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ICD lead migration case report: A lesson to learn

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During this cardiology era, the use of ICD is crucial in reducing the mortality of chronic heart failure with ejection fraction of less than 35% and post cardiac arrest. ICD is indicated for primary prevention of sudden cardiac death in patients with ischemic LV dysfunction of less than 40% EF, NYHA class II or III with optimal medical therapy, have a reasonable survival expectation and good functional status for a year. Although uncommon, ICD therapy comes with a risk of significant and even life-threatening complication of cardiac perforation which usually happens at the time of insertion. The incidence of ICD lead perforation reported between 0.34% and 5.2% according to one study. Literature review has revealed wide variety of presentation ranging from no symptoms to fatal tamponade. All cases in one study share common feature of altered lead parameters which highlights the importance of home monitoring to predict and prevent fatal complications. The right atrium and right ventricular apex are the most frequent sites of perforation. In theory, the lead movement with systole is the culprit. This made the thin and stiff leads more likely to perforate especially if mounted with helical screw. Not surprisingly, perforation through the right ventricular apex is frequently an asymptomatic event. Another explanation is related to lead mobility during patient arms movement (Twiddlers Syndrome) as in our case. What makes our case unusual is the fact that perforation symptoms started three years post ICD implantation and the massive anterior thoraco-abdominal haematoma that finally lead to the diagnosis. Previous loss of lead parameters was preceding the symptoms; therefore, high index of suspicion is required for ICD lead migration in such cases.

Biography

Ahmed A M Abbas is a Cardiothoracic Registrar at Blackpool Teaching Hospital, UK. He has graduated from Babylon University in Iraq and progressed in surgical training in the UK.

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