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个案与短篇

左冠回旋支弥漫性重度瘤样扩张并右房瘘封堵术1例

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[**关键词**] 冠状动脉右房瘘,封堵术
[**中图法分类号**] R543.305 [**文献标志码**] B

1 临床资料

患者,女性,39岁,1月前劳累后出现心悸、胸闷、气促、乏力,在当地医院心脏超声诊断为:先心病、房间隔缺损? 左冠状动脉-静脉瘘? 冠状动脉造影显示左冠状动脉-静脉瘘。为求进一步诊治患者于2007年12月25日来我院诊治。查体:一般情况好,BP 124/72 mmHg, 甲状腺不大,胸肺无异常发现,心率62次/min,心前区闻及3/6级连续性杂音,不伴震颤,P_2增强。肝脾未及,双下肢无浮肿。入院后心脏B超提示为左冠回旋支弥漫性重度瘤样扩张并心大静脉瘘,右房、右室增大。心脏64排CT提示为(图1A):左冠回旋支瘤样扩张并右房(后壁)瘘,瘤样扩张之左回旋支平均宽度约为12 mm,而瘘口宽度为4.0 mm,长度为3.0 mm;右房、右室增大,肺动脉明显扩张(图1A)。为此确诊为:先天性心脏病左冠回旋支弥漫性重度瘤样扩张并右房瘘,右房、右室增大,心脏功能2级,初步判断可以采用动脉导管封堵器封堵瘘口。进一步进行冠状动脉造影显示:左主干及回旋支明显瘤样扩张,回旋支远端狭窄并与右房相连(可见造影剂流入右房),测定瘘口直径为6.0 mm。遂采用室间隔缺损封堵术方式,即将导丝从右股动脉送入进入左冠状动脉回旋支,经回旋支瘘口进入右房、下腔静脉,然后将网篮导管从右股静脉送入下腔静脉抓住导丝并将之拉出右股静脉外建立动静脉轨道,自右股静脉沿导丝将封堵器输送鞘管经瘘口送入左回旋支,推出扩张管,然后导入PDA封堵器(8~10 mm),并在回旋支中释放封堵器伞面,回拉封堵器使其伞面紧贴回旋支面瘘口部,然后释放整个封堵器,回旋支造影见自回旋支向右房的分流完全消失,提示瘘口被完全封堵(图1B),此时心前区杂音消失。术前、术后测压显示主肺动脉压力由40/16(28) mmHg降至23/8(14) mmHg,右室流出道压力由40/10(20) mmHg降至22/6(12) mmHg,右房压力由40/8(11) mmHg降至10/4(6) mmHg,上述提示封堵术成功。术后给予低分子肝素(克赛)0.4 mL皮下注射1/12 h,连续7 d,氯吡格雷(波立维)75 mg/d,连续3个月,拜阿司匹林每次100 mg,每晚1次,持续终身。1个月后复查心脏64排CT见回旋支-右房瘘瘘口处封堵器金属影, 未见对比剂漏入右房,回旋支远端见有少许血栓形成,余同前(图1C)。继续随访至1年,患者一般情况良好,症状消失,心前区未闻及杂音。再次复查冠脉64排CT提示回旋支远端血栓消失,右房、右室明显缩小。

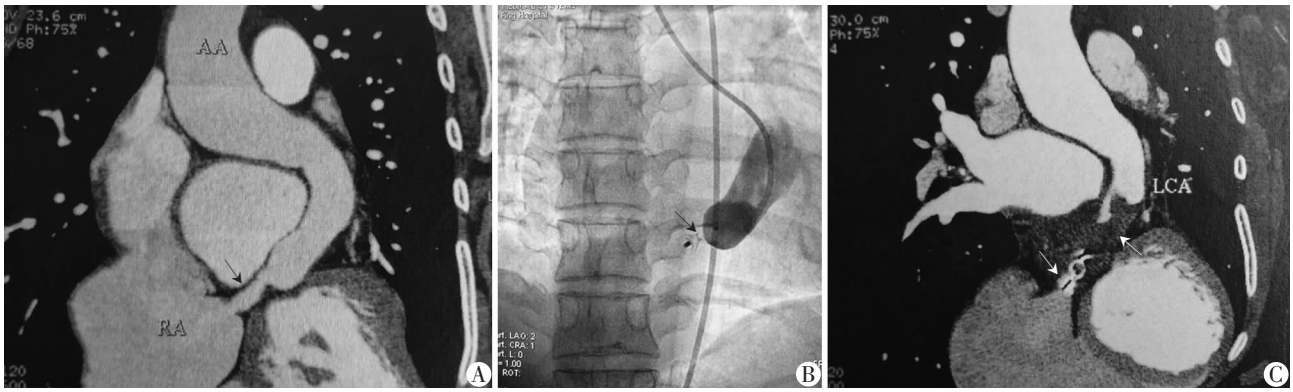
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A:封堵术前心脏64排CT提示左回旋支-右心房瘘(↘:示瘘口); B:封堵术后冠脉造影提示回旋支-右房瘘消失(↘:示封堵器); C:封堵术后1个月心脏64排CT提示回旋支末端少许血栓(↖),封堵器清晰可见(↘)

图1 左冠回旋支-右心房瘘封堵术效果观察

2 讨论

弥漫性重度冠状动脉瘤样扩张是一类少见的疾病[1],而同时合并右房瘘则更为少见。该病的治疗方法可以采用外科手术、弹簧圈封堵或安置封堵器封堵[2-3]。该例病人由于左冠回旋支弥漫性重度瘤样扩张,同时在进入右房时形成一明显较窄瘘口,因此可以采用室间隔缺损封堵术中建立动静脉轨道的方式,分别穿刺股动静脉,经由股动脉→降主动脉→主动脉弓→升主动脉→左冠回旋支→瘘口→右房→下腔静脉→股静脉建立动静脉轨道,然后选用合适的动脉导管封堵器以动脉导管未闭封堵术的手术方式封堵瘘口。之所以不直接采用动脉导管未闭封堵术的方式由股静脉→下腔静脉→右房→瘘口→左回旋支送入封堵器,是因为钢丝要在右房侧通过瘘口并进入左回旋支实属不易,并且容易损伤冠状动脉。由于封堵伞部分位于冠状动脉中,所以术后处理完全按照冠状动脉支架术后的方式进行。术后该患者症状明显减轻,心前区连续性杂音消失,1个月后复查心脏64排CT提示瘘口封闭,虽然回旋支远端有部分血栓形成,但经过1年的临床治疗随访患者一般情况良好,无特殊症状和体征,血栓也已消退。

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