Ventrikulska tahikardija u pacijenta s perzistentnom fibrilacijom atrijsa bez antikoagulantne terapije – terapijski izazovi kroz prikaz slučaja

Ventricular tachycardia in non-anticoagulated patient with persistent atrial fibrillation – therapeutic challenges and case report

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KEYWORDS: ischemic ventricular tachycardia, atrial fibrillation, electrocardioversion, intracardial ultrasound, electrophysiology.

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Uvod: Postoje hitne situacije u svakodnevnoj kardiološkoj praksi kod kojih primjena bazičnih elektrofizioloških manevara rješava problem i to uz veću sigurnost za pacijenta u odnosu na konvencionalne metode liječenja.¹

Prikaz slučaja: Prikazujemo slučaj pacijenta u dobi od 76 godina s anamnezom preboljelog infarkta miokarda prije 10 godina koji se javlja u hitnu službu zbog opresija u prsištu unatrag 3 sata. U podlozi je postojana ventrikulska tahikardija frekvencije 140/min. Pacijent aritmiju relativno dobro tolerira te osim blažih opresija u prsištu nema znakova hemodinamske nestabilnosti. Iz dostupne medicinske dokumentacije saznaje se da zadnjih 5 godina ima perzistentnu fibrilaciju atrijsa a preporučenu antikoagulantnu terapiju ne uzima (CHA2DS2-VASc = 4). Ehokardiografski se opisuje hipokinezija bazalnog segmenta posteriorne stijenke s relativno dobrom sistoličkom funkcijom ostalih segmenta (LVEF oko 45%). Medikamentna konverzija amiodaronom nije uspjela, a pacijent i nakon 10 sati trajanja aritmije ne pokazuje znakove hemodinamske nestabilnosti. Planirana je sinkronizirana elektrokardioverzija u općoj anesteziji, no uz veliku vjerojatnost konverzije atrijsa u sinusni ritam, a time i rizika za tromboembolijski incident u slučaju prisutnosti tromba u aurikuli lijevog atrijsa (LAA). Zbog toga smo se odlučili za drugačiji pristup te je pacijent premješten u elektrofiziološku salu. Nakon postavljanja sonde za intrakardijalni ultrazvuk u desni atrij prikazuje se LAA istamponirana trombotskom masom. U nastavku procedure postavi se dijagnostički elektrofiziološki kateter u desni ventrikul (RVA) te se kratkim overdrive-om prekine ventrikulska tahikardija, a pacijent ostaje u fibrilaciji atrijsa s urednom frekvencijom ventrikula i bez tegoba.

Zaključak: Ostaje dilema o daljnjem postupku s pacijentom – trajna antikoagulantna terapija, ugrađeni kardioverter defibrilator (ICD) da ili ne, radiofrekventna ablacija uz potporu sustava za elektroanatomski mapping (uz ili bez implantacije ICD-a), samo medikamentna terapija?

Introduction: There are emergency situations in everyday cardiology practice that can be easily solved with basic electrophysiological maneuvers and with greater safety for the patient compared to conventional treatment methods.¹

Case report: We report a case of a 76-year-old patient with a history of myocardial infarction 10 years ago, now presenting to Emergency Department with mild chest pain during last 3 hours, caused by sustained ventricular tachycardia with frequency of 140 bpm. Beside mild chest pain the arrhythmia was well tolerated, without signs of hemodynamic instability. From the available medical history there was information about persistent atrial fibrillation for the past 5 years and it was recommended anticoagulant therapy which he did not take (CHA2DS2-VASc = 4). Last echocardiographic report described hypokinetic basal segment of posterior wall of left ventricle with a relatively preserved LVEF of 45%. Pharmacological conversion with amiodarone was attempted but with no success, and even after 10 hours of ongoing arrhythmia a patient showed no signs of hemodynamic instability. A synchronized electrocardioversion under general anesthesia was planned but with high probability of atrial conversion as well and thus the risk for thromboembolic incident in the case of the presence of thrombus in the left atrial appendage (LAA). Therefore, we decided to try another approach and the patient was transferred to the EP lab. After placing the intracardial ultrasound probe in the right atrium, an LAA with thrombotic masses was showed. A standard diagnostic electrophysiological catheter was placed in right ventricle (RVA) and ventricular tachycardia was terminated with simple overdrive pacing and the patient remained in atrial fibrillation with normal ventricle frequency and without problems.

Conclusion: There is remaining dilemma regarding further treatment of this patient like permanent anticoagulant therapy, implantation of an implantable cardioverter-defibrillator or just radiofrequency ablation without implantation of device, only medication therapy?

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