Structural Features of the Sinus of Valsalva and the Proximal Portion of the Coronary Arteries: Their Relevance to Retrograde Aortocoronary Dissection

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Introduction and objectives. Retrograde aortocoronary dissection is an unusual complication of coronary angioplasty. Our study provides new structural details of the aortic sinuses and the proximal portions of the coronary arteries, which enable better understanding of several clinical features associated with this complication.

Methods. We studied eight aortic sinus specimens from patients with structural ischemic heart disease using dissection, histologic analysis, and scanning electron microscopy, and compared findings with those in eight control specimens.

Results. We observed the following features: a) in 10 specimens (71%), the left coronary artery diameter was greater than the right; b) the angle that the ascending aorta made with the left coronary artery was acute, whereas that with the right coronary artery was closer to a right angle, thereby possibly providing a better approach for catheterization; c) in contrast to those of the right coronary artery, the periostial wall and sinotubular junction of the left coronary artery were formed by more smooth muscle cells and by a dense matrix of collagen type-I fibers; and d) the aortic sinuses and coronary arteries in structural ischemic heart disease specimens displayed structural alterations that affected the aortic tunica media and the collagen distribution at the sinotubular junction.

Conclusions. The morphological and structural differences observed between right and left sides suggest that the left aortic sinus is more resistant to traction and is, therefore, less prone to iatrogenic dissection. Structural ischemic heart disease is a risk factor that increases the likelihood of aortocoronary dissection.

Key words: Aortocoronary dissection. Aortic sinuses. Ischemic heart disease. PTCA.

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Características estructurales de los senos de Valsalva y porción proximal de las arterias coronarias. Su relevancia durante la disección retrógrada aortocoronaria

Introducción y objetivos. La disección retrógrada aortocoronaria es una complicación poco frecuente que sigue a la angioplastia coronaria. Nuestro estudio proporciona nuevos detalles estructurales de los senos aórticos y la porción proximal de las arterias coronarias para un mejor entendimiento de aspectos relacionados con esta complicación.

Métodos. Hemos analizado mediante técnicas de sección, histológicas y de microscopía electrónica de barrido los senos aórticos de 8 especímenes con cardiopatía isquémica estructural y se comparan con 8 especímenes control.

Resultados. Hemos observado las siguientes características: a) el diámetro de la arteria coronaria izquierda en 10 especímenes (71%) fue mayor que el de la derecha; b) el ángulo que forma la aorta izquierda con la aorta ascendente es agudo, mientras que el de la coronaria derecha tiende a ser recto, por lo que puede presentar un mejor abordaje para la cateterización; c) la pared periosfial y la unión sinotubular de la coronaria izquierda contienen, a diferencia de la derecha, más células musculares lisas y una densa matriz de colágeno tipo I, y d) los senos aórticos y coronarias de los especímenes con cardiopatía estructural presentan alteraciones estructurales que alteran la túnica media aórtica y la distribución del colágeno de la unión sinotubular.

Conclusiones. Las diferencias morfológicas y estructurales observadas indican que el seno aórtico izquierdo es más resistente a las tracciones y, por lo tanto, menos propenso a la disección iatrogénica. La cardiopatía isquémica estructural es un factor de riesgo que incrementa la predisposición a la disección aortocoronaria.

Palabras clave: Disección aortocoronaria. Senos aórticos. Enfermedad isquémica. ACTP.

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INTRODUCTION

Aortic dissection is an unusual complication of percutaneous transluminal coronary angioplasty (PTCA).

ABREVIATIONS

PTCA: percutaneous transluminal coronary angioplasty.

METHODS

We studied 16 post-mortem hearts that had been previously fixed by immersing them in 10% buffered neutral formalin, while avoiding doing this under pressure via the coronary arteries as this could have distorted them and led to the samples becoming distorted. The causes of death were associated with: road traffic accident (n=6), cirrhosis of the liver (n=2), suicide (n=3), cerebral hemorrhage (n=3), and pulmonary thromboembolism (n=2). In total, 8 of the 16 specimens presented structural ischemic heart disease with stenosis of the right and left coronary arteries originating in the corresponding coronary sinuses and the proximal part of the right and left coronary arteries in post-mortem specimens with and without structural ischemic heart disease, with the aim of studying the mechanisms and factors that can make the left coronary artery less prone to retrograde dissection than the right during PTCA.

RESULTS

Aortic sinus diameters were 3.7±0.3 cm (range, 2.6-4.2 cm). The right coronary artery ostium (12 hearts, 75%) and the left coronary artery ostium (12 hearts, 85%) were located below the sinotubular junction. There were significant differences between the diameters of the left and right coronary artery ostia. The diameter of the left coronary artery ostium in 10 specimens (71%) was greater (4.5±0.4 mm) than the right coronary artery ostium (3.7±0.5 mm) (P<0.001). Using dissection and optical microscopy techniques, all the specimens showed that the ostium and the first 2-3 mm of the coronary arteries were located within the wall of the ascending aorta or the aortic wall. From here, the initial extraaortic part...
(approximately 2 cm) of the left coronary artery descends parallel to the ascending aorta and forms, with the aortic sinus wall, an angle of 35.5°±11.5° (range, 20°-55°), to course between the pulmonary trunk and the left atrial appendage (Figure 1). In contrast, the initial part of the right coronary artery originates almost perpendicular to the aortic sinus wall forming an angle of 71.5°±8.5° (range, 60°-88°), and passes in front of and slightly to the right of the right atrium, lying between this and the trunk of the pulmonary artery (Figure 1). As it approaches the atrioventricular groove, the right coronary artery descends almost vertically.

**Histological and Structural Study of the Coronary Artery Ostia and the Aortic Wall**

Using conventional, polarized light and scanning electron microscopy, histological examination showed that the walls of the sinuses of Valsalva are basically made up of type I collagen in their lower part proximal to where the aortic leaflets attach, where muscle fibers insert into the left ventricle (Figure 2); however, the number of type I collagen fibers decrease as the elastic fibers in the ascending part of the aortic sinuses increase (Figure 2). The aortic wall thickness was 1.8±0.3 mm (range, 1.1-2.4 mm) in the medial portion of each sinus, both in the normal hearts and in those presenting structural ischemic cardiopathy. However, the sinuses where structural ischemic cardiopathy was found presented non-uniform variations in thickness of the elastic lamina of the medial layer and atherosclerotic plaque, at times with hemorrhagic clotting, at the base of the leaflet attachment below its arterial wall (Figure 2).

The upper limit of each sinus at the peak of the line of the semicircular edge of each leaflet is known anatomically as the supravalvular ridge, marking the junction between the sinuses and the tubular part of the aorta. The ridge at the sinotubular junction is mainly made up of elastic and collagenous fibers mixed with smooth muscle cells and fibroblasts. The ridge in the left coronary sinus contains a greater number of smooth muscle cells within a dense extracellular matrix of type 1 collagenous fibers (Figure 3). In contrast, the right coronary artery has a smaller amount of smooth muscle fibers, which are basically set within type III collagen (Figure 3). The aortic wall thickness at the ridge is 4.3±0.5 mm (range, 3.6-5.1 mm), with significant differences
between the thickness of each sinus of Valsalva wall and the supravalvular ridge in both coronary arteries ($P<.001$).

The periostial aortic wall in the sinotubular ridge is characterized by having a prominent tunica media between the internal elastic lamina and the adventitia. This media is predominantly made up of layers of elastic material that alternate with bundles of smooth muscle cells with differing spatial orientation and type I and III collagen fibers (Figure 3). The periostial aortic wall of the right coronary artery has less interstitial type I collagen positivity than the left among the smooth muscle fibers (Figure 3). The thickness of the aortic tunica media in this location was 2.8±0.4 mm (range, 2.1-3.5 mm). The spatial orientation of the smooth muscle cells within the tunica media that surrounds the ostium in both coronary arteries is very irregular, the longitudinal fibers being mixed with oblique ones. The presence of atherosclerotic plaque and intramural hematoma in the sinotubular ridge produces a thinning of the aortic tunica media (Figure 3), less than 1 mm thick, and its visualization via polarized light shows a non-homogeneous distribution of type I collagen within the sinotubular ridge, like layers of an onion, which decreases on the periostial aortic wall (Figure 3). In one case of progressive atherosclerosis, as found in the 72 year old specimen (Figure 4), the aortic tunica media was characterized by an absence of smooth muscle fibers, immediately above the sinotubular ridge, such that the media was made up of elastic fibers only in this region (Figure 4).

In addition to aortic disease, atherosclerotic plaque affects the most proximal segment of the coronary arteries and is accompanied by marked atrophy of the tunica media with a reduction in elastic and smooth muscle fibers, and at times ulceration, i.e., rupture of the plaque coating due to an increase in pressure promoting thrombosis and coronary obstruction. Such obstruction shows positive staining under polarized light, basically for interstitial type I collagen in the adventitia and media (Figure 4). Finally, it is worth considering the possibility that the plaque is sclerosed and calcified (Figure 4), and the percentage reduction of the lumen is relevant regarding its functional impact.
The most external layer of the aortic coronary wall is the so-called tunica adventitia, which consists of a network of fibers, basically type I collagen, elastic fibers, adipocytes and macrophages (Figures 1 and 2). No visible alterations in this layer were found in the atherosclerotic arteries studied. The vasa vasorum is normally located in the adventitia, where nerve bundles are also found. The thickness of the tunica adventitia in the aortic wall is 1.2±0.4 mm (range, 0.5-1.8 mm). The aortic tunica adventitia is continuous with the adventitia of both coronary arteries.

**DISCUSSION**

Although the risk of retrogressive dissection in the ascending aorta during PTCA is rare, and that this technique is currently very common and the number of cases has increased, the number of times this serious complication occurs continues to be low. The incidence (0.029%) in our hospital is similar to that in other hospitals, ranging from 0.02 to 0.15%, with an average of 0.059%. The mechanism by which dissection of the right coronary artery (87% of cases)
between these ostia, the sinuses, and aortic wall. The coronary artery tends to be straight (range, 60°-88°). This means that the aortocoronary junction and the proximal course of the left coronary artery can provide a better approach for catheterization than the right coronary artery, due to their coaxial alignment in relation to the ascending aorta. In at least two-thirds of the cases described, dissection occurs when injecting contrast agents. Thus, these variations in angle might play a facilitating role, together with the structural factors, given that the sinotubular junction and the peristomal wall of the left coronary artery are different from those of the right. Histologically, although the walls of the right and left sinuses of Valsalva have mainly type I collagen fibers proximal to where the aortic leaflets attach, these fibers decrease in number as the elastic fibers in the ascending part of the aortic sinuses increase; however, higher up, in the sinotubular ridge, the left has a greater number of smooth muscle cells set in large amounts of type I collagen, and its peristomal wall also has greater expression of type I collagen. It is well-known that type I collagen, in contrast to type III, has greater tensile strength, which could mean that the right coronary artery ostium is less resistant to traction and, as a result, could more easily give rise to retrogressive aortic dissection as a complication of coronary intervention. We have also found structural differences between the normal coronary sinuses and sinotubular junction regarding the specimens with structural heart disease due to myocardial ischemia, which could be a risk factor for increased predisposition to aortocoronary dissection; however, these differences were not found when comparing the atherosclerotic right coronary artery with the left, which indicates that the pathogenesis of the atherosclerotic plaque should be thought of as a set of noxious conditions able to cause endothelial damage, regardless of whether the aortocoronary junction is the right or left although, as stated by Zamir and Sinclair, it is the aortocoronary junction which is compromised more often. Although one specimen varies from another, the atherosclerotic lesion penetrates the internal elastic lamina and not only affects the distribution of the sinotubular union type I collagen, but there is also thinning of the smooth muscle fibers of the aortic tunica media. In more severe cases, the weakness of the wall occurs in a 1 or 2 mm longitudinal section in the tunica media, where the smooth muscle fibers are replaced by elastic fibers. Aortic weakness in atherosclerotic disease could be a preexisting factor that may play a role in iatrogenic dissection in the face of aggressive interventions such as mechanical traction or contrast-agent injection, as done during PTCA. Another potential risk factor is the presence of total or partial coronary occlusion in its proximal part, as found in some of the specimens, which possibly plays a role radically different to that of degeneration of the aortic tunica media, since percutaneous recanalization is much more complex and requires more aggressive maneuvers than other types of stenosis.

CONCLUSIONS

Our study demonstrates structural differences between the aortic sinuses and the proximal part of the right and left coronary arteries. These differences indicate that the left aortic sinus is more resistant to traction and mechanical pressure than the right and, thus, is less prone to iatrogenic dissection. Atherosclerotic lesions that compromise the aortocoronary junction are a risk factor that increases predisposition to dissection and should be taken into account during PTCA.

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