


CR73 Transcatheter Pulmonary Valve-in-Valve Implantation due to Severe Valve Stenosis Following Bioprosthetic Pulmonary Valve Replacement Degeneration

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KEYWORDS: Case Report; Foreign Body; Heart; Heart Valve Prosthesis Implantation

INTRODUCTION/OBJECTIVES: Transcatheter pulmonary valve-in-valve implantation (TPVI) is a rare procedure consisting of the implantation of a new valve inside the degenerated old pulmonary valve (PV). We present a distinctive case of a patient undergoing the procedure, following degeneration of a previously implanted bioprosthetic PV replacement.

CASE PRESENTATION: A 59-year-old male was admitted to the emergency department due to presyncope and dyspnea and signs of right heart failure. Ten years prior to the hospitalization he had undergone several hospitalizations due to sepsis, caused by a sewing needle localized in the right ventricular outflow tract (RVOT) which was a consequence of apparent self-mutilation. The patient had initially refused a surgical removal which resulted in deterioration of clinical state and development of pulmonary valve (PV) endocarditis, requiring cardiac surgery, consisting of needle removal, bioprosthetic PV replacement, and tricuspid valvuloplasty with ring insertion. Following the procedure until this hospitalization, the patient was asymptomatic. Current echocardiography showed advanced degenerative changes of the bioprosthetic PV, with consequent severe pulmonary stenosis and regurgitation (pulmonic valve peak velocity 3,97 m/s, pulmonic valve peak gradient 63 mmHg, mean pressure gradient 35 mmHg). After discussion by the Heart Team, the patient underwent a successful valve-in-valve TPVI, which resulted in clinical improvement.

CONCLUSION: Transcatheter pulmonary valve-in-valve implantation may be a viable option for patients with pulmonary stenosis due to degenerative changes of bioprosthetic pulmonary valve.


CR74 Treatment of enterocutaneous fistula with total parenteral nutrition in combination with octreotide: a case report

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KEYWORDS: enterocutaneous fistula; octreotide; total parenteral nutrition

INTRODUCTION/OBJECTIVES: Octreotide is an analog of the polypeptide hormone somatostatin, which can reduce gastrointestinal, biliary and pancreas secretion, as well as decrease gastrointestinal motility. Octreotide in combination with total parenteral nutrition (TPN) has proven to be effective therapy in patients with high-output enterocutaneous fistula (EF).

CASE PRESENTATION: We report a case of a 29-year-old female patient with Peutz-Jeghers syndrome who underwent resection of 80 cm of jejunum with formation of jejuno-jejunal anastomosis due to intestinal intussusception. Postoperatively, patient developed suppurative intraabdominal collection and high output EF. Oral intake was restricted, and TPN was introduced in addition to broad-spectrum antibiotics and wound care. In addition, 3x50 µg/day octreotide subcutaneously and proton pump inhibitor was started. After three days, dose of octreotide was increased (3x100 µg/day). These resulted in dramatic reduction of the fistula drainage seven days after therapy was started. 20th day of octreotide therapy, drainage stopped completely, therefore we started a peroral nutrition which led to recurrence of fistula secretion. Abdominal MSCT showed remaining EF, therefore we decreased oral intake and continued octreotide therapy, along with TPN. 40 days after intravenous therapy with octreotide, fistula closure occurred. Long-acting release (LAR) octreotide administered intramuscularly at a dose 20 mg monthly was introduced for the next three months. Octreotide administration was well tolerated and led to complete fistula closure.

CONCLUSION: Although TPN is a cornerstone of conservative management of postoperative EF, octreotide administration could be considered in order to shorten the time to fistula closure, the requirement of PN and hospital stay.