2. Discussion

IMH behaves in different ways: some regress spontaneously, while others bring about unfavorable outcomes such as frank aortic dissection and/or aortic rupture. The key point of the treatment is to differentiate a group of patients who would be benefited by surgery before a catastrophic event coming in reality, which is not fully established [1]. General agreement was made in favor of surgical treatment in cases involving ascending aorta, as seen in the treatment guidelines of acute aortic dissection [2,3]. As for etiology, IMH caused by rupture of the vasa vasorum is supposed to behave more malignantly than by penetrating atherosclerotic ulcer [4].

In this case, we could not directly document recurrence of the IMH as an initiating event of her dissection as it developed so rapidly. However, it would be prudent to attribute her dissection to the recurrence of IMH taking account of her recent history of IMH in the coinciding extent of presumed entry site of the aortic dissection. What we learned from this case is that IMH has a potential to recur, which should be differentiated from late progression of the disease. One should bear in mind that careful follow-up is mandatory for IMH even after complete resolution of hematoma being documented.

As for operation, frozen elephant technique [5] might be a plausible option for this patient in favor of the elimination of distal intimal disruption. The stent graft, however, was not available at that moment.

The aortic intima was exceptionally clean with no evidence of penetrating atheromatous plaque or ulcer in this patient. Any background factor for repeated IMH could not be sought, which should be investigated further.

References


ICVTS on-line discussion A

Title: Women with Marfan syndrome
Authors: Mohamed Fahmy Ibrahim, PSHC, King Fahd Medical City, Riyadh, Saudi Arabia; Amal A. Refaut
doi: 10.1510/icvts.2006.149187A
eComment: Concerning the case report described by Baek et al. [1], we recently encountered a multiparous woman with Marfan syndrome in her 8th week of gestation who presented with acute type A aortic dissection. After reviewing the literature, it seems that pregnancy is a risk factor for the development of aortic dissection in this subset of patients. My question is about the history of pregnancy in Baek’s patient. I also agree with the author’s comment in the discussion that the frozen elephant technique would have been a perfect option for this patient. Another option would be to tackle the ascending aorta surgically, as done by Baek et al., and then as a hybrid technique to deploy a percutaneous stent graft for the distal intimal disruption.

Reference