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A case of acute ST elevation myocardial infarction in the RCA ostium with cardiac rotation

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A 78-yrs-old female referred to our hospital because she had felt severe chest pain during her shopping. She had hypertension and bronchial asthma and had been taking medication for about 30 years. An electrocardiogram demonstrated atrial fibrillation with ST elevation in leads II, III, aVF, and V1-4, and troponin T was positive. An echocardiography demonstrated hypokinesis in the inferoseptal wall. Acute ST elevation myocardial infarction was suggested, we performed emergent coronary angiogram (CAG) by right femoral approach. CAG showed that LCA was almost normal without collateral flow to the RCA. 5Fr of JR4.0 catheter was easily enter to the non-coronary cusp, and the RCA could not detect by using JR4.0, LVG and AoG. AL 1.0 catheter could confirm thrombotic occlusion in the RCA ostium. We performed PCI using 6Fr of AL 0.75 catheter. Thrombectomy catheter could not pass and get thrombus. IVUS after dilation using 2.0mm of semi-complaint balloon revealed that RCA ostium was severe calcification, including prolapse of superficial heavy calcified lesion. We performed dilation using scoring balloon (Scoreflex^{TM}3.0 x 10 mm) with buddy wire. After exchanging guide catheter to JR 3.5 SH, we implanted 3.5 x 15 mm of zotarolimus-eluting stent (ZES) from the RCA ostium by IVUS marking and dummy wire. We added dilation using 3.75mm of non-compliant balloon, and achieved good flow. 14 days after the onset of MI, the cardiac CT indicated that ZES implanted site was patent, and her RCA was front arises by cardiac clockwise rotation without anomalous origin in the RCA.