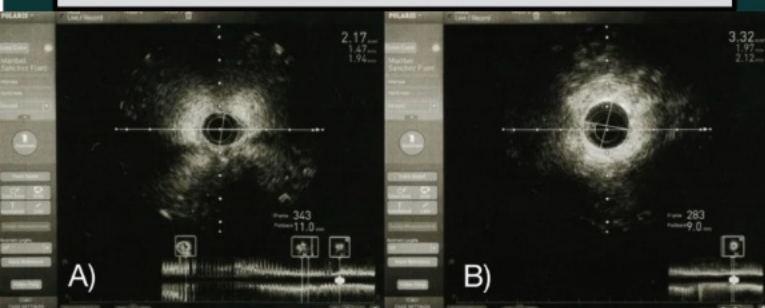


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## Case presentation:

- 38 year old female patient.
- Antecedent of idiopathic myocarditis and systemic arterial hypertension, **unstable angina**, wich progressively increased in intensity and duration , **sinus bradychardia**, **elevation of CKMB**



## Further diagnostic workup

Following aseptic and antiseptic preparation of the radial region, 2% lidocaine was infiltrated. Using the Seldinger technique, a 6-Fr introducer sheath was successfully advanced. Over a Teflon-coated guidewire, a Voda Curved 3 catheter was navigated to selectively cannulate the left coronary system, specifically the LAD. **Quantitative coronary angiography (QCA)** revealed a **91% stenosis in the LAD**, demonstrating significant vasoreactivity.

IVUS imaging confirmed the presence of a **myocardial bridge with a minimal luminal area of 2.2 mm²**. During subsequent manipulation, a transient **loss of flow in the LAD** was observed, which resolved following the administration of **200 mcg of adenosine**. Due to the vessel's high vasoreactivity, a 2.5-mm balloon catheter was prepared alongside a second insufflator. Additionally, a safety pacemaker was prophylactically inserted into the right ventricle via right femoral vein.

## Treatment

A **2.5 x 16 mm CRe8 EVO stent** was successfully deployed and inflated to 10 atm. TIMI grade 3 flow was achieved throughout the lesion and proximal segment, with no evidence of vasoreactivity upon stent deployment or myocardial bridge opening. **TIMI grade 3 flow was confirmed.**



## Conclusions

This case reinforces the growing recognition of **myocardial bridging** as a **clinically significant condition** that can lead to **ischemia** and associated symptoms. It also **highlights the efficacy of PCI** as a **treatment modality** capable of addressing the mechanical and ischemic complications of miocardial bridge.

## References

