



**ABC Cardiol**  
Arquivos Brasileiros de Cardiologia

**Abstracts**

Volume	Number	Supplement
119	4	1
October 2022		

Sociedade Brasileira de Cardiologia  
ISSN-0066-782X

## ABSTRACTS PRESENTED AT



**77° CONGRESSO BRASILEIRO  
DE CARDIOLOGIA**

together with

**WORLD CONGRESS OF CARDIOLOGY**

Rio de Janeiro - Brazil

**OCTOBER 13 TO 15, 2022**

## 111236

**MODALITY: E-POSTER YOUNG RESEARCHER - CASE REPORT**  
**CATEGORY: COVID-19 AND CARDIOVASCULAR SYSTEM**

**TITLE: AORTIC-RIGHT ATRIUM FISTULA AND PULMONARY TROMBOEMBOLISM AFTER COVID-19 INFECTION: CASE-REPORT**

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**Introduction:** Several cardiac complications have been described after the beginning of pandemic Covid-19, such as myocardial ischemia, acute cardiac heart failure, arrhythmia and myocarditis. **Case description:** M.J.F.S., female, 43 years old, denied any chronic disease or use of medication, admitted to the ward of a high complexity hospital presenting cardiac heart failure (NYHA IV) and oedema in the lower limbs. The patient had Covid-19 infection two months before and presented a normal routine transthoracic echocardiography (TT-ECHO). After the admission, a new TT-ECHO presented global dilatation of cardiac chambers, specially left atrium (LA) and signs of coronary sinus of valsalva rupture and Aortic-Right Atrium (Ao-RA) fistula. These findings were confirmed in a transesophageal echocardiography, that presented left ventricle ejection fraction of 69%, rupture of sinus of valsalva aneurysm at aortic root promoting shunt from aorta to right atrium and cardiac chambers dilatation. Thoracic angiogram described bigger dimensions of the right atrium and signs of pulmonary thromboembolism. Therapeutic decision included surgical correction of Ao-RA fistula, which occurred with complication of complete heart block requiring transitory pacemaker and cardiac arrest successfully reverted to systemic circulation. Definitive cardiac pacemaker was implanted and the patient was discharged in a stable clinical situation after 59 days of hospital stay. **Conclusion:** The clinical report presents rupture of sinus of valsalva aneurysm leading to Ao-RA fistula and pulmonary thromboembolism two months after Covid-19 infection. As a consequence, the authors suggest linkage between Covid-19 and thrombogenic state and inflammatory process leading to endomyocardial inflammation.

## 111245

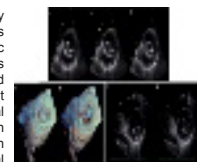
**MODALITY: E-POSTER YOUNG RESEARCHER - CASE REPORT**  
**CATEGORY: PERICARDIUM/ ENDOCARDIUM/ VALVOPATHIES**

**TITLE: THROMBOLYSIS IN BIOLOGICAL MITRAL VALVE ON A PATIENT WITH HIGH SURGICAL RISK**

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**Introduction:** Prosthetic valve thrombosis is a rare and highly lethal complication, more frequently found in mechanical valves and in the mitral position. The treatment involves systemic anticoagulation and valve replacement surgery. Thrombolysis appears as a second option, due to its complication rates and low efficacy. **Case Report:** A 65-year-old man who underwent mitral bioprosthesis implantation for severe secondary mitral regurgitation returns after 3 months with dyspnea and, on transthoracic echocardiography (TTE), prosthesis dysfunction due to thrombosis (Image 1: A-C). There was also a global dilation and left ventricular systolic dysfunction (ejection fraction of 17%). Due to a prohibitive surgical risk (EUROSCORE 34%), alteplase 25mg was administered for 6 hours followed by full anticoagulation with intravenous unfractionated heparin. TTE 24 hours post thrombolysis showed thrombus reduction, improvement in valve motion, and a drop in the transvalvular gradient (Image 1: D-E). The same dose of alteplase was repeated after 48 hours, resulting in improvement in dyspnea, and in valve opening and mobility on TTE (Image 1:F-G). There was no bleeding or adverse effect and he was discharged with Warfarin. **Conclusion:** Fibrinolytic therapy for prosthetic biological valve thrombosis remains controversial due to the lack of evidence of its benefit and safety. Hence, its use has been sporadic and restricted to critically ill patients who are at high surgical risk. The case presented here stands out for the efficacy and safety of fibrinolysis in severe thrombosis in a mitral bioprosthesis. This report deserves consideration as a therapeutic possibility either in clinical research or in similarly unfavorable clinical conditions.



## 111265

**MODALITY: E-POSTER YOUNG RESEARCHER - CASE REPORT**  
**CATEGORY: CARDIOLOGY OF SPORTS, EXERCISE, ERGOMETRY AND CARDIOVASCULAR REHABILITATION**

**TITLE: MECHANICAL VENTRICULAR ASSISTANCE DEVICES: A CASE REPORT**

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**INTRODUCTION:** Heart Failure is the final pathway for heart diseases. Considering limiting situations such as lack of donors and contraindications to the Heart Transplant (HTx) new strategies are needed. Mechanical Ventricular Assistance Devices allow patients to be able to perform physical exercises in Cardiac Rehabilitation. **DESCRIPTION OF CASES:** Case 1: FPB, male, 54 years old, ischemic etiology, Ejection Fraction 32%, HTx contraindicated due to immunological hypersensitivity. After HeartMate II, had reduced respiratory muscle strength - RMS (PIMax: 18 / PeMax: 37) and cardiorespiratory fitness - CRF (distance in six meters walking test: 261m). Preserved peripheral muscle strength - PMS (28KgF) and no self-care limitations (SCL). Case 2: JSP, female, 50 years old, chagasic etiology, Ejection Fraction 16%, HTx contraindicated due to immunological hypersensitivity. After HeartMate II, had reduced RMS (PIMax: 34 / PeMax: 46) and CRF (383m). Preserved PMS (18KgF). After hospital discharge showed improvement in CRF (429m). Case 3: MHPD, female, 61 years old, Dilated Cardiomyopathy etiology, worsened after chemotherapy, Ejection Fraction 13%, HTx contraindicated due to pulmonary hypertension. After HeartMate III, had reductions in RMS (PIMax: 50 / PeMax: 56), PMS (17KgF), CRF (273m) and SCL (Katz: 2). Case 4: LBF, female, 63 years old, Dilated Cardiomyopathy etiology, Ejection Fraction 16%, HTx contraindicated due to pulmonary hypertension. After HeartMate II, had SCL (Katz: 2) and present reductions in RMS (PIMax: 75 / PeMax: 109), PMS (28KgF) and CRF (390m). Case 5: AAV, male, 61 years old, Dilated and non-ischemic etiology, Ejection Fraction 20%. After HeartMate II, had some complications (driveline infection, massive pleural effusion, multifactorial anemia) and prolonged stay (154 days). At hospital discharge, he could walk more than 30m, but failed to perform the walking test; SCL (Katz: 3); adequate PMS (25kgF). **CONCLUSION:** Hospital Cardiac Rehabilitation was performed with aerobic, respiratory/peripheral strength and balance training. All patients had reductions in RMS and PMS. Two of them had functional SCL and two of them had low exercise tolerance (<300m). These patients' CRF may be reduced, due to low adaptive capacity to increase cardiac output during physical exercise. Potentially reversible extracardiac factors such as muscle atrophy and deconditioning seem to improve patients' functionality.

## 111274

**MODALITY: E-POSTER YOUNG RESEARCHER - CASE REPORT**  
**CATEGORY: ACUTE AND CHRONIC CORONARY DISEASE/ THROMBOLYSIS**

**TITLE: CORONARY ECTASIA AS A CAUSE OF ACUTE MYOCARDIAL INFARCTION**

ISMAR JUNIOR PEINADO LIJERON<sup>1</sup>, LARISSA KALINE SANTANA DINIZ<sup>1</sup>, MARINA ALBANEZ ALBUQUERQUE DE MEDEIROS<sup>1</sup>, SORAIA RACHID YOUSSEF DE CAMPOS<sup>1</sup>, VALERIA MOZETIC DE BARROS<sup>1</sup>

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**INTRODUCTION:** Aneurysmal dilatation of the coronary arteries is found in up to 5% of the patients undergoing coronary angiography, with higher incidence in men and proximal segments of the coronary artery. The right coronary artery (RCA) is more affected (40%), followed by the left Anterior Descending (AD) (32%). Atherosclerosis, vasculitis, genetic susceptibility and post infection are reported as possible etiologies. The presence of coronary aneurysm or ectasia has been associated with a worse long-term prognosis. **CASE DESCRIPTION:** Female, 48 years old, with no previous diseases, presented with an unprecedented typical chest pain after performing moderate physical exertion. On the electrocardiogram it was observed sinus rhythm with electrically inactive area in the inferior wall and positive troponin. Performed coronary angiography that showed important ectasia of RCA, AD with mild ectasia in the proximal third and other arteries with discrete parietal irregularities. Echocardiogram shows akinesia of the inferolateral wall and of the middle and basal segments of the inferior wall and ejection fraction 58%. The angiogram of coronary arteries confirmed ectasia of RCA, measuring in its largest diameters 10.8x10.4mm and thrombosis in the distal third. Started anticoagulation with warfarin and clopidogrel together with antianginal drugs and after treatment she got angina improvement and had no new thromboembolic events. **CONCLUSION:** Aneurysmal dilatation of the coronary vessels is an unusual. Antiplatelets and anticoagulation are the most addressed therapy, but there are possibilities of performing percutaneous coronary intervention or surgical resection. The treatment is still controversial, requiring more randomized studies to define the best and safest treatment strategy.

