and chest wall ecchymosis should be kept in mind as a clinical sign of subacute/delayed type A dissection.

Conflict of interest: none declared.

REFERENCES


eComment. Unusual presentation of acute aortic dissection

Authors: Jamil Hajj-Chahine, Christophe Jayle, Hassan Houmaida and Pierre Corbi

Department of Cardio-Thoracic Surgery, University Hospital of Poitiers, Poitiers, France

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We read with great interest the report by Yazici et al [1]. The authors presented a case of a 66-year-old patient with bilateral anterior chest wall ecchymosis suffering from a subacute type A aortic dissection. The patient was successfully managed, and the postoperative course was uneventful. However, we believe that there are some issues that need to be addressed.

Firstly, the authors stated that the intimal tear was located in the aortic arch. On the other hand in the discussion, they assumed that during coronary angiography the inappropriate engagement of the right coronary ostium with the guiding catheter was responsible for the aortic dissection. Iatrogenic aortic dissection in this setting would have been presented with an intimal tear in the vicinity of the coronary ostium.

Secondly, they speculated that the extensive anterior chest wall ecchymosis in this patient was due to the extension of the dissection to both internal thoracic arteries. The precise mechanism accounting for the bilateral chest bruising remains to be demonstrated.

Thirdly, ecchymosis in the suprasternal region in the context of acute aortic syndrome was previously depicted in two patients. Hashimi et al [2] described a 72-year-old female patient with progressive periortic haematoma of the arch and descending aorta. Al-Hity et al [3] presented a case of a 66-year-old female patient with acute aortic dissection (DeBakey type III). These two patients presented with ecchymosis in the suprasternal region secondary to the leakage of blood from the pathologic aortic arch to the neck area.

Although acute onset of severe chest or back pain is the most common presenting symptom, some patients may present with nonconforming symptoms and signs. There is a plethora of clinical presentation of this dreadful entity with varied symptomatology, including but not limited to syncope, headache, hemiparesis, atrial fibrillation, and superior vena cava syndrome [4]. Establishing a prompt diagnosis of aortic dissection can be difficult in the presence of atypical symptoms, especially in the absence of pain.

Conflict of interest: none declared

References


eReply. Re: Unusual presentation of acute aortic dissection

Authors: Pınar Yazıcı and Ersin Erkek

Istanbul Mehmet Akif Eşref Training and Research Hospital, Istanbul, Turkey
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We would like to thank Hajj-Chahine et al. for their eComment [1], which requires some explanations as follows: First of all, we recognized the intimal tear in the aortic arch in perioperative observation, but it was not the single source, there were multiple tears as it always occur. Nevertheless, all tissues were so inflamatory and fragile (subacute dissection) that finding a certain starting point for the dissection was not possible. We noted the perioperative findings and retrospectively speculated the possible mechanisms in the discussion after consulting every medical record with interventional cardiologists to figure this unusual problem out. These records suggested that the reason for the dissection could be related to right coronary engagement after re-checking the angiographic images. This is because the medical history only included angiography, which could have been a trigger for subacute aortic dissection.

As I explained above, these aetiologic explanations remain speculative for this patient. We also consulted with a forensic medical specialist for the possible mechanism of this pathology. It was not possible to examine the structure of the thoracic arteries but we know that an injury to arterial supply occurs, it is termed ecchymosis. We did not have the chance to apply meticulous forensic examinations, which are the best methods to discover the main source. The precise mechanism accounting for the bilateral chest bruising remains controversial for our case. Furthermore, neither the resolution nor quality of the magnetic resonance images (from another hospital) enabled us to figure out the exact mechanism. Thanks for your contribution on issues that we have somehow overlooked. An additional article on unusual presentation of aortic dissection by Al-Hity et al. was noted. However, these two references are both unrelated to type I dissection [2, 3]. Taken together, these studies make it reasonable to speculate that chest wall ecchymosis might have been related to another mechanism if neck ecchymosis located in the suprasternal region is a consequence of periaortic haematoma secondary to aortic dissection. Conversely, our patient had no signs of neck-related pathways, such as swelling or ecchymosis, as shown figure 1a [4].

In conclusion, acute aortic dissection may have variable presentations, making the diagnosis clinically challenging [5]. Chest pain is the key symptom as in our case, this symptom was apparent with concomitant unusual chest wall ecchymosis that we could not address the aetiology promptly. Our recent report describes a somewhat unusual presentation that we thought deserved to be shared with other clinicians. All speculations about such a different presentation are surely expectable or acceptable. However, the precise trigger for this clinical scenario is still unclear and so far, we have not been aware of chest wall ecchymosis as a sign of acute type A dissection.

Conflict of interest: none declared

References


