Percutaneous Left Atrial Appendage Closure with WATCHMAN™ Device.

Patient Case

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With the courtesy of:
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PATIENT HISTORY

Male, 77-years old. Cardiovascular risk factors: hypertension, prior smoker, ex drinker, previous TIA. Cardiovascular History: Wolff-Parkinson-White Syndrome treated with surgical ablation in 1981. Permanent Atrial Fibrillation. Last Electrocardiogram (2010): Moderate left and right atrial dilatation; moderate aortic root dilatation of 40 mm. Double mild aortic lesions. Mild mitral insufficiency. Moderate tricuspid insufficiency. Pulmonary hypertension (PAP 53 mmHg). Both ventricles with adequate size and condition. Medication: Enalapril 20 mg /24h; Eprosartan 600 /HCTZ 12.5 mg/24h; Furosemide 40 mg/24h; Acenocumarol 3 mg/24.

Pulmonary Hypertension

LATEST MEDICAL HISTORY

First hospitalization: Patient arrived at Emergency care after episodes of vomiting and immediate loss of consciousness lasting up to 5 minutes (4 episodes), without any posterior neurologic deficit or sphincter relaxation. No infectious or cardiovascular symptoms were referred. After the physical examination, a cranial CT scan showed bilateral subdural hematomas, with 17mm maximum width on the left side. Treatment: hospitalization and observation, waiting for the appropriate moment to undergo a neurological surgery. Further CTs done at 24 and 96 hours showed further bleedings. At the fifth day, as the patient developed hemiparesis, he underwent trepanation.

DECISION MAKING, LAAC INDICATION

After a meeting with the urology team, taking into account the permanent atrial fibrillation, the high risk of stroke (CHA2DS2-VASc = 5) and significant risk of bleeding (HAS-BLED = 6), the closure of the left atrial appendage (LAAC) was agreed. Plus, this patient, having had several intracranial bleeds, was at an even greater risk of the known complications of anticoagulants. LAAC was therefore felt to be a great solution. It was decided to do it before the renal surgery and to shorten the post procedure double antiplatelet therapy (DAPT) to 3 to 4 months.

LAAC

Preliminary echocardiogram: the transesophageal echocardiogram (TEE) showed an appropriate anatomy and size, and confirmed the absence of thrombus in the LAA.

PROCEDURE

LAAC was performed under general anesthesia and with the support and guidance of TEE.

FOLLOW-UP

The patient was discharged the 4th day after the implant under double antiplatelet therapy with Clopidogrel 75 mg/24 h plus Aspirin 100 mg/24h. At 45 days, the device was in good position, with neither per-device leak nor thrombus as demonstrated by trans-esophageal echocardiography. Bearing in mind that the patient had to undergo non-cardiac surgery as soon as possible, the Clopidogrel was stopped at 4 months and the patient was left with Aspirin only. Patient underwent surgery to remove the renal mass successfully - the mass was diagnosed to be a clear cell renal carcinoma. 6 months after the implant, the device showed no changes in the follow up TEE.

COMMENT

The case represents the paradigm of the LAAC indication, as it was a patient with both a high risk of stroke (CHA2DS2-VASc = 5), and a significant risk of bleeding (HAS-BLED = 6), having had gastrointestinal and intracranial bleeding. Furthermore, there was a high risk of future intracranial bleeding in the event anticoagulants were to be used. This patient had the additional challenge of needing renal surgery. WATCHMAN™ Device implantation was felt to be the best solution and it was performed with a 4 month period of post implant double antiplatelet therapy, which was not related to any complications.