A 60-year-old man presented to the emergency department complaining of recent onset angina at moderate efforts. The resting electrocardiogram (ECG) showed biphasic plus-minus T waves in the precordial leads, compatible with type A Wellens’ syndrome (Figure 1). The cardiac troponins sets were all negatives and resting cardiac echocardiogram was unremarkable. A recent coronary angiography revealed a mid-left anterior descending (LAD) myocardial bridging (MB) with massive systolic compression (Figure 2), without any significant lesions. After optimization of medical treatment (beta-blocker and calcium channel antagonist) the ECG pattern surprisingly changed (Figure 1).

A MB is described as a segment of an epicardial coronary artery that develops a transient intramyocardial course. Generally without repercussion, it may cause angina, arrhythmias, myocardial ischemia and even sudden cardiac death. The burden of ischemia correlates directly with the...
degree of systolic compression. As in the present case, most MB is found in the mid LAD (1). First-line management for MB is optimal medical treatment with beta-blockers and calcium channel blockers, causing diastolic prolongation. Nitrates cause reflex tachycardia and are therefore contraindicated. In exceptional refractory cases, surgical or percutaneous strategies can be pursued (1,2).

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None.

Footnote

Conflicts of Interest: The authors have no conflicts of interest to declare.

Ethical Statement: The authors are accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

References


Figure 2 Left anterior descending artery (cranial view). Left panel: diastolic phase. Right panel: significant systolic compression due to myocardial bridging (white arrow).