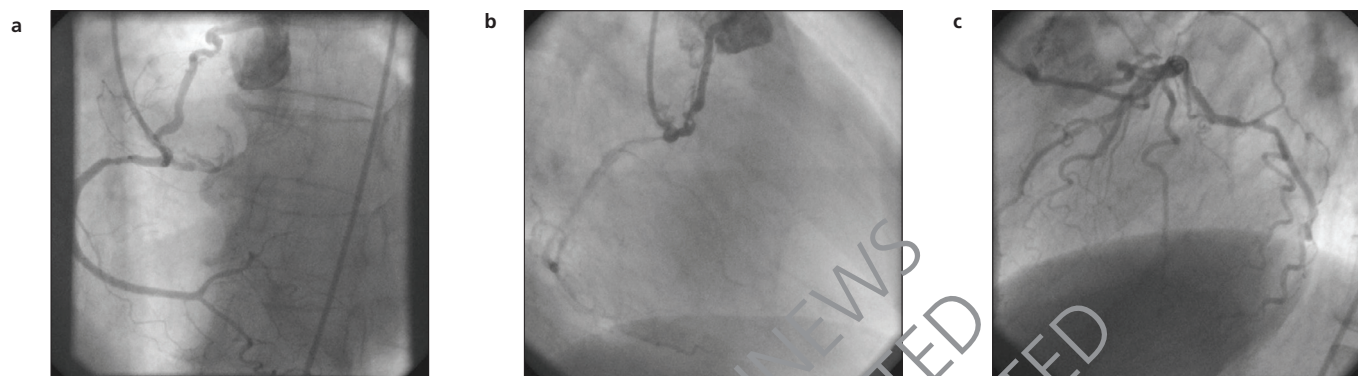


Bilateral coronary fistulae

Figure 1. Coronary angiography showing bilateral coronary artery fistulae arising from the right **a:** and **b:** and left **c:** coronary arteries



A 69-year-old woman was referred for cardiac catheterisation following a positive exercise tolerance test. Cardiac catheterisation demonstrated significant single vessel coronary disease with a severe proximal atrioventricular (AV) circumflex stenosis. In addition to this, the patient had a large proximal fistula between the right coronary artery (RCA) and the pulmonary artery and a fistula between the left anterior descending (LAD) artery and the pulmonary artery. Both the LAD and the pulmonary artery were diseased (figure 1).

After discussion, it was felt that the LAD to pulmonary artery fistula was relatively small and therefore was unlikely to be causing any significant problem. The fistula between the right coronary artery and pulmonary artery had a significant ostial stenosis which was believed to be protective (figure 1b). The patient underwent percutaneous coronary intervention (PCI) to the AV circumflex artery (2.5 x 18 mm Cypher) as this was thought to be the culprit lesion. An open mind was kept about future coil

embolisation to the coronary artery fistula if she continued to be symptomatic. To date, the patient remains asymptomatic.

Coronary artery fistulae are the commonest haemodynamically significant coronary anomaly.¹ They often drain direct into a cardiac chamber though occasionally they communicate between a coronary artery and a great vessel, as in this case. Most arise from either the LAD or the RCA.²

The most common symptoms are fatigue, chest pain, palpitations and syncope. In the absence of obstructive coronary disease they are thought to cause myocardial ischaemia through a 'steal phenomenon' but they rarely cause serious complications. As in our case, incidental detection can occur when patients undergo cardiac catheterisation for the investigation of myocardial ischaemia.

Conflict of interest

None declared.

References

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Editors' note

An article discussing whether it is time for a UK registry of percutaneous closure of coronary artery fistulae, appears on pages AIC 14–AIC 18 of this issue of the journal.

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