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IMAGES IN CARDIOLOGY

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An unexpected finding during planned primary percutaneous coronary angioplasty

A 65-year-old woman presented with acute central chest pain. Her ECG showed inferior ST elevation and she was transferred to our cardiac catheterisation laboratory for primary percutaneous coronary intervention. Coronary angiography showed no obstructive coronary atheroma, though a foreign body appeared to be lodged within the heart (panel A). The following morning her troponin T level was raised at 1.15 ng/ml.

A Port-O-Cath had previously been inserted via the right subclavian vein as part of the treatment of breast carcinoma. Thoracic CT demonstrated a fragment of the catheter lying across the fossa ovalis. There was no evidence of pulmonary thromboembolism or recurrence of the breast carcinoma. Transoesophageal echocardiography suggested thrombus was adherent to the fragment within the right atrium. After 1 week's treatment with heparin, thrombus was still visible. As we considered percutaneous retrieval might cause systemic embolism, the fragment was removed under direct visualisation through a longitudinal right atriotomy while the patient was on cardiopulmonary bypass (panel B). At

Coronary angiogram: right anterior oblique projection demonstrating the embolised venous catheter fragment within the atria.

operation, most of the catheter fragment was seen within the left atrium without any visible thrombus attached; the patent foramen ovale was repaired and the remainder of the Port-O-Cath removed. The patient has remained asymptomatic.

Catheter fracture usually results from compression of implanted catheters lying

Hub port and catheter after removal; centimetre scale rule for reference.

between the first rib and the clavicle. We suspect that the acute presentation was secondary to paradoxical thromboembolism to the coronary circulation. As far as we know, this is the first report of migration of a fractured venous catheter across a patent foramen ovale resulting in acute myocardial infarction.

Simon D Robinson, Jim Hall, Andrew T Goodwin
simon.robinson@ed.ac.uk