A 70-year-old woman had a personal history of type 2 diabetes, hypercholesterolemia and mild hypertension, and a 6-month clinical history of angina and effort dyspnea, normal baseline ECG, and a clinically and electrically positive exercise stress test. She was considered high risk.

Catheterization showed an ejection fraction of 73%. Coronariography (Figures 1 and 2) revealed the absence of the left coronary ostium and the anomalous origin of the trunk in the proximal segment of the right coronary, giving rise to a conal artery that passes in front of the right ventricular outflow tract (AC indicates conal artery; CD, right coronary artery; IVP, posterior interventricular; DA, rudimentary anterior descending arising from the conal artery; CX, circumflex system, with branches arising from the distal conal artery, right posterolateral trunk, and IVP, DG, small diagonal branches). The single ostium shows 99% stenosis (arrow).

Given the high risk of interventional action, surgery is decided on. Plasty of the right ostium is excluded due to the presence of a large calcification extending to the proximal right coronary artery. Simple anastomosis of the saphenous to the conal artery followed by stent implantation is chosen to avoid competitive flow and a possible second anastomosis to the CD. During surgery (Figure 3) the conal artery is visible (arrows) (VCS indicates superior vena cava; AD, right atrium; AO, aorta; AP, pulmonary artery).

The asymptomatic patient is released and one month later she was scheduled for rotablator treatment of the ostial lesion and placement of a 5 × 9 mm stent before the origin of the conal artery, with excellent angiographic results. The anastomosis remains permeable.

Enrique Fulquet, Salvatore Di Stefano, and Juan Manuel Durán.
Instituto de Ciencias del Corazón (ICICOR).
Hospital Universitario de Valladolid.
Valladolid. España.