A 62-year-old man with acute coronary syndrome and triple-vessel disease underwent uneventful robotic coronary bypass with right internal mammary artery graft to the ramus intermedius branch and left internal mammary artery (LIMA) graft to the left anterior descending artery (LAD). Two days later, bilateral mammary angiography performed before staged hybrid right coronary artery (RCA) intervention revealed patent right internal mammary artery. However, a hazy, discrete “napkin-ring” lesion was seen in the mid-LAD just distal to the LIMA anastomosis (Fig. 1); intra-LIMA nitroglycerin resulted in no changes. There was no impediment to flow, with preserved distal myocardial blush. A drug-eluting stent was subsequently deployed into the mid-RCA. As he remained asymptomatic, the patient was discharged, with a plan for repeat angiography. A subsequent 4-month angiography revealed patency of both arterial conduits and stent. Specifically, the previous LIMA-LAD post-anastomotic lesion had completely resolved (Fig. 2).

Robotic coronary bypass offers a minimally invasive alternative to traditional surgical revascularization (1). Routine post-operative bypass angiography may reveal such temporary “lesions.” We had avoided intravascular ultrasound due to concern of disrupting a fresh anastomotic site; furthermore, it

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*Figure 1. Post-Operative Day 2 LIMA Angiogram*

During the staged right coronary artery intervention, a post-operative left internal mammary artery (LIMA) angiogram is performed. A discrete linear hazy “lesion” is seen just distal to the anastomosis, without flow compromise. As the patient was asymptomatic, no intervention was performed at the LIMA site.

*Figure 2. Post-Operative Month 4 LIMA Angiogram*

Per previous discussion with the patient, a subsequent catheterization was performed at 4 months post-operatively. Left internal mammary artery (LIMA) angiography at that time demonstrated total resolution of the previous “lesion.” The right coronary artery stent was similarly widely patent, and the patient has remained asymptomatic.
is unknown whether interrogation would have identified the etiology. Further experience with the higher resolution optical coherence tomography may be useful in this situation. Moreover, pressure-wire would discern flow limitation, with no clarification of the etiology. This was unlikely a suture stricture, as that would have occurred exactly at the LIMA-LAD insertion, rather than distal to it in the LAD itself.

These findings likely represent transient edema near the anastomotic site and probably should not prompt mechanical intervention in the absence of symptoms or flow limitations, as such maneuvers may result in anastomotic rupture or abrupt closure. As post-operative imaging is not routinely performed following traditional open bypass procedures, it is unknown whether similar findings may occur in those cases as well.

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