**SPONTANEOUS CORONARY ARTERY DISSECTION, A FATAL DISEASE IN HIDING**

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A 33-year-old primiparous woman, 12-weeks postpartum status-post spontaneous vaginal delivery complicated by preeclampsia, presented as a hospital transfer. Initial presentation was for acute intermittent tearing, retrosternal chest pain, that started at rest. On arrival vitals were significant for blood pressure (BP) of 171/97 mmHg and pulse of 122 beats-per-minute. Initial electrocardiogram showed ST elevations in anterior leads. Troponin I drawn on arrival was <0.10. Nitroglycerin drip and IV labetolol were started for blood pressure control and she was thrombolysed with alteplase in the ER. Emergent cardiac catheterization demonstrated coronary artery dissection in the left anterior descending (LAD) artery. At that time, she was transferred to our institute for further management. She was started on aspirin 81 mg and low-dose heparin while BP was managed with carvedilol and nitroglycerin drip titration. A multidisciplinary approach with cardiology, surgery, in addition to inter-institutional conferences was implemented. With blood pressure stabilization, she was transitioned to an oral regimen of carvedilol 25mg twice daily. Follow up cardiac computerized tomography (CT) angiography at that time showed stable disease compared to initial catheterization. Significant findings showed the left main coronary artery with 20-30% luminal narrowing without active dissection, LAD with thrombosis dissection in the ostium with up to 60-70%. Additionally, CT of the neck showed mild bilateral fibromuscular dysplasia of the internal carotids. She experienced no further complications throughout her hospital course and was discharged. In conclusion, after literature review and extensive multidisciplinary discussion the management of SCAD must be managed case-by-case. Multidisciplinary teams are likely to yield more favorable outcomes by pooling collective experience.