Abstract: P473

Our experience with successfully use of a percutaneous Impella 5.0 device as a bridge to recovery in fulminant lymphotic myocarditis

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Several fulminant myocarditis (FM) resulting in early death from intractable cardiogenic shock have been reported. Nevertheless complete recovery can ensue if the patient is successfully supported during the acute phase of the illness
We report a patient with acute FM and cardiogenic shock, successfully bridged to recovery with percutaneous Impella. A 19 year-old with prior asthma bronchiale had acute onset of symptoms resulting in rapid life threatening cardiogenic shock. Delay between onset of symptoms and cardiogenic shock was 3 days. The patient required rapidly increasing inotropic support (norepinephrine 0.3ug/kg/min +levosimedian). EKG showed sinus rhythm with third-degree atrioventricular block, which was indicated for pacing. Echocardiogram showed severe biventricular hypokinesis, normal valvular anatomy, without significant pericardial effusion. The patient had coronaryography, which showed no coronary arteries disease. Due to signs of right ventriculare failure and multiorgan failure venoarterial extracorporeal membrane oxygenation (V-A ECMO ) implantation was perfomed. Endomyocardial biopsy proved diffuse lymphocytic myocarditis. Bacteriologic and viral examination was negative. Imunosupresive therapy ( intravenous immunoglobulin) and corticoid therapy was administrated. Next day she developed hemodynamically unstable ventricular tachycardia. The patients status progressively deterioted and percutaneous Impella 5.0 implantation was perfomed. Duration of Impella support was 6 days and duration of VA-ECMO was 11 days.
20th day control rest echocardiography proved normal systolic function of both ventricular.
Use of the Impella 5.0 seems to be safe and effective treatment of cardiogenic shock secondary to lymphotic myocarditis.