

Bilateral coronary-to-pulmonary artery fistulas

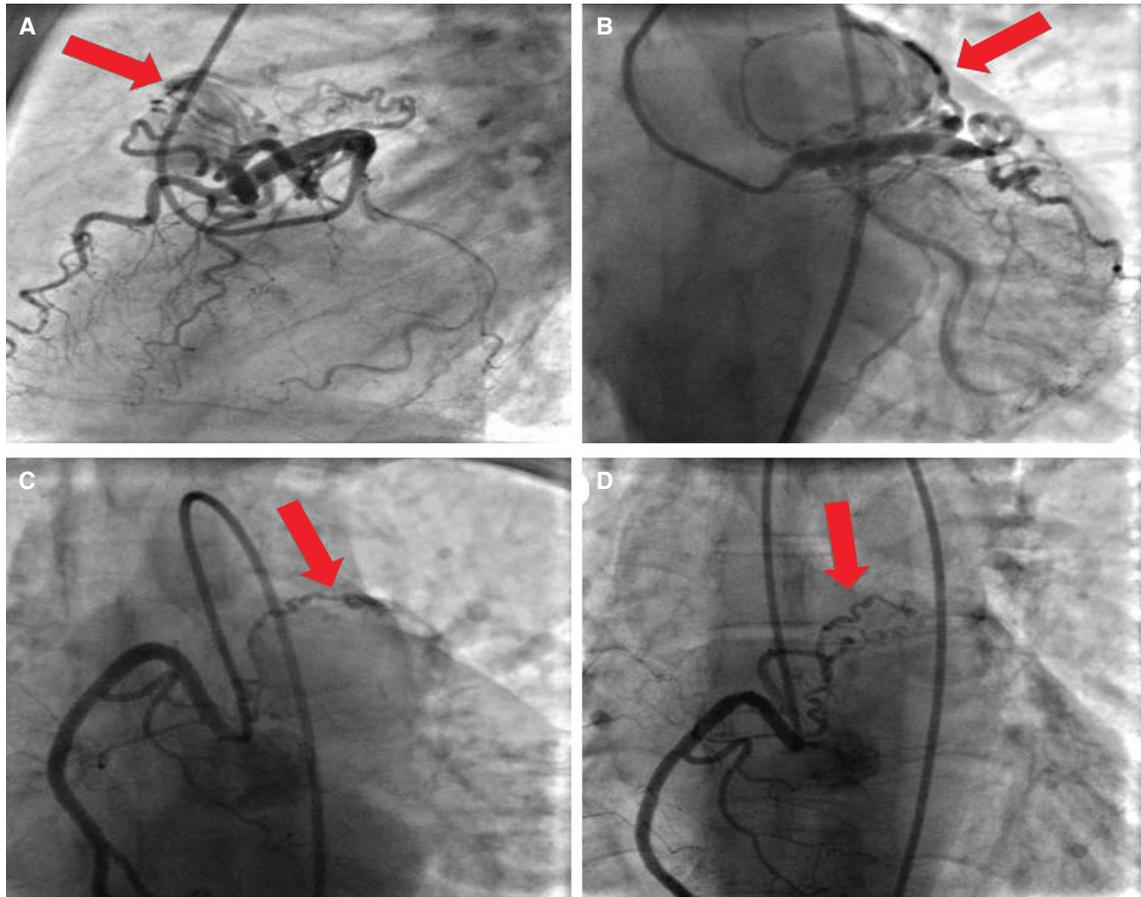
İki taraflı koroner arter-pulmoner arter fistülleri

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A 60-year-old woman was admitted with the symptoms of intermittent chest pain and progressive dyspnea on effort. Cardiac auscultation revealed 2/6 grade systolic ejection murmur at the left upper sternal border. Electrocardiography demonstrated sinus rhythm with right axis deviation and persistent precordial S waves. Trans-thoracic echocardiography revealed right atrial and ventricular enlargement. Doppler echocardiography demonstrated mild tricuspid regurgitation. Pulmonary artery pressure was 40 mmHg. She underwent tread-

mill exercise test performed in accordance with Bruce protocol. At the end of stage II, she suffered from chest pain, and 2 mm upsloping ST-segment depression was observed. In coronary angiography, bilateral coronary artery fistulas (CAF) arising from the first diagonal branch of the left anterior descending (LAD) artery (Fig. A, B) and proximal part of the right coronary artery (RCA) (Fig. C, D) were detected. Both CAFs drained into the pulmonary artery. There was no obstructive lesion in any of the three coronary arteries. Because of the presence of effort dyspnea, limited functional capacity and high-risk treadmill test, we planned CAF ligation surgery. However, the patient refused the operation and was treated medically.



Figures– (A, B) Bilateral CAFs arising from the first diagonal branch of the LAD artery, **(C, D)** and proximal part of the RCA.