is present in the mid-CX isolating the LAD.

Panel C. Aortography shows the RCA arising normally from the aorta (Ao), but no evidence of the left main coronary artery.

Panels D and E. Cardiac CT demonstrates the calcified RCA emanating from the right coronary sinus and seen later as the CX, which then continues anteriorly as the LAD (Panel F). CT reconstructions demonstrate continuity of the RCA and CX (Panel G), and that only the RCA arises from the aorta (Panel H).