Multiple septal coronary-cameral fistulae associated with paroxysmal atrial fibrillation

Paroksismal atriyal fibrilasyonla birlikte görülen koroner kameral fistüller

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A 60-year-old female with a past medical history of hypertension was admitted to our clinic after two hours of acute-onset chest pain and palpitation. On physical examination, her blood pressure and heart rate were 125/70 mmHg and 135 bpm, respectively. She had a 2/6 systolic murmur which was maximally heard over the left parasternal region. The electrocardiogram showed atrial fibrillation with a high ventricular rate (135 bpm) and left ventricular (LV) hypertrophy. Transthoracic echocardiography showed normal LV systolic function (ejection fraction 67%) and no valvular heart disease, but moderate LV hypertrophy and diastolic dysfunction. In the coronary care unit, her electrocardiogram spontaneously returned to normal. Maximal troponin I elevation was 3.0 ng/dl after the onset of clinical symptoms. Coronary angiography showed no critical atherosclerotic lesions in the coronary arteries; however, septal arteries were in communication with the LV cavity through multiple, small, diffuse fistulae, resulting in complete LV endocardial contrast opacification (Fig. 1, supplementary video file 1*). It was noted that the contrast marked the border of the ventricular endocardium in the phase of diastole, while it diminished with the contraction of septal fistulae in the systole. The size of the heart and its systolic functions were normal. High troponin I level was attributed to paroxysmal atrial fibrillation or to coronary steal phenomenon. Surgical ligation or percutaneous endoluminal procedures were not considered because of widespread fistulae and technical difficulties. The patient was discharged on medical treatment with 50 mg metoprolol succinate, 5 mg ramipril, 100 mg aspirin, and 40 mg atorvastatin and was included in the follow-up list.

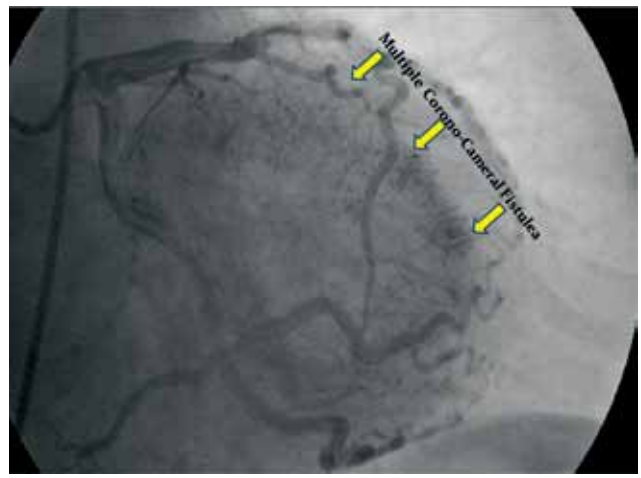

Figure. Right anterior oblique/caudal projection showing multiple coronary-cameral fistulae. **Supplementary video file associated with this case can be found in the online version.*