Thrombosis of a Mechanical Tricuspid Valve Prosthesis Resolved With Fibrinolysis

**Trombosis de prótesis tricuspidea mecánica resuelta con fibrinólisis**

To the Editor,

Implantation of a mechanical prosthesis in the tricuspid position is uncommon because most of the patients with disease in this valve choose to undergo repair consisting of annuloplasty. When mechanical prostheses are implanted in the tricuspid position, the risk of thrombosis is greater than that associated with these devices in left chambers, as the flow is slower in the right chambers and the pressure is lower. Currently, there is little literature on prosthetic tricuspid valve thrombosis and its treatment.

We report the case of a 52-year-old woman, with congenital atroventricular block, who had undergone implantation of a dual-chamber pacemaker in 1986 and developed a pressure ulcer that required deepening of the pocket in 1989. Lead dysfunction occurred in 1996, and a new system was implanted, but the leads from the previous system were not withdrawn. In March 2013, she was diagnosed with severe tricuspid stenosis due to leaflet fibrosis, secondary to the leads that passed through the valve, and a 27-mm St. Jude Masters double-disc mechanical prosthesis was implanted. During the follow-up period, while asymptomatic, she reported that she no longer could hear the sounds of the prosthesis, and auscultation detected an increase in the intensity of the murmur during tricuspid filling. Doppler ultrasound revealed an increase in the atrioregional pressure gradient across the tricuspid valve, and 3-dimensional transesophageal echocardiography demonstrated the immobility of one of the leaflets produced by a

(Reference)

**REFERENCES**


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thrombus (Figure 1). At that time, she was being treated with warfarin to maintain the International Normalized Ratio (INR) between 2.5 and 3.5. Nevertheless, her medical records show suboptimal anticoagulation levels weeks before the follow-up visit (INR 2.0-2.2).

The patient was admitted to the hospital and enoxaparin was added to the warfarin, at a dose of 1 mg/kg body weight/12 hours for 8 days. After this period, 3-dimensional transesophageal echocardiography was repeated and no changes were observed. Due to the risk of thrombus progression and its hemodynamic consequences, the decision was made to apply fibrinolysis, discontinue warfarin administration, and maintain enoxaparin. Once the INR was within normal range, 100 mg of tissue plasminogen activator was infused over 3 hours, with electrocardiographic monitoring and control of blood pressure and oxygen saturation; there were no complications.

Normalization of the atrioventricular gradient was subsequently verified by Doppler ultrasound, and a 3-dimensional transesophageal echocardiogram confirmed the disappearance of the thrombus and the mobility of the 2 discs (Figure 2). At the time of discharge, she was asymptomatic.

Currently, little available scientific evidence regarding the most effective treatment for prosthetic tricuspid valve thrombosis is based only on case series and expert recommendations. The resolution of tricuspid valve thrombosis achieved by intensifying anticoagulation therapy or adding low-molecular-weight heparin has been reported, but the level of evidence is low because of the lack of randomized studies.

A recent review of 9 studies, which included 48 patients with prosthetic tricuspid valve thrombosis who received fibrinolytic therapy, demonstrated a success rate of 88%, partial success in 1 patient, and no effectiveness in 4, who underwent surgical replacement of the prosthetic valve.

The administration of fibrinolytic therapy has been accepted as the treatment of choice for prosthetic tricuspid valve thrombosis in the latest guidelines on valve disease. It carries a IIa recommendation and level of evidence of B, based on nonrandomized studies and on retrospective cohort studies. No systemic embolisms were documented, although small subclinical pulmonary emboli were observed, and surgery was reserved for those cases in which fibrinolysis had been unsuccessful.

There is no specific recommendation as to which is the fibrinolytic agent of choice, and the options include streptokinase, tenecteplase, urokinase, and recombinant tissue plasminogen activator; the latter is most widely used.

Transesophageal echocardiography is the technique of choice for the confirmation of both the presence of a thrombus and its resolution, but there are no data concerning the utility of 3-dimensional echocardiography. In the case described here, the 3-dimensional echocardiographic images clearly showed both the presence and the resolution of the thrombus (video of the supplementary material).

Recurrences have been reported in nearly a third of the cases. Given the close relationship between tricuspid prosthetic valve thrombosis and suboptimal anticoagulation, it has been recommended that the INR be maintained between 3 and 4 and that...
acetylsalicylic acid or clopidogrel be included in the oral anti-coagulation therapy.6

SUPPLEMENTARY MATERIAL

Supplementary material associated with this article can be found in the online version available at doi:10.1016/j.rec.2014.07.018.

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Coronary Angioplasty With Catheter Extension Following Transcatheter Aortic Valve Implantation

Angioplastia coronaria con extensión de catéter tras implante transcathéter de prótesis aórtica

To the Editor,

Transcatheter aortic valve implantation has experienced exponential growth in recent years.7 Aortic stenosis is frequently associated with coronary artery disease,8 and the performance of a coronary angiogram prior to implantation is indispensable. The need for preimplantation angioplasty is a matter of debate.9 In any case, given the increase in the rate of successful implantation and in the survival of these patients, it is becoming more common to treat patients with coronary artery disease who have received these prostheses.

The CoreValve® self-expanding prosthesis (Medtronic) is designed for placement above and below the origin of the coronary arteries. The purpose of this design is to ensure the patency of the coronary ostia. Its configuration in open cells theoretically allows intubation of the coronary arteries after implantation. On occasion, intubation of the coronary arteries can be difficult, since the imaging techniques usually employed do not have sufficient temporal and spatial resolution to determine the position of the cells with respect to the origin of the coronary arteries.

We present the case of a 75-year-old man who underwent implantation of a 26-mm CoreValve® prosthesis to treat symptomatic severe aortic stenosis and was at high surgical risk. Coronary angiography performed prior to implantation revealed no evidence of angiographically significant stenosis (Figure 1). Two years after implantation, the patient was admitted to the hospital with non-ST segment elevation acute coronary syndrome. Coronary angiography revealed 90% stenosis in the proximal circumflex artery (Figure 1), and the decision was made to perform angioplasty.

Left coronary artery was nonselectively intubated from a right radial approach through the cells of the prosthesis using a 4.0 Fr EBU guiding catheter, after attempting intubation unsuccessfully

Figure 1. A: Coronary angiography prior to transcatheter aortic valve implantation. B and C: Angiographically significant stenosis in proximal circumflex artery.

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