

World Journal of *Clinical Cases*

World J Clin Cases 2022 June 6; 10(16): 5124-5517



Contents

Thrice Monthly Volume 10 Number 16 June 6, 2022

OPINION REVIEW

- 5124 Malignant insulinoma: Can we predict the long-term outcomes?
Cigrovski Berkovic M, Ulamec M, Marinovic S, Balen I, Mrzljak A

MINIREVIEWS

- 5133 Practical points that gastrointestinal fellows should know in management of COVID-19
Sahin T, Simsek C, Balaban HY
- 5146 Nanotechnology in diagnosis and therapy of gastrointestinal cancer
Liang M, Li LD, Li L, Li S
- 5156 Advances in the clinical application of oxycodone in the perioperative period
Chen HY, Wang ZN, Zhang WY, Zhu T

ORIGINAL ARTICLE

Clinical and Translational Research

- 5165 Circulating miR-627-5p and miR-199a-5p are promising diagnostic biomarkers of colorectal neoplasia
Zhao DY, Zhou L, Yin TF, Zhou YC, Zhou GYJ, Wang QQ, Yao SK

Retrospective Cohort Study

- 5185 Management and outcome of bronchial trauma due to blunt *versus* penetrating injuries
Gao JM, Li H, Du DY, Yang J, Kong LW, Wang JB, He P, Wei GB

Retrospective Study

- 5196 Ovarian teratoma related anti-N-methyl-D-aspartate receptor encephalitis: A case series and review of the literature
Li SJ, Yu MH, Cheng J, Bai WX, Di W
- 5208 Endoscopic surgery for intraventricular hemorrhage: A comparative study and single center surgical experience
Wang FB, Yuan XW, Li JX, Zhang M, Xiang ZH
- 5217 Protective effects of female reproductive factors on gastric signet-ring cell carcinoma
Li Y, Zhong YX, Xu Q, Tian YT
- 5230 Risk factors of mortality and severe disability in the patients with cerebrovascular diseases treated with perioperative mechanical ventilation
Zhang JZ, Chen H, Wang X, Xu K

- 5241** Awareness of initiative practice for health in the Chinese population: A questionnaire survey based on a network platform

Zhang YQ, Zhou MY, Jiang MY, Zhang XY, Wang X, Wang BG

- 5253** Effectiveness and safety of chemotherapy for patients with malignant gastrointestinal obstruction: A Japanese population-based cohort study

Fujisawa G, Niikura R, Kawahara T, Honda T, Hasatani K, Yoshida N, Nishida T, Sumiyoshi T, Kiyotoki S, Ikeya T, Arai M, Hayakawa Y, Kawai T, Fujishiro M

Observational Study

- 5266** Long-term outcomes of high-risk percutaneous coronary interventions under extracorporeal membrane oxygenation support: An observational study

Huang YX, Xu ZM, Zhao L, Cao Y, Chen Y, Qiu YG, Liu YM, Zhang PY, He JC, Li TC

- 5275** Health care worker occupational experiences during the COVID-19 outbreak: A cross-sectional study

Li XF, Zhou XL, Zhao SX, Li YM, Pan SQ

Prospective Study

- 5287** Enhanced recovery after surgery strategy to shorten perioperative fasting in children undergoing non-gastrointestinal surgery: A prospective study

Ying Y, Xu HZ, Han ML

- 5297** Orthodontic treatment combined with 3D printing guide plate implant restoration for edentulism and its influence on mastication and phonic function

Yan LB, Zhou YC, Wang Y, Li LX

Randomized Controlled Trial

- 5306** Effectiveness of psychosocial intervention for internalizing behavior problems among children of parents with alcohol dependence: Randomized controlled trial

Omkarappa DB, Rentala S, Nattala P

CASE REPORT

- 5317** Crouzon syndrome in a fraternal twin: A case report and review of the literature

Li XJ, Su JM, Ye XW

- 5324** Laparoscopic duodenojejunostomy for malignant stenosis as a part of multimodal therapy: A case report

Murakami T, Matsui Y

- 5331** Chordoma of petrosal mastoid region: A case report

Hua JJ, Ying ML, Chen ZW, Huang C, Zheng CS, Wang YJ

- 5337** Pneumatosis intestinalis after systemic chemotherapy for colorectal cancer: A case report

Liu H, Hsieh CT, Sun JM

- 5343** Mammary-type myofibroblastoma with infarction and atypical mitosis-a potential diagnostic pitfall: A case report

Zeng YF, Dai YZ, Chen M

- 5352** Comprehensive treatment for primary right renal diffuse large B-cell lymphoma with a renal vein tumor thrombus: A case report
He J, Mu Y, Che BW, Liu M, Zhang WJ, Xu SH, Tang KF
- 5359** Ectopic peritoneal paragonimiasis mimicking tuberculous peritonitis: A care report
Choi JW, Lee CM, Kim SJ, Hah SI, Kwak JY, Cho HC, Ha CY, Jung WT, Lee OJ
- 5365** Neonatal hemorrhage stroke and severe coagulopathy in a late preterm infant after receiving umbilical cord milking: A case report
Lu Y, Zhang ZQ
- 5373** Heel pain caused by os subcalcis: A case report
Saijilafu, Li SY, Yu X, Li ZQ, Yang G, Lv JH, Chen GX, Xu RJ
- 5380** Pulmonary lymphomatoid granulomatosis in a 4-year-old girl: A case report
Yao JW, Qiu L, Liang P, Liu HM, Chen LN
- 5387** Idiopathic membranous nephropathy in children: A case report
Cui KH, Zhang H, Tao YH
- 5394** Successful treatment of aortic dissection with pulmonary embolism: A case report
Chen XG, Shi SY, Ye YY, Wang H, Yao WF, Hu L
- 5400** Renal papillary necrosis with urinary tract obstruction: A case report
Pan HH, Luo YJ, Zhu QG, Ye LF
- 5406** Glomangiomas - immunohistochemical study: A case report
Wu RC, Gao YH, Sun WW, Zhang XY, Zhang SP
- 5414** Successful living donor liver transplantation with a graft-to-recipient weight ratio of 0.41 without portal flow modulation: A case report
Kim SH
- 5420** Treatment of gastric hepatoid adenocarcinoma with pembrolizumab and bevacizumab combination chemotherapy: A case report
Liu M, Luo C, Xie ZZ, Li X
- 5428** Ipsilateral synchronous papillary and clear renal cell carcinoma: A case report and review of literature
Yin J, Zheng M
- 5435** Laparoscopic radical resection for situs inversus totalis with colonic splenic flexure carcinoma: A case report
Zheng ZL, Zhang SR, Sun H, Tang MC, Shang JK
- 5441** PIGN mutation multiple congenital anomalies-hypotonia-seizures syndrome 1: A case report
Hou F, Shan S, Jin H

- 5446** Pediatric acute myeloid leukemia patients with i(17)(q10) mimicking acute promyelocytic leukemia: Two case reports
Yan HX, Zhang WH, Wen JQ, Liu YH, Zhang BJ, Ji AD
- 5456** Fatal left atrial air embolism as a complication of percutaneous transthoracic lung biopsy: A case report
Li YW, Chen C, Xu Y, Weng QP, Qian SX
- 5463** Diagnostic value of bone marrow cell morphology in visceral leishmaniasis-associated hemophagocytic syndrome: Two case reports
Shi SL, Zhao H, Zhou BJ, Ma MB, Li XJ, Xu J, Jiang HC
- 5470** Rare case of hepatocellular carcinoma metastasis to urinary bladder: A case report
Kim Y, Kim YS, Yoo JJ, Kim SG, Chin S, Moon A
- 5479** Osteotomy combined with the trephine technique for invisible implant fracture: A case report
Chen LW, Wang M, Xia HB, Chen D
- 5487** Clinical diagnosis, treatment, and medical identification of specific pulmonary infection in naval pilots: Four case reports
Zeng J, Zhao GL, Yi JC, Liu DD, Jiang YQ, Lu X, Liu YB, Xue F, Dong J
- 5495** Congenital tuberculosis with tuberculous meningitis and situs inversus totalis: A case report
Lin H, Teng S, Wang Z, Liu QY
- 5502** Mixed large and small cell neuroendocrine carcinoma of the stomach: A case report and review of literature
Li ZF, Lu HZ, Chen YT, Bai XF, Wang TB, Fei H, Zhao DB

LETTER TO THE EDITOR

- 5510** Pleural involvement in cryptococcal infection
Georgakopoulou VE, Damaskos C, Sklapani P, Trakas N, Gkoufa A
- 5515** Electroconvulsive therapy plays an irreplaceable role in treatment of major depressive disorder
Ma ML, He LP

ABOUT COVER

Editorial Board Member of *World Journal of Clinical Cases*, Shivanshu Misra, MBBS, MCh, MS, Assistant Professor, Surgeon, Department of Minimal Access and Bariatric Surgery, Shivani Hospital and IVF, Kanpur 208005, Uttar Pradesh, India. shivanshu_medico@rediffmail.com

AIMS AND SCOPE

The primary aim of *World Journal of Clinical Cases* (WJCC, *World J Clin Cases*) is to provide scholars and readers from various fields of clinical medicine with a platform to publish high-quality clinical research articles and communicate their research findings online.

WJCC mainly publishes articles reporting research results and findings obtained in the field of clinical medicine and covering a wide range of topics, including case control studies, retrospective cohort studies, retrospective studies, clinical trials studies, observational studies, prospective studies, randomized controlled trials, randomized clinical trials, systematic reviews, meta-analysis, and case reports.

INDEXING/ABSTRACTING

The WJCC is now indexed in Science Citation Index Expanded (also known as SciSearch®), Journal Citation Reports/Science Edition, Scopus, PubMed, and PubMed Central. The 2021 Edition of Journal Citation Reports® cites the 2020 impact factor (IF) for WJCC as 1.337; IF without journal self cites: 1.301; 5-year IF: 1.742; Journal Citation Indicator: 0.33; Ranking: 119 among 169 journals in medicine, general and internal; and Quartile category: Q3. The WJCC's CiteScore for 2020 is 0.8 and Scopus CiteScore rank 2020: General Medicine is 493/793.

RESPONSIBLE EDITORS FOR THIS ISSUE

Production Editor: Xu Guo; Production Department Director: Xiang Li; Editorial Office Director: Jin-Lei Wang.

NAME OF JOURNAL

World Journal of Clinical Cases

ISSN

ISSN 2307-8960 (online)

LAUNCH DATE

April 16, 2013

FREQUENCY

Thrice Monthly

EDITORS-IN-CHIEF

Bao-Gan Peng, Jerzy Tadeusz Chudek, George Kontogeorgos, Maurizio Serati, Ja Hyeon Ku

EDITORIAL BOARD MEMBERS

<https://www.wjgnet.com/2307-8960/editorialboard.htm>

PUBLICATION DATE

June 6, 2022

COPYRIGHT

© 2022 Baishideng Publishing Group Inc

INSTRUCTIONS TO AUTHORS

<https://www.wjgnet.com/bpg/gerinfo/204>

GUIDELINES FOR ETHICS DOCUMENTS

<https://www.wjgnet.com/bpg/GerInfo/287>

GUIDELINES FOR NON-NATIVE SPEAKERS OF ENGLISH

<https://www.wjgnet.com/bpg/gerinfo/240>

PUBLICATION ETHICS

<https://www.wjgnet.com/bpg/GerInfo/288>

PUBLICATION MISCONDUCT

<https://www.wjgnet.com/bpg/gerinfo/208>

ARTICLE PROCESSING CHARGE

<https://www.wjgnet.com/bpg/gerinfo/242>

STEPS FOR SUBMITTING MANUSCRIPTS

<https://www.wjgnet.com/bpg/GerInfo/239>

ONLINE SUBMISSION

<https://www.f6publishing.com>



Successful treatment of aortic dissection with pulmonary embolism: A case report

Xu-Guang Chen, Sheng-Yi Shi, Yun-Yan Ye, Huan Wang, Wen-Fei Yao, Lan Hu

Specialty type: Emergency medicine

Provenance and peer review: Unsolicited article; Externally peer reviewed.

Peer-review model: Single blind

Peer-review report's scientific quality classification

Grade A (Excellent): 0
Grade B (Very good): B
Grade C (Good): C
Grade D (Fair): 0
Grade E (Poor): 0

P-Reviewer: Kharlamov AN, Netherlands; uz Zaman M, Pakistan

Received: September 10, 2021

Peer-review started: September 10, 2021

First decision: January 10, 2022

Revised: January 19, 2022

Accepted: April 9, 2022

Article in press: April 9, 2022

Published online: June 6, 2022



Xu-Guang Chen, Sheng-Yi Shi, Yun-Yan Ye, Huan Wang, Wen-Fei Yao, Lan Hu, Department of Emergency, Ruijin Hospital Affiliated to Medical College of Shanghai Jiaotong University, Shanghai 201800, China

Corresponding author: Lan Hu, Doctor, Deputy Director, Department of Emergency, Ruijin Hospital Affiliated to Medical College of Shanghai Jiaotong University, No. 999 Hope Road, Jiading District, Shanghai 201800, China. 442037735@qq.com

Abstract

BACKGROUND

Aortic dissection (AD) and pulmonary embolism (PE) are both life-threatening disorders. Because of their conflicting treatments, treatment becomes difficult when they occur together, and there is no standard treatment protocol.

CASE SUMMARY

A 67-year-old man fell down the stairs due to syncope and was brought to our hospital as a confused and irritable patient who was uncooperative during the physical examination. Further examination of the head, chest and abdomen by computed tomography revealed a subdural hemorrhage, multiple rib fractures, a hemopneumothorax and a renal hematoma. He was admitted to the Emergency Intensive Care Unit and given a combination of oxygen therapy, external rib fixation, analgesia and enteral nutrition. The patient regained consciousness after 2 wk but complained of abdominal pain and dyspnea with an arterial partial pressure of oxygen of 8.66 kPa. Computed tomography angiograms confirmed that he had both AD and PE. We subsequently performed only nonsurgical treatment, including nasal high-flow oxygen therapy, nonsteroidal analgesia, amlodipine for blood pressure control, beta-blockers for heart rate control. Eight weeks after admission, the patient improved and was discharged from the hospital.

CONCLUSION

Patients with AD should be alerted to the possibility of a combined PE, the development of which may be associated with aortic compression. In patients with type B AD combined with low-risk PE, a nonsurgical, nonanticoagulant treatment regimen may be feasible.

Key Words: Aortic dissection; Pulmonary embolism; Treatment; Case report

Core Tip: Here we show a case of a patient with multiple injuries from a fall who was admitted 2 wk later and found to have a concurrent type B aortic dissection, and low-risk pulmonary embolism. We determined that the thrombosis was probably related to compression of the aortic hematoma. After 6 wk of nasal high-flow oxygen therapy, analgesia, slowing of heart rate, lowering of blood pressure, and non-anticoagulation, the patient was discharged. This case shows us that non-surgical non-anticoagulation may be appropriate for patients with aortic dissection combined with low-risk pulmonary embolism.

Citation: Chen XG, Shi SY, Ye YY, Wang H, Yao WF, Hu L. Successful treatment of aortic dissection with pulmonary embolism: A case report. *World J Clin Cases* 2022; 10(16): 5394-5399

URL: <https://www.wjgnet.com/2307-8960/full/v10/i16/5394.htm>

DOI: <https://dx.doi.org/10.12998/wjcc.v10.i16.5394>

INTRODUCTION

Aortic dissection (AD) is a fatal disease that involves an intimal tear of the aortic wall and allows blood to flow within the layers of the vessel. Based on the Stanford classification criteria, AD can manifest in two ways: Type A affects the ascending aorta, whereas type B affects all other aortic segments. While type A: AD cases often demand urgent surgical intervention, the vast majority of type B: AD cases can be treated with conventional methods[1]. Pulmonary embolism (PE), which is caused by a clot in one of the pulmonary arteries and blocks blood flow to the heart and lungs, can also be life-threatening. Nevertheless, these two diseases rarely occur simultaneously in the same patient. If a patient suffers from both life-threatening diseases at the same time, it becomes much more challenging to define treatment options and interventions. In fact, currently, there are no well-recognized guidelines for the treatment of simultaneous AD and PE in the same patient. In this report, we describe the case of a 67-year-old man with both AD type B and acute PE who was successfully treated with nonsurgical methods.

CASE PRESENTATION

Chief complaints

Fall once 6 h ago with disturbance of consciousness.

History of present illness

A 67-year-old man fell down the stairs due to syncope and was brought to our hospital as a confused and irritable patient who was uncooperative during the physical examination.

History of past illness

He has a history of hypertension and thyroidectomy.

Personal and family history

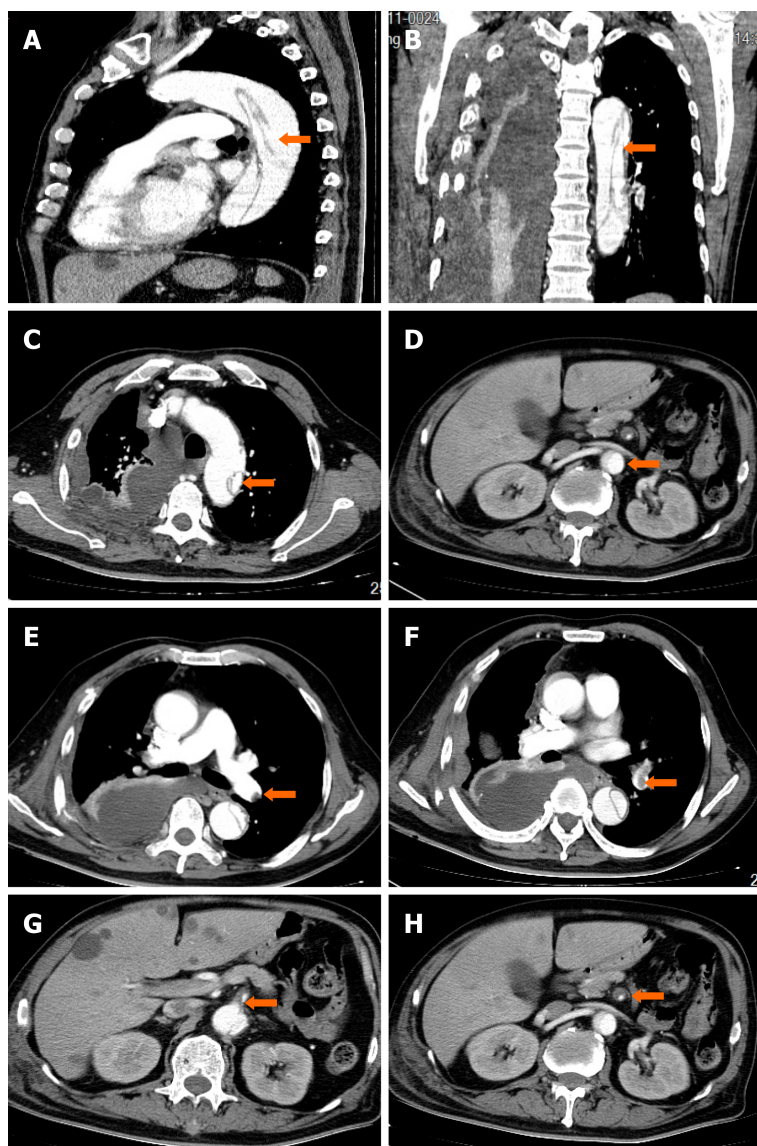
The patient had no disease-related personal or family history.

Physical examination

The examination at admission revealed a heart rate of 150 beats per minute, a respiratory rate of 28 breaths per minute, SpO₂ of 92% and a blood pressure of 138/92 mmHg. After 2 wk, he had a heart rate of 116 beats/min, a respiratory rate of 26 breaths per minute, SpO₂ of 88% and a blood pressure at 138/79 mmHg.

Laboratory examinations

The laboratory findings on admission were white blood cell (WBC) at $16.67 \times 10^9/L$, hemoglobin at 145 g/L, platelets at $229 \times 10^9/L$, APTT at 33.4 s, fibrin degradation products at 265.78 µg/mL, D-dimer at 36.69 µg/mL, blood creatinine at 115 µmol/L and arterial partial pressure of oxygen at 10.2 kpa. After 2 wk, The laboratory findings were WBC at $17.19 \times 10^9/L$, hemoglobin at 92 g/L, platelets at $506 \times 10^9/L$, APTT at 30.4 s, fibrin degradation products at 19.98 µg/mL, D-dimer at 3.62 µg/mL, blood creatinine at 57 µmol/L, cTNI at 0.01 ng/mL, and BNP at 73 pg/mL.



DOI: 10.12998/wjcc.v10.i16.5394 Copyright ©The Author(s) 2022.

Figure 1 Computed tomography presentation of aortic coarctation and thrombosis. A: AD sagittal plane; B: AD coronal surface; C: AD aortic arch cross-section; D: AD renal artery level; E: Proximal left lower lobe thrombosis; F: Distal left lower lobe thrombosis; G: Proximal superior mesenteric artery thrombosis; H: Distal superior mesenteric artery thrombosis. AD: Aortic dissection. Orange arrows point to lesions.

Imaging examinations

Admission examination of the head, chest and abdomen by computed tomography revealed a subdural hemorrhage, multiple rib fractures, a hemopneumothorax and a renal hematoma. After 2 wk, computed tomography angiograms (CTAs) of his chest and abdomen were then collected, which revealed a type B AD located across the aortic arch to the renal artery (Figure 1A-D), a left lower lobe PE (Figure 1E-F), and a superior mesenteric artery thrombus (Figure 1G-H). Subsequent cardiac ultrasound assessed pulmonary artery pressure at 40 mmHg, right ventricular end-diastolic internal diameter at 28 mm, left atrial internal diameter at 38 mm, left ventricular end-diastolic internal diameter at 62 mm, left ventricular ejection fraction at 54%, no thrombus on lower limb vascular ultrasound, and an electrocardiogram of sinus tachycardia (Figure 2).

FINAL DIAGNOSIS

Stanford type B aortic coarctation combined with pulmonary embolism.



DOI: 10.12998/wjcc.v10.i16.5394 Copyright ©The Author(s) 2022.

Figure 2 Electrocardiogram in the detection of aortic coarctation and pulmonary embolism.

TREATMENT

He was admitted to the Emergency Intensive Care Unit and given a combination of oxygen therapy, external rib fixation, analgesia and enteral nutrition. 2 wk later, he was found to have both AD and PE by CTA. PE and superior mesenteric artery thrombosis require anticoagulation; however, in the acute phase of AD, there is a risk of exfoliation and rupture, which is a contraindication to anticoagulation. Initially, we proposed vascular surgery or interventional treatment of AD followed by anticoagulation, but this option was rejected by the patient's family. We subsequently performed only nonsurgical treatment, including nasal high-flow oxygen therapy (FiO₂ 50%, 50 L/min), nonsteroidal analgesia, amlodipine for blood pressure control, beta-blockers for heart rate control, thoracentesis drainage to improve dyspnea, and antibiotics to treat pulmonary infection complications; ultimately, he did not receive any anticoagulation therapy.

OUTCOME AND FOLLOW-UP

Eight weeks after admission, the patient's abdominal pain and dyspnea improved significantly, hypoxemia was corrected, and he was discharged in good condition. He reported no other symptoms during the 6-mo follow-up period.

DISCUSSION

The coexistence of AD and PE in the same patient is not common, and only a limited number of cases have been reported[2,3]. The mechanism underlying the simultaneous development of AD and PE remains unclear, and various factors may contribute to such a comorbidity. One likely cause of this simultaneous occurrence is the close anatomical relationship between them, where compression of the right pulmonary artery induced by AD can cause the stagnation of blood flow that may lead to PE[2,4-8]. Another plausible cause is that deep vein thrombosis occurring in the lower extremities may travel up to the pulmonary artery and cause PE. Finally, the occurrence of AD can trigger a widespread coagulation response that results in multiple thromboses traveling throughout the circulatory system. In the present case, the patient had thrombosis in both the left lower pulmonary artery and the superior mesenteric artery, while no thrombus was found in other sites, such as the lower extremity vessels. Because the locations of the left lower pulmonary and superior mesenteric artery thrombi were adjacent to the location of the aortic hematoma, we speculate that thrombosis was likely caused by the stagnation of blood flow after compression of the corresponding vessels.

The simultaneous occurrence of AD and PE often leads to contradictory treatment strategies, and there is currently no standard treatment. In a recently reported case of concurrent type B AD and PE[9], conventional treatments did not result in a positive outcome. However, the patient was successfully treated with more complex approach involving thoracic endovascular aortic repair and a stent graft. Nevertheless, another reported case with both PE and AD was successfully treated with conventional therapies, as was done in the current report[10]. Previous reports[7] have indicated that successful emergency surgery can be administered for concurrent type A: AD and hematoma to relieve compression of the pulmonary artery. In summary, the adverse consequences of bleeding and

thrombosis should be weighed against the treatment of AD combined with PE. This patient had both AD and PE but was fortunate to have low-risk PE risk stratification; although he did not receive anticoagulation, his PE gradually improved as the AD was controlled and the overall condition continued to improve.

CONCLUSION

In conclusion, patients with AD should be alerted to the possibility of combined PE, the development of which may be associated with aortic compression. In patients with type B: AD combined with low-risk PE, a nonsurgical treatment plan without anticoagulation and appropriate oxygen therapy support, along with heart rate and blood pressure control, may be feasible.

FOOTNOTES

Author contributions: Chen XG did the data curation, formal analysis, writing-original draft; Shi SY did the conceptualization; Ye YY did the investigation; Wang H and Yao WF did the resources; Hu L did the supervision, writing-review and editing.

Informed consent statement: Informed written consent was obtained from the patient for publication of this report and any accompanying images.

Conflict-of-interest statement: The authors declare that they have no conflict of interest.

CARE Checklist (2016) statement: The authors have read the CARE Checklist (2016), and the manuscript was prepared and revised according to the CARE Checklist (2016).

Open-Access: This article is an open-access article that was selected by an in-house editor and fully peer-reviewed by external reviewers. It is distributed in accordance with the Creative Commons Attribution NonCommercial (CC BY-NC 4.0) license, which permits others to distribute, remix, adapt, build upon this work non-commercially, and license their derivative works on different terms, provided the original work is properly cited and the use is non-commercial. See: <https://creativecommons.org/licenses/by-nc/4.0/>

Country/Territory of origin: China

ORCID number: Lan Hu [0000-0002-2178-8218](#).

S-Editor: Xing YX

L-Editor: A

P-Editor: Xing YX

REFERENCES

- 1 Suzuki T, Mehta RH, Ince H, Nagai R, Sakomura Y, Weber F, Sumiyoshi T, Bossone E, Trimarchi S, Cooper JV, Smith DE, Isselbacher EM, Eagle KA, Nienaber CA; International Registry of Aortic Dissection. Clinical profiles and outcomes of acute type B aortic dissection in the current era: lessons from the International Registry of Aortic Dissection (IRAD). *Circulation* 2003; **108** Suppl 1: II312-II317 [PMID: [12970252](#) DOI: [10.1161/01.cir.0000087386.07204.09](#)]
- 2 Buja LM, Ali N, Fletcher RD, Roberts WC. Stenosis of the right pulmonary artery: a complication of acute dissecting aneurysm of the ascending aorta. *Am Heart J* 1972; **83**: 89-92 [PMID: [5010978](#)]
- 3 Elmali M, Gulel O, Bahcivan M. Coexistence of pulmonary embolism, aortic dissection, and persistent left superior vena cava in the same patient. *J Cardiovasc Med (Hagerstown)* 2008; **9**: 1180-1181 [PMID: [18852601](#) DOI: [10.2459/JCM.0b013e32830ce51e](#)]
- 4 Charnsangavej C. Occlusion of the right pulmonary artery by acute dissecting aortic aneurysm. *AJR Am J Roentgenol* 1979; **132**: 274-276 [PMID: [105599](#) DOI: [10.2214/ajr.132.2.274](#)]
- 5 Sorensen B, Moyat C, Marlois O, Vaisse B, Montiès JR, Poggi L. [Compression of the right pulmonary artery by a dissecting aneurysm of the ascending aorta. Apropos of a case occurring long after aortic valve replacement]. *Arch Mal Coeur Vaiss* 1986; **79**: 1111-1115 [PMID: [3096236](#)]
- 6 Worsley DF, Coupland DB, Lentle BC, Chipperfield P, Marsh JI. Ascending aortic dissection causing unilateral absence of perfusion on lung scanning. *Clin Nucl Med* 1993; **18**: 941-944 [PMID: [8269672](#)]
- 7 Neri E, Toscano T, Civieli L, Capannini G, Tucci E, Sassi C. Acute dissecting aneurysm of the ascending thoracic aorta causing obstruction and thrombosis of the right pulmonary artery. *Tex Heart Inst J* 2001; **28**: 149-151 [PMID: [11453130](#)]
- 8 De Silva RJ, Hosseinpour R, Screaton N, Stoica S, Goodwin AT. Right pulmonary artery occlusion by an acute dissecting aneurysm of the ascending aorta. *J Cardiothorac Surg* 2006; **1**: 29 [PMID: [17007637](#) DOI: [10.1186/1749-8090-1-29](#)]

- 9 **Dong ZC**, Hua YZ. Pulmonary Embolism and Stanford Type B Aortic Dissection in the Same Patient. *JVMS* 2015; **3**: 226
- 10 **Tudoran M**, Tudoran C. High-risk pulmonary embolism in a patient with acute dissecting aortic aneurysm. *Niger J Clin Pract* 2016; **19**: 831-833 [PMID: [27811460](#) DOI: [10.4103/1119-3077.181355](#)]



Published by **Baishideng Publishing Group Inc**
7041 Koll Center Parkway, Suite 160, Pleasanton, CA 94566, USA

Telephone: +1-925-3991568

E-mail: bpgoffice@wjgnet.com

Help Desk: <https://www.f6publishing.com/helpdesk>

<https://www.wjgnet.com>

