A 39-year-old man presented with a 6-month history of stable angina that had recently worsened to unstable angina. He had no conventional risk factors for coronary artery disease. His medical history included a painless ulcer on his penis when he was 18 years old.

Cardiovascular examination revealed moderate aortic regurgitation that was confirmed on echocardiograms (Fig. 1). An electrocardiogram showed ST depression in the inferior and anterolateral leads. Results of routine biochemistry tests and a fasting lipid profile were within normal ranges. A rapid plasma reagin card test and *Treponema pallidum* hemagglutination test were strongly positive. Coronary angiograms showed critical ostial stenosis of the left main coronary artery (LMCA) with Thrombolysis in Myocardial Infarction (TIMI)-I flow (Fig. 2A) and critical ostial stenosis of the right coronary artery (RCA) (Fig. 3A). Aortic root angiograms showed moder-
ate aortic regurgitation with no evident root dilation or ascending aortic aneurysm (Fig. 4).

The patient underwent percutaneous transluminal coronary angioplasty (PTCA). Engaging the guide catheter in the coronary arteries was difficult because of displaced, deformed, critical aorto-ostial stenosis secondary to syphilitic aortitis with possible cicatrization and fibrosis. After the LMCA lesion was predilated and a 4 × 10-mm drug-eluting stent was deployed in the ostium, angiograms showed TIMI-III flow (Fig. 2B). In the RCA ostium, PTCA and a 4 × 13-mm drug-eluting stent yielded TIMI-III flow (Fig. 3B). A year later, the patient was asymptomatic, and an exercise stress test induced no ischemia.

Comment

Well-known cardiovascular manifestations of tertiary syphilitic infections include aortitis, aortic root dilation, aneurysm formation, aortic regurgitation, and coronary ostial stenosis. Coronary ostial lesions have been detected in as many as 26% of patients with syphilitic aortitis; however, bilateral coronary ostial stenosis is rare. The elective stenting of unprotected LMCA lesions was once considered to be contraindicated; however, several studies have validated its safety, acceptable short- and intermediate-term success, and feasibility as an alternative to coronary artery bypass grafting (CABG).

Stenting in cases of syphilitic aorto-ostial stenosis is rarely mentioned in the literature, probably because the condition is rare in the era of stenting. Although cardiovascular syphilis is rarely reported, it should be considered in the differential diagnosis in patients who have bilateral coronary ostial lesions but no conventional risk factors for atherosclerosis. In the case of these nonatherosclerotic lesions, PTCA with stenting can be a safe and effective alternative to CABG.

References