

INTRODUCTION

Aortic dissection is a potentially fatal surgical emergency that often presents with non-specific symptoms. Its atypical presentation could lead to misdiagnosis, adding to its diagnostic challenge.

CASE DESCRIPTION

A 49-year-old gentleman with underlying hypertension complained of severe jaw pain radiating to the right side of his chest for 1 day. Without a history of trauma, he described the pain as crushing with a pain score of 9.

On examination, there were no significant findings in the respiratory or cardiovascular systems. Despite the bradycardia (Heart rate: 52 BPM), the patient was normotensive and saturated under room air. The ECG displayed deep T wave inversion at V2-5, while the CXR revealed cardiomegaly.

The patient was treated as NON-ST ELEVATION MYOCARDIAL INFARCTION. Double antiplatelet therapy was served. Strong analgesia (IV Fentanyl 50mcg and IV Morphine 2mg) was required to control his pain.

Subsequently, the patient became less responsive with GCS of E1V1M3. The left upper limb demonstrated complete paralysis. Blood glucose was 6.7 mmol/L. The patient was intubated for airway protection. Bedside ultrasound showed a flap in the right common carotid artery with false lumen.

No intracranial bleed was noted from the CT brain. CT angiogram confirmed extensive dissection arising from the aortic root to the ascending aorta, abdominal aorta, and left internal and external iliac artery.

The larger false lumen has compressed the smaller true lumen of ascending aorta. The patient was referred to the cardiothoracic surgery team for BENTALL PROCEDURE.



FIGURE 1: INTIMAL FLAP SEEN IN RIGHT COMMON CAROTID ARTERY from POCUS

DISCUSSION

Presentation of aortic dissection might vary from chest pain to neurological deficit depending on the extent of dissection. When in doubt, Point-of-Care Ultrasonography (POCUS) is very helpful in looking for features of dissecting arteries. The compression of the true lumen by the false lumen in the right common carotid artery may stimulate the baroreceptor which results in bradycardia (1). CT angiogram remained the gold standard for making the diagnosis.

CONCLUSION

It is crucial to acknowledge the presenting complaint and be cautious in ruling out the life-threatening diagnosis. Aortic dissection can present atypically and prompt recognition is vital to improve patient outcomes.

REFERENCES

1. Fenech I, Ferriggi A, Abela M. A Rare Case of Profound Sinus Bradycardia in a Patient With Descending Aortic Dissection. Cureus. 2023 Nov 23;

KEYWORD

Aortic dissection, POCUS