

COMPLICATIONS I WISH I HAD NEVER SEEN

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CASE NUMBER (3)

A 1 year old boy presented with dyspnoea, diaphoresis on feeding and cyanosis on crying. There was delayed motor and mental development, poor weight gain, systolic murmur and clear chest. Saturation was 99% and weight was 5.7kg. Despite balloon pulmonary valvuloplasty at the age of 6 months and Inderal treatment he was increasingly symptomatic since a few months.

Echocardiography revealed 2 small ASDs and mildly hypertrophic ventricles with good systolic function. In addition, valvular pulmonary stenosis with thickened leaflets was diagnosed with a pressure gradient of approximately 100mmHg and adequately sized pulmonary branches. Furthermore, a moderate aortic stenosis with trivial regurgitation and a tricuspid aortic valve with thickened leaflets with a mean pressure gradient of approximately 25mmHg were found.

The severe pulmonary stenosis causing cyanosis required intervention and, therefore, balloon pulmonary valvuloplasty was performed. During inflation of the balloon the right pulmonary artery ruptured and caused massive fatal bleeding.

MESSAGE: Careful inflation of the balloon is required if you are in the branches even if it is a compliant balloon.



CASE NUMBER (4)

A 2 months old boy presented with cyanosis during crying since birth. Physical examination revealed a cyanosed child (saturation 52%), chest was clear and motor and mental development was intact.

Echocardiography revealed pulmonary artery atresia, VSD with right to left shunt and overriding aorta (50%), duct dependent pulmonary circulation, severe right ventricular outflow tract obstruction with blind end of the right ventricle with no forward flow from the right ventricle to the pulmonary artery. The PDA was connected to the right pulmonary artery. Diameter of the right pulmonary artery was 4mm and of the left pulmonary artery was 3mm. Good biventricular dimensions and function were confirmed. The presence of a symptomatic duct dependent pulmonary circulation led to the consensus to place a PDA stent.

During placement of the PDA stent, a body wire was used to keep the duct open and providing support during stent placement. After successful stent implantation we observed an improvement in saturation to 90%. During removing of the body wire, which was fixed by the PDA stent, the stent

fractured and embolized to the descending aorta. The stent was then snared and crushed, and finally removed surgically.

