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109337

MODALITY: E-POSTER YOUNG RESEARCHER - CASE REPORT
CATEGORY: HEMODYNAMICS AND INTERVENTIONAL CARDIOLOGY

TITLE: LEFT INTERNAL THORACIC ARTERY FISTULA TO THE BRONCHIAL ARTERY: A RARE CAUSE OF CORONARY FLOW THEFT

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Introduction: The Left Internal Thoracic Artery (LITA) fistula to the pulmonary artery and its branches is a rare clinical condition, but should be suspected in cases of persistent angina after myocardial revascularization surgery (MRS). From a pathophysiological perspective, there is a pressure difference between the vessels, resulting in coronary flow diversion and myocardial ischemia. Diagnosis requires coronary angiography and treatment may include drug therapy, surgical or endovascular intervention. Case Description: A 75-year-old man, with chronic obstructive pulmonary disease, hypertension, former smoker with a 60 pack-year smoking history. In 2014, the patient underwent MRS with LITA grafts to the anterior interventricular artery (AIA) and bypass graft to the right coronary artery, without complications. Five years later, he developed dyspnea on mild exertion, whose investigation revealed lung adenocarcinoma in the left apex, and a lobectomy was performed. After eight months, he presented with dry cough and dyspnea. The propaedeutics indicated a substernal goiter and heterogeneous thyroid, thus requiring a new surgical intervention in the mediastinum. After two months, he presented with complaints of chest pain on moderate and mild exertion associated with dyspnea. Pharmacological stress echocardiogram showed transient hypokinesia of the left ventricular anterior wall. Coronary computed tomography angiography detected an arterial fistula originating from the LITA following the lateral wall of the heart, confirmed by an angiographic study which indicated its destination for the left bronchial artery, besides blood flow diversion from the AIA. The patient underwent percutaneous embolization and trapping, with Onyx polymer and the release of six Axium micro-coils (Medtronic) into the fistular tract, via left radial access with a modified Seldinger technique. The procedure was successfully performed, and flow was immediately restored to the AIA. The patient was discharged remaining asymptomatic in the early follow-up. Conclusions: Due to the number of MRS procedures performed in the modern era and the preference for LITA as a graft, although rare, the occurrence of fistulas should be considered in cases of persistent angina after MRS. Notably, with the advancement of techniques, endovascular therapy, in addition to sparing patients from the risks of a thoracotomy, has been well documented in the treatment of symptomatic patients with a favorable anatom

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MODALITY: E-POSTER YOUNG RESEARCHER - CASE REPORT
CATEGORY: ACUTE AND CHRONIC CORONARY DISEASE/ THROMBOLYSIS

TITLE: DOUBLE JEOPARDY: ACUTE LEFT ANTERIOR DESCENDING AND RIGHT CORONARY ARTERIES THROMBOTIC SUBOCCLUSIONS IN A YOUNG HEALTHY TESTOSTERONE USER

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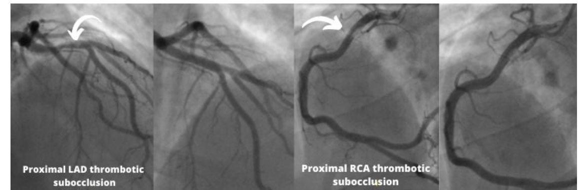
Background: Utilization of steroids to improve physical performance increase the risk of adverse cardiovascular events by acceleration of atherosclerosis and thrombogenesis. We report a case of acute two-vessel coronary thrombotic subocclusions in an otherwise young healthy testosterone user. Case Report: 37 year-old male, bodybuilder, presented with anterolateral myocardial infarction, six hours progression. He reported steroid use since 2013, using 250 mg of intramuscular testosterone decanoate daily at this time. He was taken to primary percutaneous coronary intervention (pPCI), which depicted highly thrombotic proximal left anterior descending coronary artery (LAD) and proximal right coronary artery (RCA) subocclusions, both with TIMI III antegrade flow. Given the high thrombotic burden and the presence of normal flow, pPCI was deferred and intravenous IIb/IIIa inhibitor and unfractionated heparin were administered for the following 24 hours. Repeated angiography with coronary intravascular ultrasound assessment demonstrated an atherosclerotic plaque rupture at proximal LAD, so PCI with a drug-eluting stent strongly discouraged and aggressive secondary prevention of ischemic heart disease was initiated. Conclusion: The potential increased risk of acute coronary syndromes with exogenous testosterone administration needs to be put in perspective and the testosterone to improve physical performance should be avoided.



109365

MODALITY: E-POSTER YOUNG RESEARCHER - CASE REPORT
CATEGORY: PERICARDIUM/ ENDOCARDIUM/ VALVOPATHIES

TITLE: EBSTEIN ANOMALY IN ELDERLY : CASE REPORT

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INTRODUCTION: Ebstein's abnormality, a rare congenital heart defect caused by malformation in the posterior and septal leaflets of the tricuspid valve, has an incidence of around 1:20,000 births and a prevalence of about 0.5% among patients with congenital heart disease . It causes clear consequences on the right heart, but because the severity of anatomical alteration is variable, the clinical course of the disease is also variable, ranging from intrauterine heart failure to mild manifestations beginning in adulthood . CASE REPORT : Female, 66 years old, history of congenital heart disease, with interatrial communication closure in 2002, atrial block - total ventricular with pacemaker placement in 2012, evolved in early 2022 with dyspnea and edema of the lower limbs of progression of 2 months .He underwent outpatient follow-up with cardiology, diagnosed with Ebstein's anomaly on the november 2021 echocardiogram, he showed important tricuspid regurgitation and valve alterations suggestive of Ebstein's anomaly, with indication of surgical correction . Admitted electively on 02/06/2022 at Hospital Santa Casa, she underwent surgery with placement of bioprosthesis in a tricuspid valve on 02/08/2022. In the immediate postoperative period, she developed cardiogenic shock and was extubated after clinical improvement on 02/15/2022. Soon after, he developed fever, leukocytosis, pulmonary congestion. Collected cultures in the catheter tip culture was isolated Staphylococcus capitis, started antibiotic vancomycin. New echocardiogram 25/02/22 that suspected endocarditis or thrombosis in the bioprosthesis . After improvement of the congestive and laboratory condition, transesophageal echocardiogram was performed, seen in the lateral leaflet of the tricuspid thrombus bioprosthesis, discarded endocarditis. Started anticoagulation with xarelto and was discharged from the hospital on 03/10/2022 for outpatient control with cardiology and cardiac surgery. CONCLUSION : Despite being considered the longest natural evolution of all, often exceeding until the third or fourth decade of life, acquired phenomena such as volume overload and ventricular dysfunction right affect this trajectory to the point of increasing the operative risk and morbidity in the postoperative period with the advent of arrhythmias of difficult control, in addition to the greater deterioration of ventricular function.

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MODALITY: E-POSTER YOUNG RESEARCHER - CASE REPORT
CATEGORY: PERICARDIUM/ ENDOCARDIUM/ VALVOPATHIES

TITLE: NONBACTERIAL THROMBOTIC ENDOCARDITIS (NBTE) IN A PATIENT WITH CLEAR CELL PAPILLARY CARCINOMA WITH IMPLANT IN THE OMENTUM, PERITONEUM AND PELVIS: CASE REPORT

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INTRODUCTION: Nonbacterial thrombotic or marantic endocarditis (NBTE) is a rare condition of non-infectious lesions of the heart valves (mainly aortic and mitral) due to platelet deposition and hypercoagulable state, associated with neoplasms. Epidemiological data show higher prevalence in people with cancer compared to the general population (1.25% versus 0.2%, respectively), most cases are diagnosed in autopsies, with rates ranging from 0.9% to 1.6% and when compared to malignancy, it occurs more in patients with adenocarcinoma. In addition, it affects all age groups, especially in the fourth to eighth decade of life, with no predilection for sex. Overall, treatment is based on systemic anticoagulation and the surgical indications are the same as for infective endocarditis. CASE DESCRIPTION: 49 years old female patient was hospitalized due to ischemic stroke. Transthoracic echocardiogram (TTE) showed a mobile filamentary structure adhered to the ventricular face of the aortic valve, along with a moderate aortic regurgitation. The intracranial arterial computed tomography (CT) angiography demonstrated left frontoinsular hypodensity related to ischemic vascular event without further alterations; CT scan of the abdomen and pelvis detected voluminous ascites, multiple soft tissue peritoneal formations, enhanced by contrast, sparse throughout the abdominal cavity and suggesting peritoneal implant. Furthermore, liver hypocaptant images of irregular contours was showed, mainly in segment VII, measuring 2.2 x 1.5 cm; enlarged uterus with heterogeneous density and oval formations suggesting fibroids, large solid-cystic expansive formation in the pelvis, of well-defined edges, with the solid portions enhanced by contrast measuring about 11.0 x 11.8 x 9.2 cm diagnosed ovarian neoplasm. Carotid doppler USG and thoracic aorta CT angiography was normal. Peritoneal biopsy has shown clear cell carcinoma with omentum, peritoneum and pelvis implant; patient status worsened with septic shock and respiratory failure, requiring orotracheal intubation, vasoactive drugs and intensive care unit support. After ten days, brain death was diagnosed. CONCLUSION: NBTE is a rare disease with high mortality, finding in advanced stages of cancer. Treatment consists in anticoagulation .