massive airway hyperemia and subsequent hemoptysis occurred and the patient was strangulated by acute superior vena cava obstruction, massive hemoptysis and concomitant hemoptysis without aorto-bronchial fistula. Acute pulmonary arterial compression caused right ventricular failure, and combined with acute superior vena cava obstruction, massive hemoptysis occurred and the patient was strangulated by acute massive airway hyperemia and subsequent hemoptysis.

In conclusion, mediastinal hematoma should not be underestimated, especially presenting obstruction of pulmonary artery and superior vena cava caused by thoracic aortic dissection, and should be recognized as one of the acutely fatal signs of type A dissection, and emergency surgical repair should be performed to avoid subsequent catastrophic events.

References


eComment: Aortic dissection and confusing nomenclature

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I read Inoue and colleagues case description of a mediastinal haematoma in type A dissection with interest [1]. There is looseness in our use of terms when we talk of aortic dissection. Whether we address type A or B. Everyone knows one affects the ascending aorta, the other the descending. Emotions rise, however, when addressing categorisation of an isolated dissected arch! Of course the point of interest is the presence of aortic dissection within or without the pericardium as it is intra pericardial involvement that leads to the complications of dissection that we, surgeons, can do something about (tamponade, myocardial ischaemia or acute heart failure with valvular regurgitation).

There is also confusion in our profession between dissection of the aorta and aneurysmal dilatation often leading to inappropriate use of the term dissection aneurysm. A mediastinal haematoma immediately suggests aortic rupture, not the complication of further dissection (that is enlargement of the false lumen that has formed within the problematic media of the aorta).

In this intriguing report by Inoue et al, the mediastinal haematoma has been confined – it appears – to track along the pulmonary arterial tree. For this to occur it is clear that blood has escaped the confines of the false lumen through rupture out of the aortic media. I do believe that these authors have not described further dissection but an unusual rupture of a previously dissected aorta. Trivial point perhaps but only with clarity of labelling will we better understand the problems we deal with. It is always through better understanding that more effective treatment can be achieved with a reasonable expectation of better patient outcomes.

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Reference