

Woo-Young Chung¹Hae-Chan Cho¹

1 Department of Internal Medicine, Boramae Medical Center, Seoul National University, College of Medicine,
Korea

A 73 year-old female was admitted to intensive care unit because of respiratory failure by aspiration pneumonia. She was suffering from Parkinson's disease. During the admission, sudden massive hemoptysis occurred. Chest CT did not show the focus of bleeding. We found the bleeding from right upper bronchus, right bronchus intermedius (figure 1), and succeeded blood stasis by bronchial artery embolization with 1:4 diluted glue. (NBCA, N-butyl-2 cyanoacrylate) (figure 2). However, she was fell in shock with identifiable cause a few hours later. ECG showed marked ST depression in lead V1-3, and the echocardiography showed definite posterior wall akinesia. (figure 3)

Surprisingly immediate coronary angiography (CAG) demonstrated contrast stained foreign material in big left circumflex artery (LCX) with flow limitation. We recognized coronary artery was connected right upper bronchial artery through tiny fistula by comprehensively reviewing CAG and bronchial selective angiography. (figure 4) Because of concerning about rebleeding, we neither could try invasive treatment nor anticoagulation. A few days later, ECG still show ST depression in V 1-3, and Troponin-I level surged again. (figure 5) We checked coronary angiography again. LCX flow looked better than before, but the first obtuse marginal branch (OM1) flow was occluded. We tried thrombosuction and balloon angioplasty for OM1 finally recovered. Inevitably we started anticoagulation with enoxaparin. Fortunately she escaped from cardiogenic shock, and could be discharged on day 44. We can still radiopaque lining the glue made along her LCX on her chest X ray (figure 6). The thicker, more concentrated glue could have avoid this disastrous event.