The Images behind intramural haematoma

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Case 1 (day 1)

- 64 y/r male
- One episode of chest pain at rest, asymptomatic since then
- Exclusion of coronary artery disease and ACS
- Subclinical hypothyroidism
- Partial thyroidectomy – 20yrs ago
- Current smoker, 20/day
- No family history of dissection
- Multi-nodular thyroid goitre
- BP well controlled - ~100-110 sys

Initial CT on November 5, 2017
Case 1 (day 1)

Initial CT recon on November 5, 2017

IMH, no visible communications, ulcers or dissection
Case 1 (day 9)

- **IMH progressing** to type B aortic dissection with penetrating ulcer resulting in pseudoaneurysm
- **Strategy: medical management (anti-impulse)**
  - Amlodipine 5mg
  - valsartan 160mg BD
  - hydralazine 25mg TDS
  - metoprolol 75mg BD

2\textsuperscript{nd} CT on November 14\textsuperscript{th} 2017
Case 1 (day 9)

Progression to ulcers and initiation of dissection

2nd CT on November 14th 2017
Case 1 (day 30)

- Localized ulcer progressing to type B aortic dissection with formation of a pseudoaneurysm; IMH at distal arch has resolved. No symptoms.

- Strategy changed: *Intervention* under continued anti-impulse medication
Localized distal type B dissection with entry close to CT

3rd CT recon on December 5th 2017
Case 1 – Progression over 30 days

Intervention:
Precise placement
Vicinity to CT
Fragile aorta
Progressive lesion

Choice:
Gore Active
Control TAG
(31x100mm)
Case 1 (day 33/Intervention)
Case 1 (Day 5 post Intervention; day 38)

4<sup>rd</sup> CT recon on December 13<sup>th</sup> 2017
Case 1 (Progressive pathology & Intervention)
Take home message

• This case illustrates the dynamic evolution of IMH (in the spectrum of the AAS) and the importance of serial imaging to manage IMH properly.

• Serial imaging using CT and/or MRI for surveillance are essential in the management of the dynamic entity of IMH.