Case Report

Coronary Flow Interruption Following Balloon Rupture in an Elderly Patient

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Introduction

As a result of the increased life expectancy, elderly with acute coronary syndromes (ACS) referred to coronary catheterization facilities for emergency percutaneous coronary interventions (PCI) increase in numbers. Whereas PCI has proven effective in this setting, management of elderly with ACS remains a challenging issue. Concerns about benefit-risk ratio include physiological age and associated co-morbidities such as renal and/or cognitive impairment. More specific conditions should also be taken into account when deciding an invasive approach, including presentation with symptoms of heart failure (HF) and the extent of coronary artery lesions. This case report relates of an unusual but potentially harmful complication of percutaneous revascularization that may be observed in elderly patients with severely calcified coronary lesions.

Case Report

An 88-year-old woman was admitted to hospital for increasing shortness of breath lasting for 2 days. Her past history included prior surgery for hip fracture and for gall bladder lithiasis migration-related angiocholitis 5 and 10 years before, respectively. She also had mild to moderate chronic obstructive lung disease associated with past cigarette smoking and bronchial hyper reactivity.

There was no cough, wheezing, nor chest pain. Blood pressure was 140/90 mmHg, the pulse was 100 per minute, regular, and breath rate was 22 per minute. Physical examination revealed normal heart sounds. The lung bases were clear at auscultation. Palpation of the abdomen was normal. The electrocardiogram showed no abnormalities. There was no pulmonary edema on a chest X-ray, which also showed a slightly enlarged cardiac silhouette.

Routine laboratory examinations showed mild leukocytosis (WBC count: 11,900/ mm3, 90% PMN), no anemia (hemoglobin: 12.1 g/100 mL), plasma creatinine level 78 µmol/L. Plasma troponin I level was normal (0.05 µg/L). As plasma Elisa D-dimers levels were slightly increased, a duplex Doppler ultrasound examination of the lower extremities was performed, but excluded deep venous thrombosis.

A blood gas sampling showed pH 7.36, PaCO2 49.5 mmHg, and PaO2 62 mmHg. As the pro-BNP levels were increased (2,822 ng/mL), a treatment with diuretics and oxygen was started in the emergency department. The patient substantially improved (PaO2: 80 mmHg) and was subsequently discharged to the department of medicine.

Two days later, she complained of recurrent increasing dyspnea, without chest pain, wheezing nor crepitations over the lung bases. The electrocardiogram showed sinus rhythm with a heart rate 116 per minute and recent onset electrocardiographic changes suggesting ST-elevation anterior myocardial infarction. Blood pressure was 90/65 mmHg. Troponin I was 1.01 µg/L. A 2-dimensional echocardiography (2-DE) showed impaired septal and apical wall motion, with a reduced left ventricular ejection fraction (LVEF: 40%).

Emergency coronary angiography was performed after a therapy with aspirin 250 mg, clopidogrel 300 mg and low molecular weight heparin was administered. A significant stenosis (80%) was seen on segment 2 of the left anterior descending coronary artery (LAD). There was no coronary thrombus within the lumen of the vessel, which was, however, heavily calcified. No other critical stenosis was found. The left main coronary artery and circumflex coronary artery were plaque- and stenosis-free. A 40% stenosis was seen in segment 1 of the right coronary artery. Primary coronary angioplasty was attempted using a 2 mm balloon inflated within the lumen of the mid LAD stenosis. As repeat inflations failed to achieve any effective dilatation, a 2.5 mm balloon was placed with stepwise increases in inflation pressure. Balloon rupture occurred during a 22 atm inflation and instantaneously resulted in a prolonged no flow within the target vessel lasting for 30 seconds (Figure 1), followed by a slow flow associated with severe hypotension (systolic blood pressure 70 mmHg) which lasted for a few minutes. This slow flow was ultimately reverted after intracoronary administration of adenosine (3 bolus of 36 µg each). At the end of the procedure, a TIMI-3 flow grade was obtained, with a residual stenosis accounting for 40% of the target vessel lumen. Blood pressure was 110/60 mmHg.

Troponin levels rose to 3.79 µg/L 24 hours later and subsequently returned to normal values. A week later, the patient said her shortness of breath had disappeared. The electrocardiogram showed an improved repolarization pattern in leads V1 to V4, without constitution of any Q wave. Septal motion abnormalities substantially improved, with a LVEF ranging between 50% and 55%.

Discussion

Elderly patients with ACS often present with atypical or absent chest pain, complaining more frequently of dyspnea or manifestations of worsening heart failure [1,2]. Delay in seeking medical care, misleading clinical symptoms and electrocardiographic changes, as well as a lower rate of patients referred for early invasive strategy affect the prognosis of ACS in the elderly [2,3], whereas several studies have...
shown that PCI is as safe and effective in this population [3-5]. Efficacy of PCI may however be limited by severe target vessel calcifications, which are a common finding in the elderly [5].

The present study shows a potentially harmful complication of balloon angioplasty elicited by high inflation pressures and severely calcified coronary lesions. Transient hemodynamic failure may adversely affect elderly patients, especially those with HF or LV diastolic dysfunction associated with myocardial ischemia. In our patient, the no flow/slow flow phenomenon resulted in a sustained drop in blood pressure that reverted only after several intracoronary administration of adenosine. This case study would be worthy of further research to assess the frequency and the consequences of this complication in a large sample of patients in whom stenting is not performed, especially when platelet inhibition is contraindicated.

Accordingly, decision making for primary PCI in elderly patients with ACS should take into account the extent of target vessel calcifications in association with the patient's baseline clinical condition. Facing with severely calcified coronary lesions, the risk of balloon rupture and PCI failure should be considered in a pre-inflation benefit-risk ratio analysis.

References


