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Stroke prevention with percutaneous left atrial appendage transcatheter occlusion in a patient after AV and MV replacement with persistent left atrial tachycardia, who underwent two RF ablations of accessory pathway and typical atrial flutter.



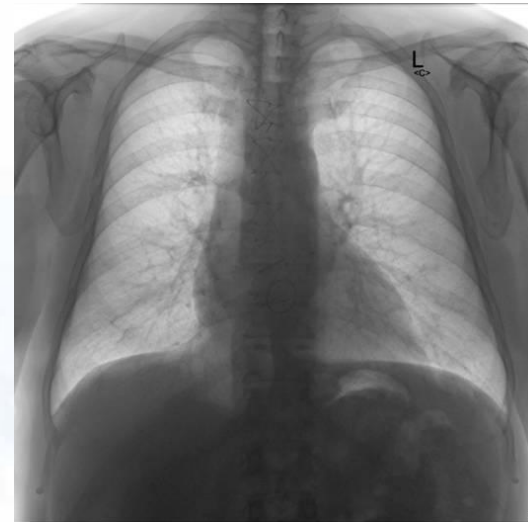
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A 67-year-old patient with persistent left atrial tachycardia was admitted to our hospital because of palpitations, which were accompanied by shortness of breath, weakness, chest pain and dizziness, and lasted about a week.

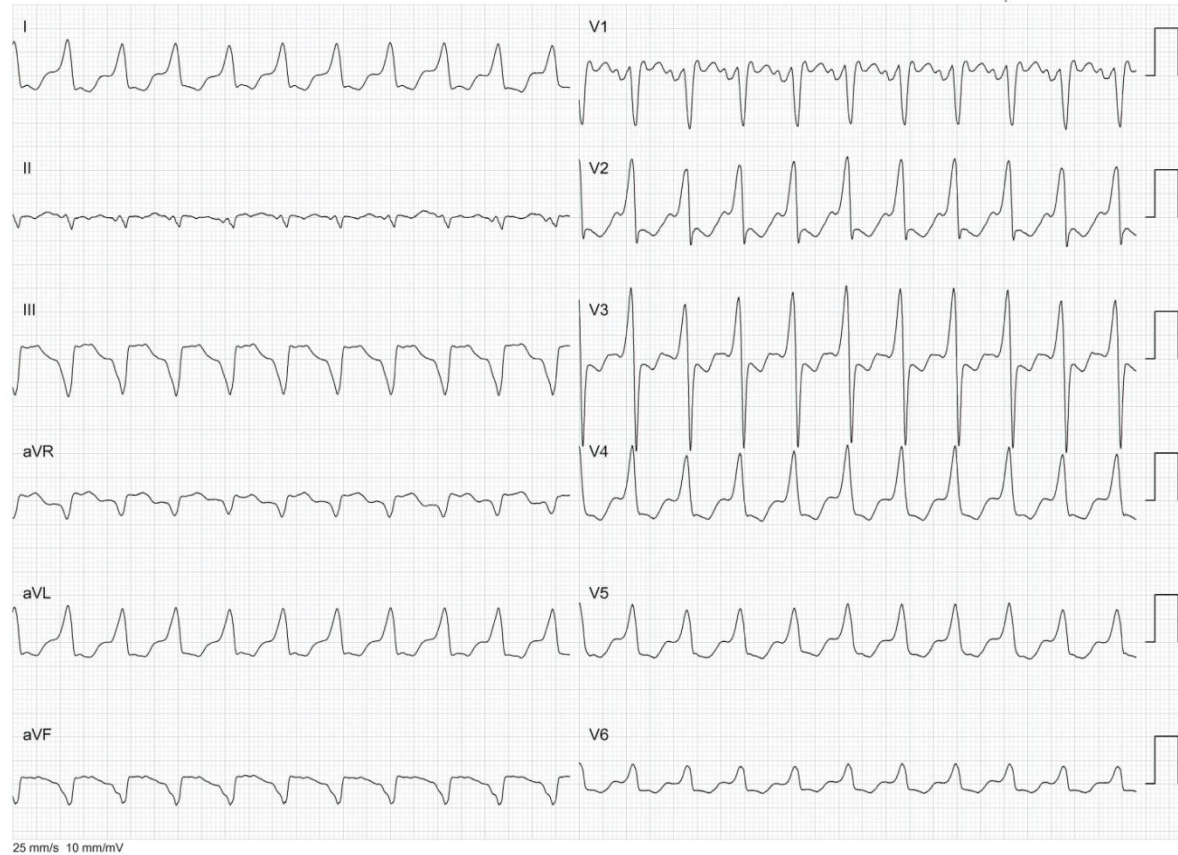
The medical history of the patient:

- **AVR** with 19 mm SJM, and **MVR** with 25 mm SJM (26.03.2006)
- Persistent atrial fibrillation / left atrial tachycardia since 2012
- **WPW syndrome** – two radiofrequency **ablations of accessory pathway** (right septal pathway - 10.2005, 12.2005),
- Two sessions of typical (cavotricuspid isthmus dependent) **atrial flutter ablation** - 27.04.2009r, 2011r),
- Hypertension
- Diabetes
- Dyslipidemia

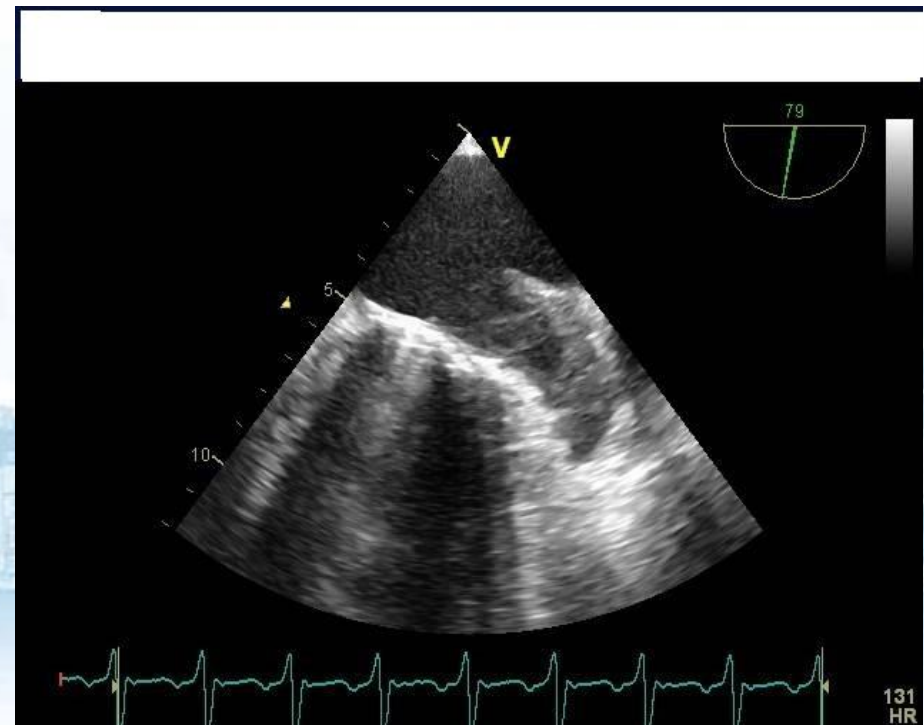
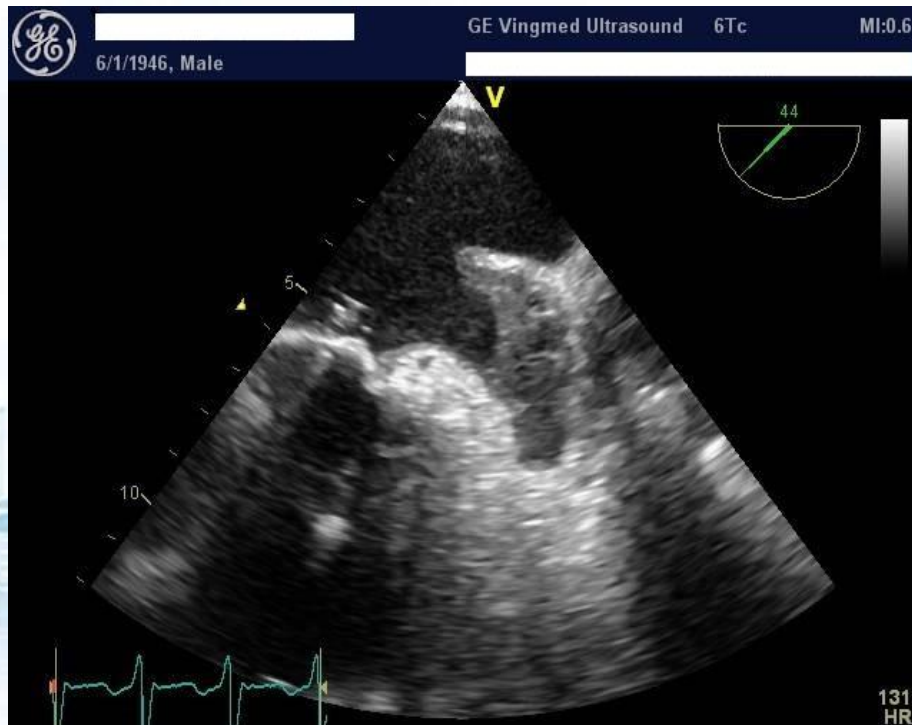


The ECG revealed tachycardia with a wide QRS complex which suggested recurrence of the accessory pathway that in the patient with the atrial fibrillation or the left atrial tachycardia can be life threatening.

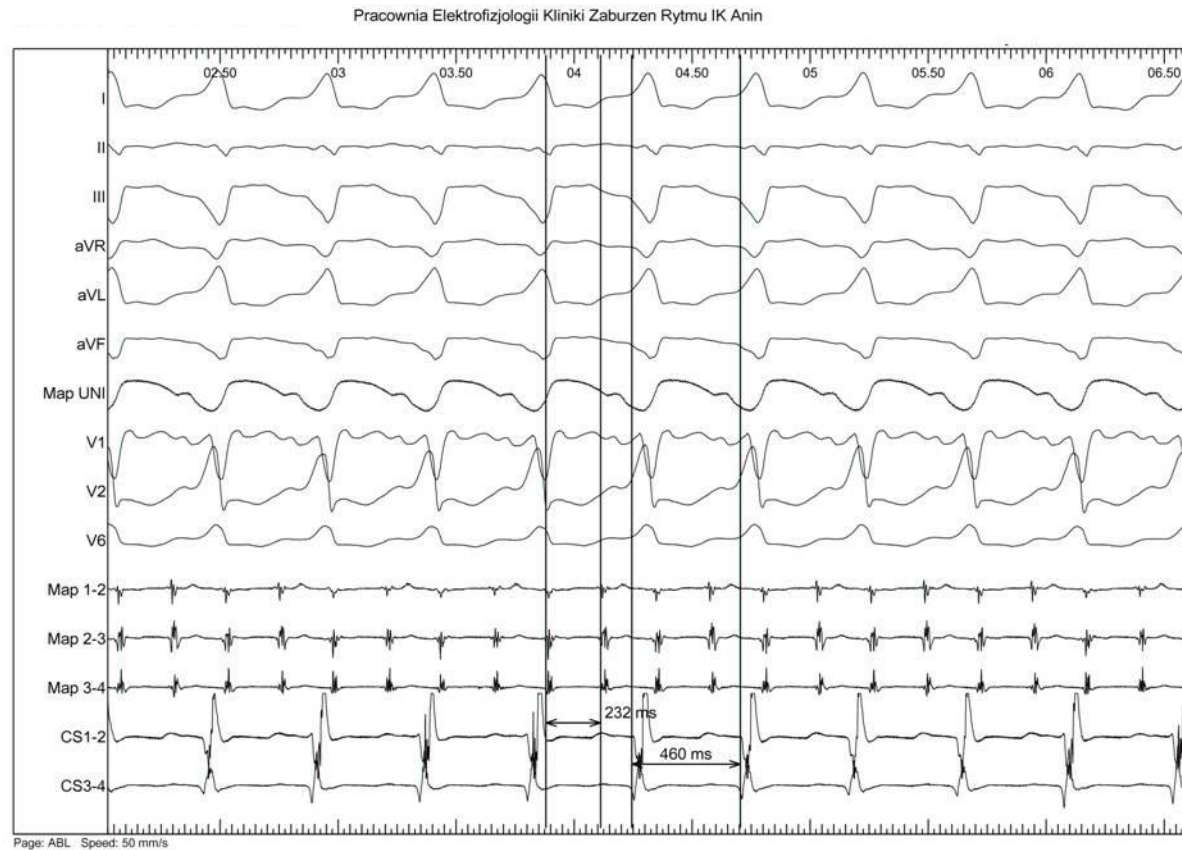
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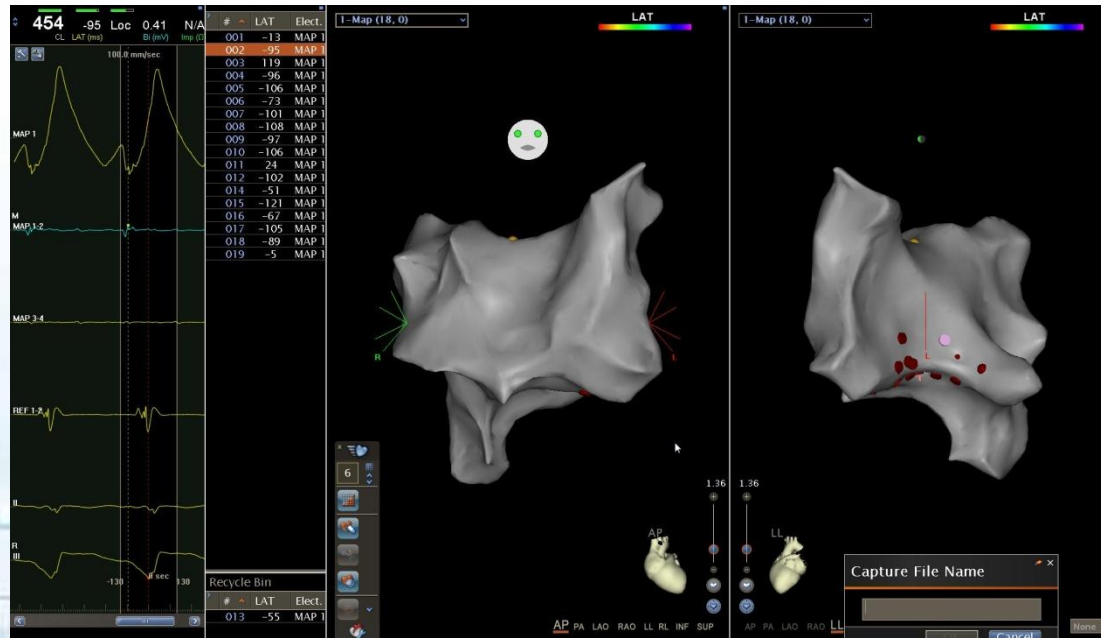
The transesophageal echo revealed a thrombus in the left atrial appendage
in spite of the frequent measurement and therapeutic INR value
(2,5-3,5).



The patient had an electrophysiological study which confirmed the presence of left atrial tachycardia conducted by the accessory pathway.

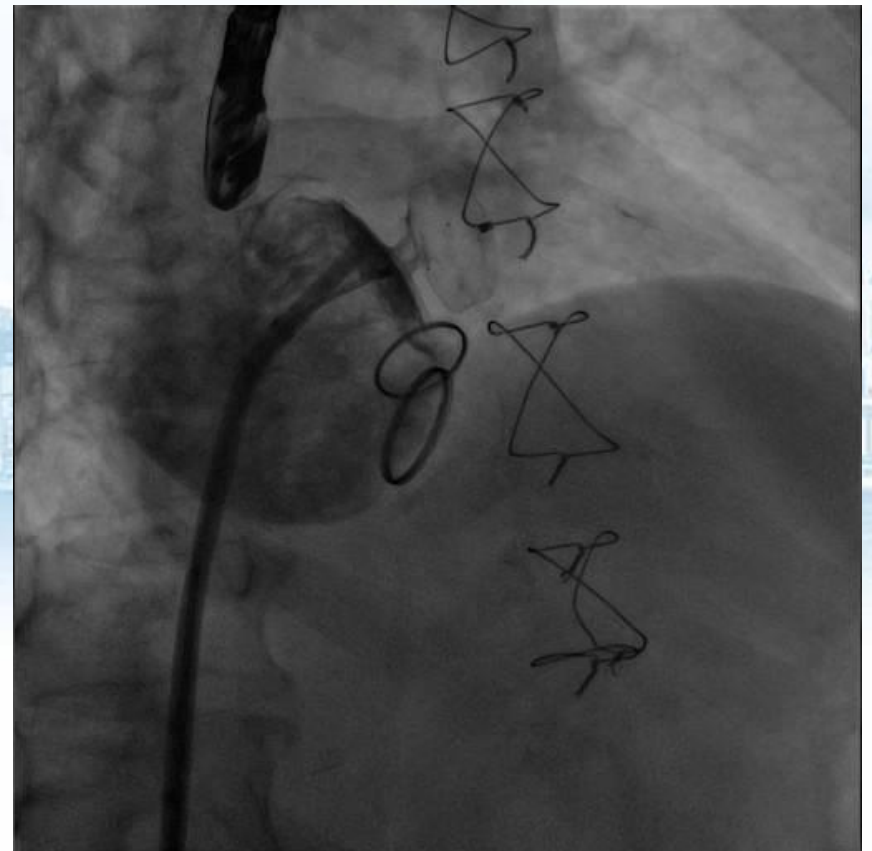
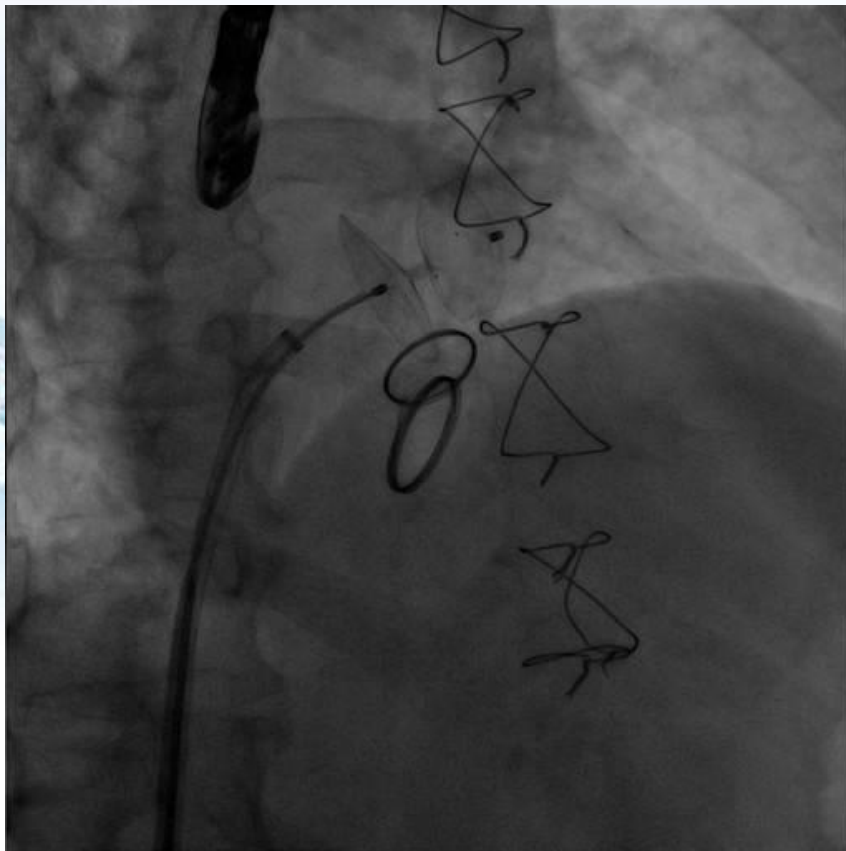


The radiofrequency ablation of the *right posteroseptal accessory pathway* was made using the 3D electro-anatomical mapping system (Carto).



The thrombus had dissolved six months after we intensified anticoagulation (low-molecular-weight heparin plus warfarin). Because of the high risk of thromboembolic events the patient was qualified for the transcatheter closure of the left atrial appendage with the Amplatzer Cardiac Plug.

24th of June 2014 a 28mm left atrial appendage occluder was implanted.



Six weeks after the implantation of the occluder we confirmed its correct position in the left atrium without any signs of the leakage, and we made a successful electrical cardioversion.

