Emergency ("Bailout") balloon aortic valvuloplasty following diagnostic cardiac catheterisation in a patient with severe valvular aortic stenosis and severe coronary artery disease.

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INTRODUCTION
Calcific aortic stenosis remains the most prevalent form of valvular heart disease in the western world and is the most common indication for valve replacement surgery. Once a patient develops symptoms, the prognosis without surgery is poor, with an expected life expectancy of less than three years. The most widely performed treatment, and that with the best evidence base, remains surgical aortic valve replacement (AVR). Percutaneous treatment options include balloon aortic valvuloplasty (BAV) and, more recently, transcatheter aortic valve implantation (TAVI). BAV fell out of favour after studies in the 1980s and 1990s suggested no difference in actual survival between BAV and medically managed patients. We report a rare case of unplanned emergency ("bailout") BAV that was necessary to reverse acute haemodynamic compromise in a patient with severe aortic stenosis and coronary artery disease undergoing diagnostic cardiac catheterisation.

CASE REPORT
Our patient is a 79 year old man who presented in 2008 with exertion related chest pain. He had an impressive ejection systolic murmur on cardiac auscultation. Transthoracic echocardiography (TTE) revealed severe calcific aortic stenosis, with a peak pressure gradient of 130mmHg, mean gradient 67mmHg and a calculated aortic valve area of just 0.44cm². He was therefore referred for diagnostic coronary angiography prior to referral for urgent surgical AVR.

At cardiac catheterisation, he was found to have occlusions of both the dominant right coronary and circumflex coronary arteries as well as severe stenosis in the left anterior descending (LAD) coronary artery. Immediately following the completion of the procedure, he developed haemodynamic embarrassment with marked ST segment depression on resting electrocardiography (ECG). This did not settle with initial medical therapy and the decision was made to return to the cath lab for urgent revascularisation. Two Driver bare metal stents (Medtronic, Santa Rosa, California) were inserted into the proximal LAD coronary artery, extending back into the distal left main stem artery, with an excellent angiographic result.

Unfortunately the haemodynamic compromise did not resolve, even after an intra-aortic balloon pump (IABP) was inserted. Arterial blood gases at this time revealed a partial pressure of oxygen (PO₂) of just 5.3kPa. As the left coronary
Outflow tract obstruction (LVOTO) – in this case valvar left main stem stenosis is present. If severe left ventricular patients with severe coronary artery disease, especially if a catheterisation can induce haemodynamic deterioration in concomitant severe coronary artery disease. Cardiac

The difference in our patient was the presence of who were undergoing diagnostic cardiac catheterisation for emergency BAV to reverse acute haemodynamic situation and arterial blood gases improved dramatically following BAV. The patient was subsequently transferred uneventfully to our nearest cardiothoracic centre, where he subsequently underwent bypass graft surgery and bioprothetic AVR without complication and has made a good recovery.

**DISCUSSION**

After its first description in 1986 by Professor Cribier and colleagues, BAV gained widespread popularity across the globe. Although a good short term haemodynamic and clinical improvement was observed, in the long-term high restenosis rates and poor overall survival were also noted. Some authors did also, however, note that BAV may be an appropriate palliative option in those unwilling or unable to undergo surgery.

BAV has previously been employed as an emergency measure to rescue patients presenting in cardiogenic shock secondary to critical aortic stenosis. There is one previous article – a case series of 3 patients – of unplanned emergency BAV to reverse acute haemodynamic deterioration in patients with known severe aortic stenosis who were undergoing diagnostic cardiac catheterisation.

The difference in our patient was the presence of concomitant severe coronary artery disease. Cardiac catheterisation can induce haemodynamic deterioration in patients with severe coronary artery disease, especially if a left main stem stenosis is present. If severe left ventricular outflow tract obstruction (LVOTO) – in this case valvar aortic stenosis – is also present, the deterioration would be even more marked and unless both problems are treated restoration of normal cardiac function would not be expected.

Although some feel that BAV may be re-emerging into the clinical arena, it remains rare for a non-surgical centre to offer this service. Our case highlights an unusual benefit of having a BAV programme on site, since our patient would almost certainly not have survived transfer to the surgical centre without emergency BAV. The case re-emphasises the fact that BAV can occasionally act as an emergency measure to bridge a patient to surgical valve replacement as well as reminding us of the potential dangers of diagnostic cardiac catheterisation in patients with significant aortic stenosis.

**References**

8. Moreno PR, Jang IK, Newell JB, Block PC & Palacios IF. The role of percutaneous balloon aortic valvuloplasty in patients with cardiogenic shock and critical aortic stenosis. J Am Coll Cardiol; 1994; 23(5); 1071-1075
9. Losordo DW, Ramaswamy K, Rosenfeld K & Isner JM. Use of emergency balloon dilation to reverse acute haemodynamic decompensation developing during diagnostic catheterization for aortic stenosis (bailout valvuloplasty). Am J Cardiol; 1989 Feb 1; 63 (5); 388-389
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