CLINICAL CASE

A 75-year-old man had a large anterior myocardial infarction complicated by a ventricular septal defect, which was treated in the first 48 h by transcatheter closure using the Amplatzer septal occluder. Treatment was successful (with only mild residual post-procedure shunting) and coronary angioplasty with stent implantation at the point of occlusion of the middle left anterior descending artery was performed in a later intervention. However, the patient died 7 days after the procedure as a result of sepsis and ventricular failure.

Key words: Ventricular septal defect. Myocardial infarction. Coronary angioplasty.

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crossed from the LV using a guide, to create an arteriovenous loop as described in previous publications. From the vein end of the guide we introduced into the left ventricle a Mullins-type 10 Fr catheter. Then an Amplatzer 20-mm septal occluder was advanced through it. This device is made up of a fine mesh of nitinol with dacron patches, and consists of two discs (left and right) linked by a 4-mm waist. The left disc was expanded first, and after checking by echocardiography that its placement in the ventricular septum was correct, the central stent and the right disc were expanded. Subsequent echocardiography and contrast ventriculography showed their correct placement and a very slight residual shunt between the lower edge of the device and the apex of the ventricle (Figure 2B), and so the device was finally deployed (Figures 1B and 2C). Later, angioplasty with a stent for an occlusion in the middle left anterior descending artery was performed. In the following days the patient showed hemodynamic improvement and the echocardiograms confirmed the correct placement of the device, with a slight residual shunt between its lower end and the ventricular apex. The ejection fraction was 35%, and the value of Qp/Qs obtained by oximetry was 1.2. Four days after the procedure, the patient developed sepsis of unknown origin—blood culture yielded negative results—which proved impossible to control with the use of wide-spectrum antibiotics. The patient died 10 days after the infarction from septic shock and ventricular failure.
DISCUSSION

Experience in the treatment of VSD that arises as a complication of myocardial infarction is limited. In most published cases, a VSD occluder was successfully implanted, but variations have been reported regarding residual shunt. In the study with the largest sample available (12 patients), an Amplatzer device was successfully implanted in 83% of the patients. The incidence of residual shunt was higher than 30% and hospital mortality reached 25%. In fact, in those cases that reported the time span between the onset of complications and transcatheter closure, survival was restricted to either patients treated in the subacute stage (>15 days postinfarction) or to those whose VSD was residual after surgical repair. The high rate of early mortality has been attributed to secondary ventricular failure from extensive infarction, or associated co-morbidity, as in the septic process that occurred in the patient we present.

For logistical reasons, the Amplatzer device implanted in our patient was designed for the closure of atrial septal defects. An Amplatzer occluder specially designed for VSD would probably have been more suitable, because it has a longer connecting waist (7 mm), such that it would have provided a better fit to the ventricular septum. In any case, we think that the use of an oversized device to support the discs on healthy myocardial tissue (as done in our case) is a key factor to reduce residual shunts and prevent possible embolism caused by the device.

In conclusion, postinfarction VSD can be treated with a transcatheter closure procedure. Although surgical intervention is still the treatment of choice for this kind of complication, the transcatheter approach could be considered an alternative in high-risk patients.

REFERENCES