A very unusual cause of hypotension during CTO PCI

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Simon Soo Siong Lo[1], Michael Lo Jianhui[2]

[1]Gleneagles Hospital Penang, [2]Surrey and Sussex Healthcare NHS Trust

[Purpose] Retroperitoneal haemorrhage (RPH) during PCI is very rare, but intraperitoneal haemorrhage (IPH) during PCI is even rarer. Urgent recognition and treatment can be lifesaving.[Methods] A 75-year-old man with hypertension, dyslipidaemia and CKD1 underwent elective RCA CTO PCI. He was on DAPT and given Heparin 8000 units. The CTO was successfully treated in 45 minutes with two DES. Immediately after post-dilatation of the proximal stent, his BP dropped to 62 mmHg and was presumed to be a vasovagal reaction. RCA angiogram showed no perforation and echocardiogram showed no pericardial effusion. Resuscitation with IV saline, atropine and adrenaline restored haemodynamics. Before sheath removal, BP dropped to 70 mmHg again and IV vasopressors were restarted. A second echocardiogram excluded tamponade. Bifemoral angiography excluded perforation. Marked abdominal distension was present and prompted urgent CT abdominal imaging.[Results] CT revealed a large pseudoaneurysm with AVM originating from the distal SMA. Haematoma was also seen in the peri-hepatic and peri-splenic regions. Urgent selective angiography confirmed active bleeding from ileocaecal branches of the SMA. Coil embolisation of both feeding vessels achieved immediate haemostasis. The heparin was reversed with Hb at 9.4 g/dL. He was transfused with 2 units of blood while in ICU. He remained haemodynamically stable and was discharged on dual antiplatelet therapy five days later.[Conclusion] Intra-abdominal AVM rupture or haemorrhage can mimic femoral access-related RPH and should be considered when unexplained abdominal distension accompanies shock during PCI. Immediate CT imaging can differentiate IPH and RPH and lead to appropriate life-saving treatment.