

A Non-Coronary Left Main Obstruction Causing Chest Pain

Haim Shmilovich MD, Itzhak Herz MD and Gad Keren MD

Cardiology Division, Tel Aviv Sourasky Medical Center, affiliated with Sackler Faculty of Medicine, Tel Aviv University, Tel Aviv, Israel

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Chest pain is a common complaint with a wide differential diagnosis. The workup depends on thorough history-taking and physical examination. The findings may be subtle, borderline, or in discrepancy with other tests or symptoms, and the patient may be referred to invasive coronary angiography to rule out severe coronary artery disease. We present here a case of chest pain in a patient with risk factors who was referred for invasive coronary angiography which revealed a surprising diagnosis.

PATIENT DESCRIPTION

An 84 year old woman was admitted to our cardiology department due to dyspnea and atypical chest pain not related to effort lasting one day. The chest pain was described as a continuous and dull sensation over a small region of her mid- to left chest. Her past medical history was remarkable for ischemic heart disease, paroxysmal atrial fibrillation, diabetes mellitus and hypertension and she had undergone several coronary interventions with stent implantations.

On admission she complained of dull chest pain at a magnitude of 4 out of 10. Her vital signs were normal, as were blood oxygen saturation, serum troponin levels measured more than 6 hours after the onset of chest pain, electrocardiogram

(ECG) and chest X-ray. No heart murmurs or pathological breath sounds were heard.

In view of her past medical history and due to the chest pain, which did not subside after a trial of both nitroglycerin and paracetamol, a coronary angiogram was ordered. It did not reveal any obstructive coronary artery lesion but demonstrated a left main bronchus radio-opaque, “coin” or “pill-like” lesion [Figure 1]. With the thorough history-taking, she indeed remembered choking when taking all her morning pills together the previous morning. These included aspirin, furosemide, bisoprolol, omeprazole, amlodipine, losartan, sulfonyleurea and amiodarone. Amiodarone is known to be composed of 37.3% iodine by weight [1], and indeed was the only one of all her pills that was radio-opaque on fluoroscopy (panel III, A) and had the same radio-opacity as the pill that was aspirated.

At bronchoscopy, the amiodarone pill was not found, probably because it had already dissolved, but a small area of mucosal irritation was seen in the presumed location. On day 3 of her admission, the chest pain and dyspnea resolved and she was

discharged home. She was instructed to take the pills one by one with a lot of water.

COMMENT

This case emphasizes the importance of a thorough history-taking for making a correct diagnosis. Also important is that an aspirated solid object can mimic an acute coronary syndrome. It also reminds us that amiodarone contains a fairly high amount of iodine, although it was not shown to cause adverse effects in patients with a medical history of iodine allergy [2].

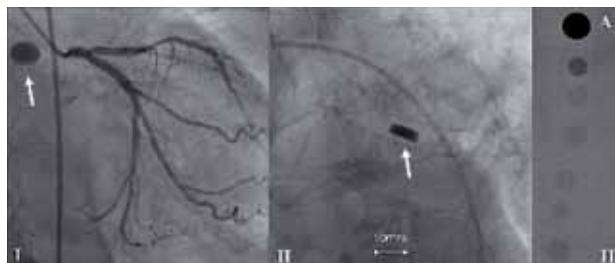
Correspondence

Dr. H. Shmilovich
Cardiology Division, Tel Aviv Sourasky Medical Center, Tel Aviv 64239, Israel
Fax: (972-3) 697-4976
email: haim.shmilovich@gmail.com

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Figure 1.
A radio-opaque pill lodged in the left main bronchus



[Panel I] Left coronary artery system with a “coin or pill-like” mass in the left main bronchus (white arrow); **[Panel II]** Orthogonal view of the “pill-like” mass in the left main bronchus (white arrow); **[Panel III]** Fluoroscopy of the pills showing that the radio-opaque aspirated pill was amiodarone (designated A)

“Neither genius, fame, nor love show the greatness of the soul. Only kindness can do that”

Jean Baptiste Henri Lacordaire (1802-1861), French preacher, journalist, and activist