irreversible injury (LGE) but oedema formation on T2-weighted images. The definite differentiation between TTC and a truly aborted MI without myocardial necrosis is indeed difficult. A definitive answer may be provided by a large study using intravascular ultrasound of the LAD to exclude the possibility of significant underlying plaque rupture.

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Acute coronary syndrome following a recent Bentall-De Bono procedure

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A 55-year-old woman with a past (about 5 years ago) aortic replacement due to ascending aorta aneurysm and, more recently (about 4 months ago), replacement of aortic valve, implantation of tube graft, and native coronary arteries due to Type I aortic dissection presented with new onset, crescendo typical angina. Physical examination was normal and blood pressure was 120/80 mmHg. EKG showed a sinus rhythm and reflected left ventricular dilatation and hypertrophy. Laboratory findings were all within the normal range. Trans-oesophageal echocardiography revealed the residual endoluminal flap but stable diameter of both ascending and descending aorta. A cardiac CT-scan showed a thoraco-abdominal endoluminal flap (residual aortic dissection, Panel A) but revealed severe lumen narrowing of both right (Panels B and C) and left coronary ostium (Panels B and D).

Ostial stenosis of one or both main coronaries is a very rare complication of surgical correction of Type A aortic dissection. Indeed, the most common stenosis complication after a Bentall-De Bono procedure is pseudoaneurysms and aneurysms formation. The aetiology of ostial stenosis is poorly understood, although inflammation/cell proliferation response to the gelatine–resorcinol–formaldehyde utilized at the time of the surgical procedure has been suspected. Thus, new angina occurring few months after a Bentall-De Bono procedure should prompt to suspicion of iatrogenic ostial stenosis. Therapy for this condition remains surgical but stenting of left main coronary artery may be considered. Due to patient’s refusal to undergo another major cardiac surgery, stenting of both coronary ostia was successfully performed and patency at 6 months was demonstrated by cardiac CT (Panels E and F). Patient outcome was uneventful.

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