



Aortic Wall Injury: Intimal Flap Formation after Aortic Balloon Valvuloplasty, a Rare Complication

CASE REPORT

Onur Taşçı, Ali Baykan, Süleyman Sunkak, Özge Pamukçu

ABSTRACT

Injury of the aortic wall occurs in about 15% of patients after balloon aortic valvuloplasty. Formation of an intimal flap is a rare type of vessel wall injury, which is not well recognized yet. We report a case of a newborn with critical aortic stenosis who had an aortic wall injury after balloon aortic valvuloplasty.

Keywords: Newborn, critical aortic stenosis, balloon aortic valvuloplasty, intimal flap

INTRODUCTION

Critical aortic stenosis (CAS) is a rare and important disease in newborns. If diagnosis and treatment are delayed, decreased systemic perfusion and left ventricular dysfunction can cause fatal outcomes. Prostaglandin E1 infusion is necessary to maintain tissue perfusion via the ductus arteriosus until percutaneous intervention or surgery is performed. Diagnosis is possible by fetal echocardiography. Clinical manifestations because of the effect of decreased ductal flow may be observed immediately at birth or after discharge. Severe valve stenosis results in left ventricular dysfunction and hypoperfusion in most cases (1, 2).

Aortic valve anomalies account for approximately 3.5%-5% of congenital heart diseases (3). Including the cases with asymptomatic bicuspid aortic valve, the incidence may increase by 2% in the general population (4).

In many institutes, transcatheter balloon aortic valvuloplasty (TBAV) is the first line therapy for neonatal CAS (5). In the acute period, after TBAV, aortic regurgitation, mitral valve injury, and vascular damage of the great vessels may be seen (6, 7).

Recently, the incidence of aortic wall injury is reported to be approximately 15%. Specifically, the creation of an intimal flap in the aortic wall is a rarely defined complication after neonatal TBAV. As this complication is frequently overlooked, the aorta should be carefully examined in terms of wall injury after TBAV (5).

In this report, we present an aortic wall injury complication after TBAV.

CASE REPORT

A newborn male weighing 2380 g, diagnosed with intrauterine aortic stenosis, was hospitalized for postnatal follow-up.

Electrocardiogram revealed left ventricular hypertrophy (Figure 1). The left ventricle was hypertrophic, and the cavity was partially hypoplastic. The aortic valve was bicuspid and stenotic like atretic. 35-mmHg gradient was measured by Doppler examination of the aortic valve. There was third-degree mitral and first-degree tricuspid regurgitation. Left ventricle ejection fraction was decreased (45%), and prostaglandin E1 infusion was initiated.

In the catheterization laboratory, the aortic annulus diameter was 5.2 mm and 28-mmHg pressure gradient was measured at the valve level. Balloon valvuloplasty was performed using a 5 mm x 2 cm Tyshak II balloon. Following the balloon valvuloplasty, first-degree aortic insufficiency and significant residual gradient was detected using a transthoracic echocardiography.

The second TBAV was performed for the residual gradient on the aortic valve level. The gradient was decreased to 13 mmHg, and first-degree aortic regurgitation was detected after the second TBAV.

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Department of Pediatric Cardiology, Erciyes University Faculty of Medicine, Kayseri, Turkey

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Correspondence

Onur Taşçı, Department of Pediatric Cardiology, Erciyes University School of Medicine, Kayseri, Turkey
Phone: 0352 207 66 66
e-mail: medonur@gmail.com, dr_onurtasci@hotmail.com

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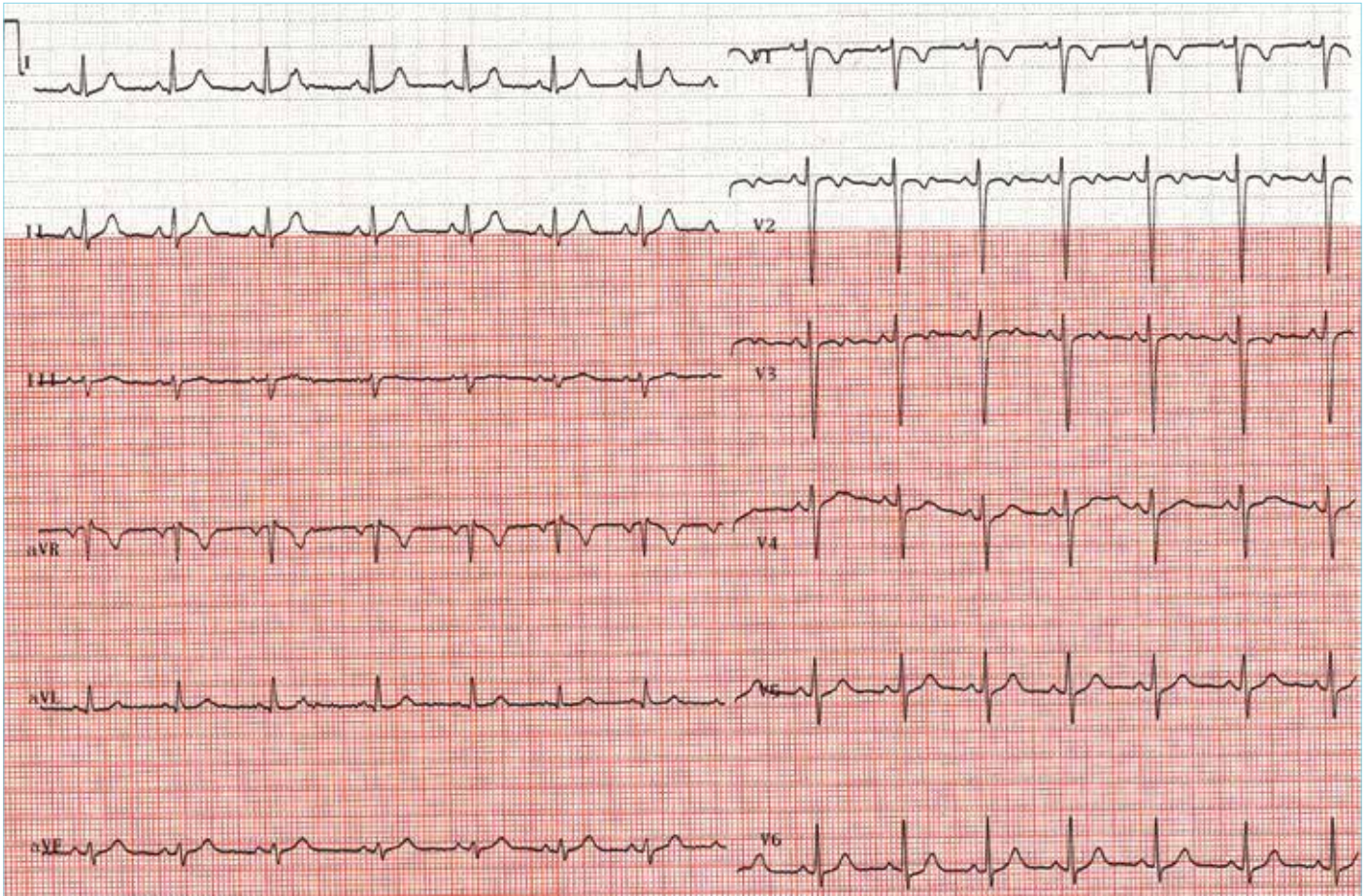


Figure 1. Electrocardiography of the patient showing left ventricular hypertrophy

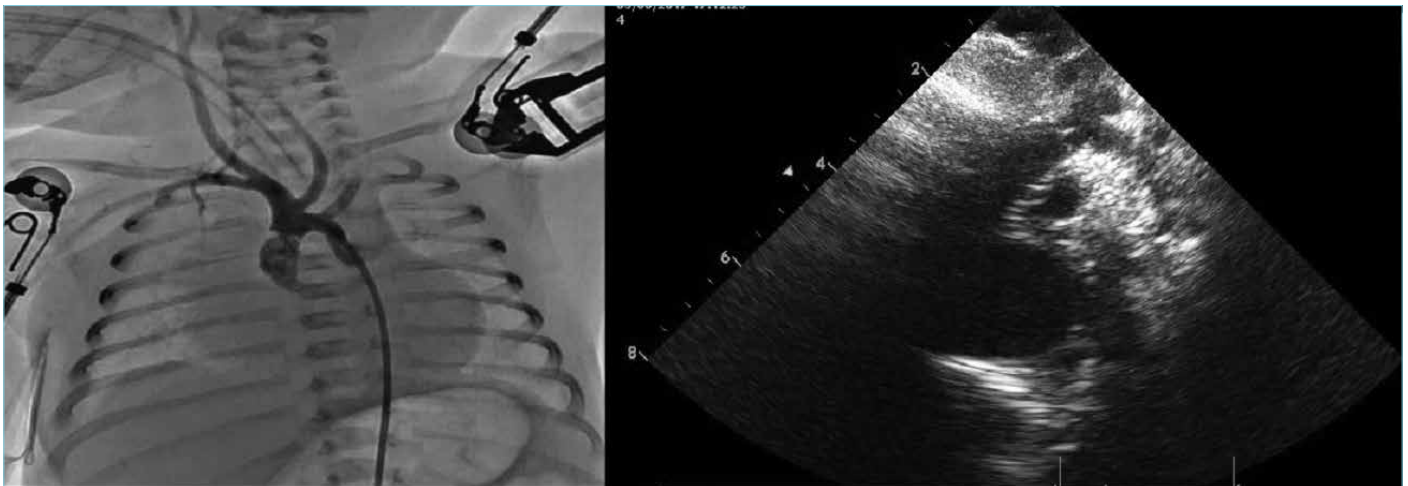


Figure 2. Left: Cineangiography showing intimal flap with radiopaque material
Right: Intimal flap diagnosed by the suprasternal echocardiographic view in the ascending aorta after balloon valvuloplasty

After the procedure, we observed a flap-like mobile structure in the ascending aorta, above the aortic valve, which had an appearance similar to a second valve proximal to the brachiocephalic artery (Figure 2, Left). Doppler echocardiography revealed a gradual filling defect with color in this area compatible with the intimal flap in the ascending aorta (Figure 2, Right), and the gradient at the flap level was measured to be 15 mmHg in the cath lab.

After the procedure, the patient was extubated, and a control echocardiography revealed increased the left ventricle ejection fraction (82%) and decreased mitral and tricuspid regurgitations. Upon echocardiography, no clinically significant changes or gradient were detected. He was discharged with limited clinical symptoms.

DISCUSSION

Transcatheter balloon aortic valvuloplasty (TBAV) is an efficient and safe intervention for CAS in the pediatric population. Compared with aortic valve surgery, it is believed to be a more feasible palliative approach (8).

In a multicenter study, Torres et al (9) reported favorable outcomes in over 70% of patients who underwent TBAV for congenital aortic stenosis under 1 month. In that study, the safety and efficacy results of the TBAV were shown. The procedural adverse events are relatively rare; however, minor complications can be seen. In patients aged <1 month, the reported minor complications are transient hemodynamic compromise, difficulties in vascular access, and adverse events related to sedation or airway. Patients were evaluated for the severity of adverse events because of major complications, and there was no significant difference between <1 month-old and older patients. Vascular trauma was reported more frequently in patients younger than 1 month in that study (15% vs. 5%; $p=0.03$) (9).

Brown et al. (5) published the results of a single-centered study in Boston in 2008. The objective of this research was to determine the incidence of aortic wall injury and other complications during TBAV. They reported that injury to the aorta wall was in 15% of the interventions among 173 infants who underwent neonatal TBAV over a 20-year time in this center. Most injuries were reported to have occurred in the transverse aortic arch (58% in the distal ascending aorta). They supposed the outcomes of significant dysfunction of left ventricle, recurrence of balloon dilations, and an inexperienced team were related to the injury.

The movement of stiff dilation catheters were accused for flap formation (10). Furthermore, the intimal flap may also occur during balloon movement in the aortic arch when the lumen of the stiff balloon catheter is incompatible with the guide wire. Similarly, intimal flaps can also be seen in the descending aorta during aortic balloon angioplasty performed for aortic coarctation. These therapeutic interventions can to be identified as risk factors for adverse events (10).

CONCLUSION

Transcatheter balloon aortic valvuloplasty (TBAV) is an efficient and safe treatment method for aortic stenosis. Infants under 1 month of age who underwent balloon valvuloplasty, particularly CAS patients, are at a higher risk for complications. Complications associated with aortic balloon valvuloplasty have rarely been reported in literature. However, studies have reported that these

complications are about 15%. Thus, intimal flap creation as a complication of aortic wall damage during aortic balloon valvuloplasty is a rare and important complication and should not be ruled out.

Informed Consent: Written informed consent was obtained from patients' parents who participated in this study.

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Conflict of Interest: Authors have no conflicts of interest to declare.

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