Abstract: **P600**

**A rupture of cardiac pseudoaneurysm - Devastating complication**

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**Background/Introduction**

Left ventricular (LV) pseudoaneurysm is usually associated with myocardial infarction and rupture of ventricular wall. The clinical presentation of these patients is non-specific, making the diagnosis challenging. It needs to be differentiated from a true aneurysm by the fact that there is lack of myocardial tissue in the wall of a pseudoaneurysm. There are no treatment guidelines considering the exact time of the surgery, which may be complicated due to the necrosis of the myocardium as well as risk of thromboembolic events prevention.

**Case presentation**

A 42-year-old previously healthy male presented to emergency department with abdominal pain for 7 days before hospitalization. In addition, he reported an attack of acute chest pain that lasted = 24 hours 3 weeks ago. Upon examination, the patient had stable vital signs (heart rate 65/min, blood pressure 130/70mmHg), no murmurs, crackles bilateral over lower lung field.

**Confirmation of diagnosis**

An electrocardiogram showed deep Q waves and 2 mm ST elevation with biphasic T wave in V1-V4. His white blood cell count: 8.71 x 10⁹/L, hemoglobin: 143 g/L, troponin I: 12.8 ng/mL, BNP: 308.9 ng/L. Transthoracic echocardiogram revealed a poor LV systolic function due to an akinetic anterior wall, dyskinetic apex containing a thrombus (19 x 12 mm) and massive pericardial effusion with signs of right ventricle compression. The acute abdominal pathology was excluded, hepatomegaly was confirmed by ultrasound.

**Procedures**

Aspirin, clopidogrel, ramipril, metoprolol, atorvastatin, spironolactone, intravenous furosemide were initiated. The patient refused for angiographic investigations. The Heart Team decided to proceed to surgery in order to graft the left coronary artery in addition to pseudoaneurysm repair after a few days. We discontinued clopidogrel before the surgery and added low molecular weight heparin to the treatment. Patient was stable and TTE was performed daily. Unfortuantelly, on the 7th day the patient collapsed due to cardiac arrest. During the cardiopulmonary resuscitation, pericardiocentesis was performed and 1 liter of the blood was drained. The patient was operated urgently the same day. Intra-operatively a ruptured apical LV pseudoaneurysm was idetified; the rupture was covered with thrombus. Dor’s operation was performed. Postoperative period was without complications, but the patient suffered from post-hypoxic encephalopathy due to the long duration of brain’s hypoperfusion. On the 3 months follow up patient had heart failure symptoms NYHA class I.

**Questions/ problems**

As this condition is lethal, prompt diagnosis and timely treatment is life preserving. This case reveals the dilemma
of anticoagulation prescription in patients with LV pseudoaneurysm against the risk of bleeding or rupture of pseudoaneurysm.