





Nehotično otkrivena disekcija uzlazne aorte – prikaz bolesnika

Incidentally Discovered Ascending Aortic Dissection: A Case Report

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SAŽETAK: Prikazujemo slučaj asimptomatske – bezbolne, Stanford A disekcije aorte koja je otkrivena na kompjutoriziranoj tomografskoj angiografiji koronarnih arterija. Bolesnik, 82-godišnji muškarac, bez anamnestičkih podataka o prethodno dijagnostificiranim bolestima ili kroničnoj terapiji, hospitaliziran je radi evaluacije zbog kliničkih i subjektivnih znakova zatajivanja srca. Negirao je bilo kakvu vrstu boli u prsnom košu, prije ili tijekom boravka u bolnici. Na transtorakalnoj ehokardiografiji pronađena je dilatacija aorte s umjerenom aortalnom regurgitacijom (bez intimalnog rascijepa na prikazu u lijevoj parasternalnoj dugoj osi), ejekcijska frakcija lijeve klijetke bila je uredna te nije bilo znakova perikardijalnog izljeva. Zbog sumnje na ishemijski incident (dinamika elektrokardiograma tijekom boravka u bolnici, no bez tegoba) upućen je na kompjutoriziranu tomografsku angiografiju koronarnih arterija na kojoj je konstatirana višezilna koronarna bolest srca sa stenozama do 60 %, ali i intimalni flap u uzlaznoj aorti – Stanford A disekcija, što je potom dodatno potvrđeno kompjutoriziranom tomografskom angiografijom cijele aorte. Bolesnik je odbio preporučeno kirurško liječenje i napustio bolnicu na vlastit zahtjev, a preporučena mu je medikamentna terapija i praćenje. Zbog varljivosti kliničke slike i diferencijalno dijagnostičkog izazova, promptna dijagnoza disekcije aorte kao medicinske hitnosti izazov je u svakodnevnoj kliničkoj praksi pa stoga treba uzeti u obzir njezine atipične oblike u smislu kliničke prezentacije i rezultata slikovnih dijagnostičkih metoda.

SUMMARY: We present a case of an asymptomatic, painless, Stanford type A aortic dissection (AD) that was discovered on computed tomography coronary angiography. The patient, a 82-year-old man, who had no previous medical records and no prescribed chronic therapy, presented with clinical and subjective signs of congestive heart failure and was hospitalized for further assessment. He denied any type of chest pain, whether before or during hospital stay. On transthoracic echocardiography, aortic dilatation with moderate aortic regurgitation was found (without the intimal flap on the left parasternal long axis view), left ventricular ejection fraction was preserved, and there were no signs of pericardial effusion. Due to the suspicion of an ischemic incident (the electrocardiogram was dynamic, the patient remained painless), the patient was referred for a computed tomography coronary angiogram, which revealed multivessel coronary artery disease with stenosis up to 60%, but also an intimal flap in the ascending aorta – Stanford type A dissection, which was then further confirmed by computed tomography angiography of the aorta. The patient refused the recommended surgical treatment, left the hospital at his own request, and was recommended drug therapy and follow-up. Because of the deceptiveness of clinical presentation and challenging differential diagnosis, prompt diagnosis of AD as a medical emergency remains a challenge in everyday clinical practice, and its atypical forms in terms of clinical presentation and imaging tests should be taken into account.

KLJUČNE RIJEČI: disekcija aorte, transtorakalna ehokardiografija, kompjutorizirana tomografska angiografija.

KEYWORDS: aortic dissection, transthoracic echocardiography, computed tomography angiography.

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Uvod

Disekcija aorte (AD) rijetko je, ali za život opasno, hitno stanje povezano s visokom učestalošću

Introduction

Aortic dissection (AD) is a rare but life-threatening medical emergency associated with a high

smrtnosti i pobola. Primarni je događaj u AD-u odvajanje slojeva aortalne stijenke potaknuto ozljedom intime, nakon čega krv, prolazeći kroz rascjep uzrokuje raslojavanje unutarnjeg i srednjeg sloja aortalne stijenke. Procijenjena incidencija AD-a kreće se od 2,6 do 3,5 na 100 000 osoba godišnje.¹

Akutni aortalni sindrom (AAS) uključuje spektar od triju za život opasnih bolesti aorte: akutnu disekciju aorte, intramuralni hematoma i penetrirajući aortalni ulkus. Prema konvenciji, akutna se bolest razlikuje od kronične u proizvoljnoj vremenskoj točki od dva tjedna od početka kliničke slike, i to: hiperakutna: <24 sata, akutna: 1 do 14 dana, subakutna: >14 do 90 dana, kronična: >90 dana i obično se manifestira simptomima.²

AD je, prema Stanford klasifikaciji, kategorizirana u dvije glavne vrste: tip A u kojem je disekcijom zahvaćen korijen aorte, uzlazna aorta i/ili luk aorte te tip B u kojem disekcija počinje u descendentnoj aorti distalno od izlazišta lijeve potključne arterije. Stanford disekcija tipa A češća je i ima veću stopu smrtnosti u usporedbi sa Stanford disekcijom tipa B.³

AD se obično manifestira iznenadnom, razdirućom boli u prsima, koja često propagira u leđa i čini medicinsku hitnost. Ostali uobičajeni simptomi uključuju bol u trbuhu, znojenje, krizu svijesti, otežano disanje, simptome slične moždanom udaru ili bol u nogama.⁴

Kompjutorizirana tomografska angiografija aorte (CTA) slikovna je dijagnostička metoda koja je modalitet izbora za dijagnosticiranje AD-a u hemodinamski stabilnih bolesnika. Vrlo je osjetljiva i specifična za slikovni prikaz patologije aorte. Pretraga treba obuhvatiti čitavu aortu, uključujući ilijakalne i femoralne krvne žile. Drugi modaliteti slikovne dijagnostike kao što su transtorakalna ehokardiografija (TTE) ili transezofagealna ehokardiografija (TEE) mogu biti korisni u hemodinamski nestabilnih bolesnika kao prva dijagnostička linija. I TTE i TEE mogu identificirati oštećenja aortalnog zalistka koja dovode do regurgitacije, hemoragičnog perikardijalnog izljeva uz eho znakove tamponade, te do abnormalnosti regionalne kinetike stijenke lijeve klijetke zbog moguće zahvaćenosti koronarnih arterija disekcijom. Međutim, potpun prikaz distalnog luka aorte i silazne aorte te dijagnosticiranje intramuralnih hematoma limitirani su TTE-om.⁵

Ovdje prikazujemo slučajno otkrivenu AD na kompjutoriziranoj tomografskoj angiografiji koronarnih arterija (CTCA) u bolesnika koji nije imao upečatljivu anamnezu i koji je bio bez tipičnih simptoma, kako prije, tako i prilikom prijema te boravka u bolnici.

Prikaz bolesnika

Bolesnik, muškarac star 82 godine, upućen je u Kliniku za hitan prijam bolesnika iz ambulante primarne zdravstvene zaštite zbog simptoma u obliku otežanog disanja, otjecanja donjih ekstremiteta, suhog kašlja, koji su trajali 5 – 6 tjedana, a intenzivirali su se desetak dana prije upućivanja. Bolesnik je inače dugogodišnji pušač koji nije imao redovite liječničke preglede, bez propisane bilo kakve kronične terapije i bez prethodno utvrđenih bolesti srca i hospitalizacija. U anamnezi navodi podatak da je sedam godina ranije navodno doživio moždani udar (no nema medicinske dokumentacije kojom se to potkrijepljuje).

Prilikom prijema u bolnicu u fizikalnom pregledu auskultorni nalaz na srcu i plućima bio je bez osobitosti, bolesnik je

mortality and morbidity rate. The primary event is a separation of the layers of the aortic wall by an inciting intimal injury, after which the blood rushes through the tear, causing the inner and middle layers of the aorta to dissect. The estimated incidence ranges from 2.6 to 3.5 per 100,000 person-years.¹

Acute aortic syndromes (AASs) include a spectrum of life-threatening aortic conditions. By convention, acute disease is distinguished from chronic disease at an arbitrary time point of two weeks from initial clinical presentation (hyperacute: <24 hours, acute: 1 to 14 days, subacute: >14 to 90 days, chronic: >90 days) and typically manifests with symptoms.²

AD is categorized into the following two main types by Stanford: type A involving the aortic root, ascending aorta, and/or arch of the aorta, and type B in which the dissection begins in the descending part of the aorta, distal of the left subclavian artery. Stanford dissection type A is more common and has a high mortality rate compared with Stanford type B.³

AD usually presents with sudden tearing chest pain that often radiates to the back, and is a medical emergency. Other common symptoms include abdominal pain, diaphoresis, loss of consciousness, shortness of breath, stroke-like symptoms, or leg pain.⁴

Computed tomographic angiography (CTA) is the diagnostic imaging modality of choice in hemodynamically stable patients. It is highly sensitive and specific for imaging aortic pathology. The study should include the entire aorta, including the iliac and femoral vessels. Other imaging modalities such as transthoracic echocardiography (TTE) or transesophageal echocardiography (TEE) may be useful in hemodynamically unstable patients as first line diagnostic tools. Both TTE and TEE can identify aortic valve disruption leading to regurgitation, hemorrhagic pericardial effusion, and tamponade, as well as regional wall motion abnormalities from coronary artery involvement. However, complete imaging of the distal arch and descending aorta are limited with TTE, and these may not be diagnostic for intramural hematoma.⁵

Herein, we present a case of an incidental finding of AD on computed tomography coronary angiography (CTCA) in a patient who did not have any corresponding medical history and was without typical symptoms both before and on hospital admission, as well as also during the hospital stay.

Case report

The patient, a 82-year-old man, was referred to the Emergency Medicine Clinic from the corresponding primary level outpatient clinic due to symptoms in the form of shortness of breath, swelling of the lower extremities, and dry cough, which had lasted for the past 5-6 weeks and intensified ten days before referral. The patient was otherwise without any prescribed chronic therapy, and was a long-time smoker who had not attended regular medical check-ups, with no previous cardiac diagnoses and hospitalizations. The patient claimed that he had allegedly had a stroke 7 years ago, but did not provide any medical documentation.

Upon admission, the auscultatory findings on the heart and lungs were without peculiarities on physical examination, and discrete pretibial bilateral edema was present, whereas the patient was normotensive and properly saturated. The patient complained of shortness of breath and swelling in both legs, denied that he ever had any form chest pain, whether sudden

imao diskretne pretibijalne tjestaste edeme, bio je normotenzivan i normosaturiran. Žalio se na kratkoću daha i otjecanje obiju nogu, a negirao je krize svijesti te bilo kakav oblik boli u prsnom košu. Na 12-kanalnom elektrokardiogramu kod prijema (EKG) ustanovljen je sinusni ritam normalne frekvencije s dvjema pojedinačnim ventrikularnim ekstrasistolama, a nije bilo znakova ishemijske. U laboratorijskim je nalazima registrirana blaga normocitna anemija: visokosenzitivni troponin (hsTnI) iznosio je 48 ng/L (referentne vrijednosti do 14 ng/L), dok je ostatak laboratorijskih parametara bio u referentnim granicama. RTG snimka srca i pluća pokazala je uvećan medijastinum na račun vaskularnih struktura uz slabiju diferencijaciju desnog hilusa, inhomogeno zasjenjenje lijevoga frenikokostalnog sinusa i početno inhomogeno zasjenjenje lijevo parakardijalno (**slika 1**). Bolesnik je bio hospitaliziran na Klinici za kardiologiju pod dijagnozom kongestivnog zatajivanja srca blažeg oblika sa svrhom da se izvrši evaluacija stanja. Ordinirana je parenteralna diuretska uz ostalu suportivnu terapiju, nakon čega se stanje subjektivno i klinički poboljšalo. Pri pregledu TTE-om vizualizirana je dilatirana ascendentna aorta (tubularni dio 4,9 cm), bez intimalnog flapa u lijevom parasternalnom presjeku duge osi – PLAX (**slika 2**); znaci aortalne regurgitacije umjerenog stupnja (**slika 3**); sistolički tlak u plućnoj arteriji procijenjen na oko 38 mmHg; znakovi mitralne i trikuspidalne regurgitacije blagog stupnja; indeksirani volumen lijevog atrija bio je blago uvećan (LAVI 38 ml/m²), a sistolička funkcija lijeve klijetke bila je očuvana (EF LV-a >55 %) bez regionalnih poremećaja kinetike; nije bilo znakova perikardijalnog izljeva. Naglašavamo da pri prvom TTE pregledu aorta nije pregledana iz desnoga parasternalnog, suprasternalnog i subkostalnog prikaza.

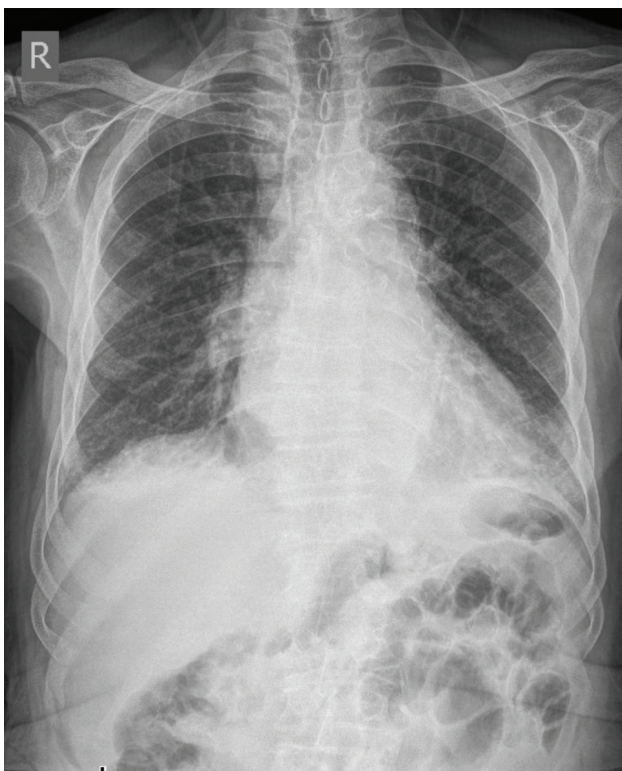


FIGURE 1. Chest X-ray on hospital admission.

or gradually increasing, also he denied any loss of consciousness. An electrocardiogram (ECG) was performed on admission – a favorable sinus rhythm with two single premature ventricular contractions and no signs of ischemia was noted; mild normocytic anemia was present in laboratory findings; high-sensitivity troponin I results were hsTnI 48 ng/L (reference values up to 14 ng/L), while the rest of the laboratory results were within reference ranges. Chest X-ray showed signs of enlarged mediastinum at the expense of vascular structures, the right hilum was less differentiated, the left phrenicocostal sinus was inhomogeneously shadowed, and there were signs of inhomogeneous opacity in the left paracardial space (**Figure 1**). The patient was hospitalized at the Department of Cardiology under a diagnosis of congestive heart failure. Parenteral diuretic and other supportive therapies were prescribed, after which the patient's condition subjectively and clinically improved. TTE was performed, which showed a dilated ascending aorta (tubular section 4.9 cm); there was no evident intimal flap on the left parasternal long axis (PLAX) view (**Figure 2**), and signs of moderate aortic regurgitation were present (**Figure 3**), while estimated systolic pulmonary artery pressure was at approximately 38 mmHg. Left atrial volume index was mildly above the normal limits (LAVI 38 mL/m²), left ventricular systolic function was preserved (LV EF above 55%), no regional wall motion abnormalities were found, the mitral and tricuspid valves showed signs of mild, first-degree regurgitation, and there were no signs of pericardial effusion. We emphasize that no right parasternal, suprasternal, or subcostal aortic imaging was performed during the first TTE exam.

CTCA was performed on the twelfth day of hospitalization due to suspected ischemic changes on a control ECG: biphasic and negative T waves in precordial leads that were not observed on admission (patient did not report any type of chest pain, he complained only of fatigue). Multivessel coronary

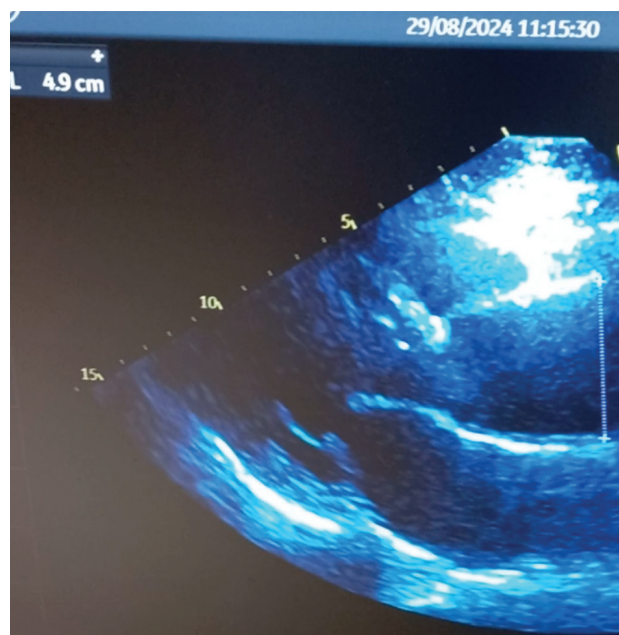


FIGURE 2. Ascending aorta dilatation with no signs of intimal flap in the left parasternal long axis view on transthoracic echocardiogram.

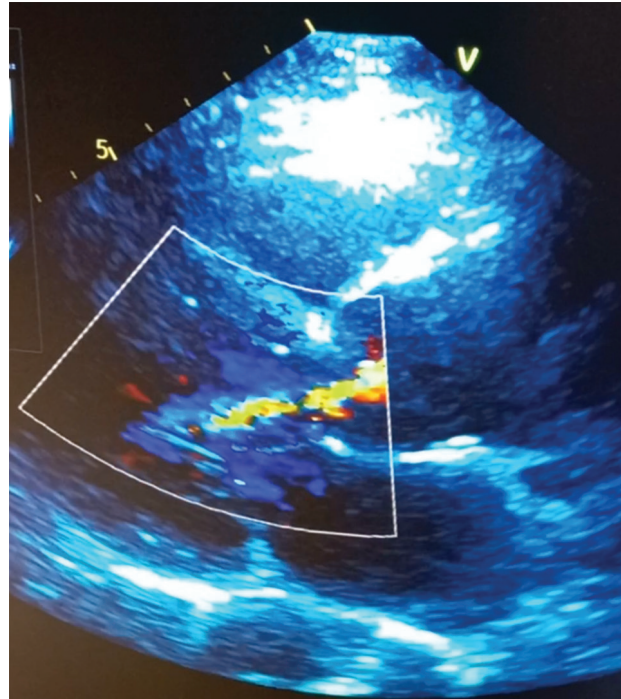


FIGURE 3. Aortic regurgitation detected on color doppler with transthoracic echocardiography.

Dvanaesti dan hospitalizacije, zbog suspektnih ishemijskih promjena na kontrolnom EKG-u – bifazični T-valovi u prekordijalnim odvodima koji nisu bili prisutni na snimci prilikom prijema (bolesnik je negirao bilo kakvu vrstu boli u

disease was verified: right coronary artery – proximal stenosis up to 50%; left anterior descending artery – proximal stenosis approximately 60%; left circumflex artery – proximal stenosis approximately 60%; first obtuse marginal artery proximal ste-

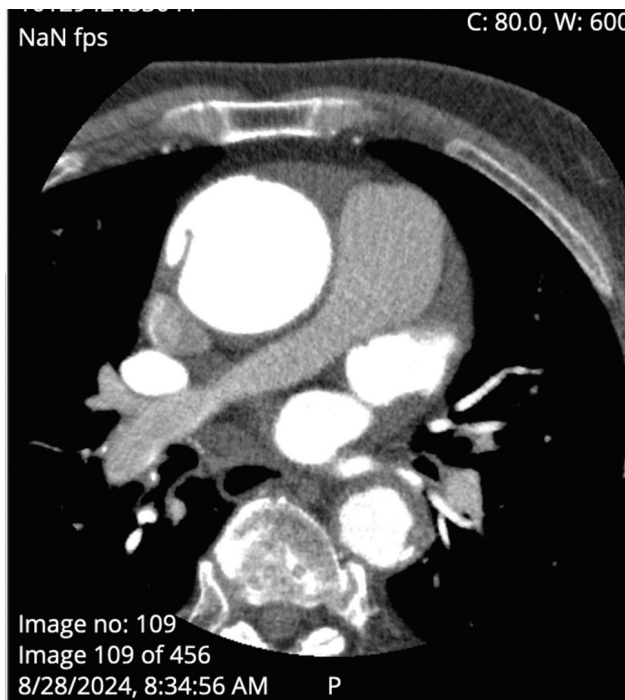


FIGURE 4. Intimal flap in the ascending aorta on computed tomography coronary angiography.

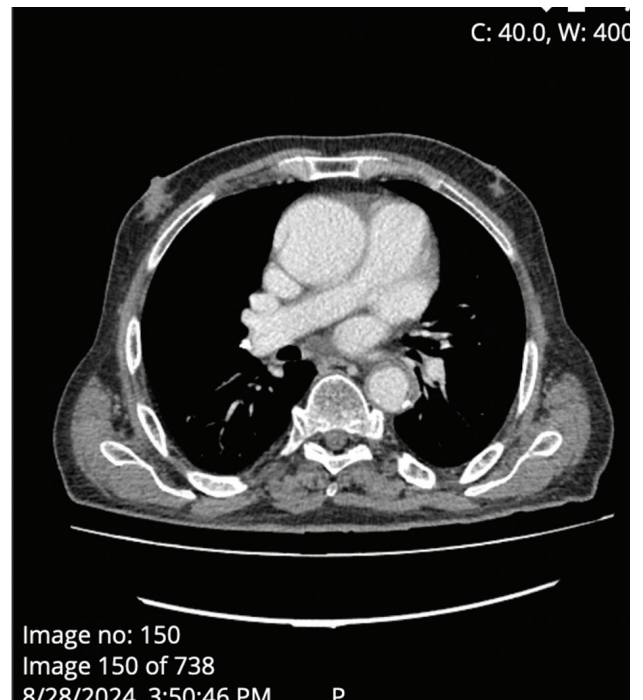


FIGURE 5. Ascending aorta dissection on computed tomography angiography of the aorta.

prsnom košu, žalio se samo na ubrzano zamaranje), učinjena je CTCA. Utvrđena je višežilna koronarna bolest s 50 %-tnom proksimalnom stenozom desne koronarne arterije – RCA, 60 %-tnom proksimalnom stenozom lijeve prednje silazne arterije (LAD), 60 %-tnom proksimalnom stenozom cirkumfleksne arterije (LCx) i 55 %-tnom stenozom prve marginalne grane (OM1), ali isto i aneurizmatički uvećana ascendentna aorta (promjera 5,2 cm) u tubularnom dijelu s vidljivim disekcijskim flapom (**slika 4**) ventralno i uz gornju konturu desnoga koronarnog sinusa, koji se prati kranijalno, što ide u prilog disekcije tipa Stanford A. Nakon CTCA-a učinjena je CTA cijele aorte, potvrđena je dilatacija aortalnog sinusa (3,9 cm) i ascendentne aorte (4,9 cm) i prisutnost disekcijskog flapa u desnoj lateralnoj stijenci koji se prati do završnog dijela ascendentne aorte (**slika 5**) – potvrđujući Stanford A disekciju. U descendentnom dijelu torakalne aorte koja je bila promjera 31 mm nije registrirano znakova disekcije.

Slučaj ovog bolesnika prikazan je kardiokirurgima. Bolesnik nije bio motiviran za preporučeno liječenje te je na vlastiti zahtjev otpušten uz preporuku za medikamentnu terapiju i redovite kontrolne preglede, na koje se nije javljao.

Rasprava

Disekcija aorte i drugi aortalni sindromi klasificirani su prema anatomskom položaju intimalnog rascijepa, protekloga vremena od njenog nastanka i kliničkih obilježja, uključujući odsutnost ili prisutnost simptoma i mogućih komplikacija. Priroda komplikacija koje se mogu pojaviti razlikuje se za svaku varijantu, ali svaka može uzrokovati komplikacije opasne za život ili ekstremitete.⁶

Iako mnogi bolesnici s AD-om prijavljuju simptome kao što su bol u prsima, leđima i trbuhu, postoji i znatno preklapanje s drugim akutnim sindromima i znakovima, što čini znatno otežanim postavljanje precizne dijagnoze. Zapravo, dosta bolesnika s AD-om nema ovakve klasične simptome, nego samo neke od pokazatelja. To je dovelo do toga da se AD naziva 'velikom maškarom'.⁷

U opisanom prikazu nije bilo tipičnih kliničkih znakova i simptoma disekcije u bolesnika (deficit pulsa, znakovi prijetće tamponade, novonastali šum, razdiruća iznenadna bol u prsnom košu, sinkopa), a intimalni je flap prvi put konstatiran kao slučajni nalaz na CTCA-u. Nasuprot tome, AAS-i se malokad identificiraju kao slučajni nalazi s minimalnim simptomima na naprednim metodama oslikavanja, iako su i takvi slučajevi zabilježeni.⁸

TTE omogućuje adekvatnu procjenu više segmenata aorte, posebno aortalnog korijena i proksimalne ascendentne aorte. Treba se koristiti svim ravninama skeniranja da bi se prikupile informacije o aortalnim segmentima. Desni parasternalni prozor preporučuje se za procjenu stvarnoga promjera ascendentne aorte, a od iznimne je važnosti za evaluaciju torakalne aorte i modificirani suprasternalni prozor, dok u nekim slučajevima (češće u djece) i modificirani supkostalni prozor može pomoći, iako je u ovom slučaju uzlazna aorta udaljena od sonde.

Međutim, ako su prisutne abnormalnosti ili inkonzistentne informacije na ultrazvučnom pregledu, potreban je drugi modalitet snimanja za kompletiranje ili proširenje dijagnostičkih informacija.⁹ Pokazalo se da multimodalitetno snimanje, kao što su CTA aorte, TTE i TEE, te eventualno i magnetna

nosis of 55%, but an aneurysmatic, enlarged ascending aorta with a diameter of 5.2 cm in the tubular section was also observed, on which a dissection flap (**Figure 4**) was observed ventrally and along the upper contour of the right coronary sinus, followed cranially in favor of dissection type A according to the Stanford classification. After CTCA, CTA of the whole aorta was performed, and dilatations of the aortic sinus (3.9 cm) and ascending aorta (4.9 cm) were confirmed, with a visible dissection flap on the right lateral wall continuing to the final part of the ascending aorta (**Figure 5**) – confirming the Stanford type A dissection. In the descending part of the thoracic aorta the diameter was up to 31 mm, without signs of dissection.

The patient's case was presented to cardiac surgeons, but the patient was not willing to accept the recommended treatment. He left the hospital at his own request in a clinically compensated state, and medication therapy with regular follow-up clinical examinations were recommended, which the patient refused to attend.

Discussion

Aortic dissection and other aortic syndromes are described in terms of the anatomic location of the intimal tear, the duration of time from its occurrence, and clinical features, including the absence or presence of symptoms and whether disease complications occur. The nature of the complications differs for each variant, but each has the potential to cause life or limb-threatening complications.⁶

Although many patients report symptoms such as chest, back, or abdominal pain, there is significant overlap with other acute syndromes and signs, making a precise diagnosis particularly difficult. In fact, most patients with AD do not present these classic symptoms, but only some of the well-known indicators. This has led to AD being referred to as "the great masquerader".⁷

In the presented case, there were no typical clinical signs and symptoms of dissection in the patient (pulse deficit, signs of threatening tamponade, newly-occurring murmur, excruciating sudden chest pain, syncope), and the intimal flap was first confirmed as an incidental finding on CTCA. In contrast to this, AASs are rarely identified as incidental findings with minimal symptoms on advanced imaging studies, although this has been reported.⁸

TTE allows adequate assessment of several aortic segments, particularly the aortic root and proximal ascending aorta. All scanning planes should be used to obtain information on most aortic segments. The right parasternal view is recommended for estimating the true size of the ascending aorta. The suprasternal modified view is of paramount importance for evaluation of the thoracic aorta, whereas in some cases (more frequently in children) the modified subcostal view may be helpful, but here the ascending aorta is far from the transducer. However, if inconclusive information or abnormalities are present, another imaging modality is required to either complete or add diagnostic information.⁹

Multimodality imaging, such as an aortic CTA, TTE, and TEE, as well as magnetic resonance imaging, have been shown to play an important role in the diagnosis, treatment of complications, and clinical management of AD.¹⁰ Deep learning algorithms are being developed with automatic triage

rezonancija, ima ključnu ulogu u dijagnozi, procjeni komplikacija i kliničkom liječenju AD-a.¹⁰ Razvijaju se i *deep learning* algoritmi s automatskim sustavima trijaže koji bi potencijalno mogli ubrzati klinički tijek rada, omogućujući brzu i preciznu dijagnozu koja je ključna za stanja koja zahtijevaju hitnu kiruršku intervenciju (kao što je AD tipa A).¹¹

Nedostaje konsenzus o tome što bi se to trebalo smatrati reproducibilnim da definiira kliničku sumnju na AAS. Stoga razlike između liječnika i pojedinih centara mogu biti velike. U sjevernoameričkoj retrospektivnoj seriji bolesnika koji su bili podvrgnuti CTA-u zbog sumnje na AAS, prevalencija AAS-a bila je ~3 %. U opsežnom izvanbolničkom istraživanju koje je procjenjivalo alat za detekciju rizika (ADD-RS) u netraumatskim emergencijama, prevalencija AAS-a bila je 0,9 %.¹²

U prikazanom slučaju pri TTE pregledu nisu učinjeni desni parasternalni, suprasternalni i supkostalni presjeci aorte, dok se na lijevom PLAX-u nije uočavao intimalni flap. Ostaje pitanje bi li u ovom slučaju AD bila ranije otkrivena da se, primjereno smjernicama, pri inicijalnom TTE pregledu dilatirana aorta pogledala i iz atipičnih prozora (što je moglo povećati sumnju za daljnju procjenu).

Nakon što je dijagnoza AD potvrđena, ponovljen je TTE i nisu pronađeni jasni znakovi rascijepa intime u atipičnim prozorima, iako oni nisu bili pogodni za detaljniju analizu. S obzirom na atipičnu kliničku prezentaciju i nespecifičan nalaz TTE-a, ostaje pitanje bi li inače bolesnike u kojih je TTE pregledom ustanovljena dilatacija aorte u bilo kojem scenariju trebalo, u pravilu, upućivati na CT angiografiju bez obzira na veličinu dilatacije i bez obzira na to jesu li su prisutni simptomi i klinička sumnja na AAS.

Iako nije bilo dramatičnih posljedica, slučajevi kao što je ovaj potvrđuju da je, bez obzira na nečiju ekspertizu i učinjeno u dijagnostičkoj procjeni i tretmanu, varljivost kliničke slike uvijek moguća i ishod bolesnika uvijek u sebi nosi element šanse.

Zaključak

Disekcija aorte rijetko je, ali potencijalno smrtonosno hitno stanje, čija promptna dijagnoza ostaje izazov u kliničkoj praksi zbog svoje rijetkosti i moguće varljive prezentacije koja komplicira diferencijalnu dijagnozu, pa stoga treba imati na umu njezine atipične oblike u smislu kliničke slike i slikovnih pretraga.

systems that could potentially accelerate clinical workflow by enabling rapid and precise diagnosis, which is crucial for conditions that require urgent surgical intervention such as type A AD.¹¹

Consensus is lacking on what should reproducibly define a clinical suspicion of AASs. The differences between physicians and centers can therefore be profound. In a North American retrospective series of patients undergoing CTA for suspected AAS, the prevalence of AASs was ~3%. In a large out-of-hospital study evaluating the AD detection risk score (ADD-RS) in non-traumatic emergencies, the prevalence of AASs was 0.9%.¹²

In the present case, no right parasternal, suprasternal, or subcostal views of the ascending aorta were performed during the TTE exam, while no intimal flap was present on the left PLAX. The question remains whether AD would have been discovered earlier in this case if the dilated aorta was viewed from atypical windows during the initial TTE examination, according to the guidelines (which might have raised suspicion for further assessment).

After the diagnosis of AD was confirmed, TTE was repeated and no clear signs of intimal flap were observed in atypical windows, although they were not suitable for a more detailed analysis. Given the atypical clinical presentation and nonspecific findings on TTE, the question arises whether TTE-determined dilatation of the ascending aorta in any scenario should by default be referred to CT angiography regardless of the size of the aortic dilatation and whether symptoms and clinical suspicion for AASs are present.

Even though there were no severe outcomes, cases such as this confirm that regardless of one's expertise and what has been done as part of patient's diagnostic assessment and treatment, the deceptiveness of clinical presentation is always a possibility, and the outcome for the patient always carries an element of chance.

Conclusion

Aortic dissection is a rare but potentially lethal medical emergency, in which prompt diagnosis remains a challenge in clinical practice because of its rarity and possible deceptiveness of presentation that complicates the differential diagnosis; therefore, its atypical forms in terms of clinical presentation and imaging tests should be taken into account.

