

Left anterior descending artery injury during routine dual-chamber pacemaker implantation leading to myocardial infarction

Piotr Denysiuk¹, Erwin Ciechański^{1,2}, Tomasz Klecha¹, Adrianna Denysiuk³, Gerard Grossmann¹, Marcin Szczasny¹, Piotr Błaszczak¹

¹Department of Cardiology, Stefan Cardinal Wyszyński Province Specialist Hospital, Lublin, Poland

²Department of Toxicology, Medical University of Lublin, Lublin, Poland

³Voivodeship Center of Occupational Medicine Prevention and Treatment Center in Lublin, Lublin, Poland

Correspondence to:

Piotr Denysiuk, MD,
Department of Cardiology,
Stefan Cardinal Wyszyński
Regional Specialist Hospital,
Kraśnicka 100,
20-718 Lublin, Poland,
phone: +48 79 146 05 07,
e-mail:
piotr.denysiuk@gmail.com

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A 73-year-old male was admitted to the Cardiology Ward from the Emergency Department after an episode of syncope for further evaluation and treatment. The patient had a history of hypertension and recurrent presyncope episodes. On admission, he was in stable condition with no significant findings on physical examination. Electrocardiography (ECG) recorded after the syncope showed sinus bradycardia with junctional escape rhythm and a heart rate of 38 beats per minute. There were no other significant findings on 24-hour Holter monitoring. The patient was diagnosed with symptomatic sinus node dysfunction and scheduled for dual-chamber pacemaker implantation the next day. The procedure was carried out routinely with a 52 cm right atrial lead placed in the right atrial appendage with a capture threshold of 1 V at 0.4 ms, sensing at 3 mV, and impedance of 628 Ω , and a 58 cm ventricular lead placed in the right ventricular outflow tract with a capture threshold of 0.5 V at 0.4 ms, sensing at >12 mV and impedance of 640 Ω . Lead placement was confirmed with two independent fluoroscopy angles. Within minutes after placement of the ventricular lead, the patient developed chest pain and became hypotensive with a sudden drop in blood pressure to 60/30 mm Hg. Pneumothorax and cardiac tamponade were ruled out using fluoroscopy in 30° left anterior oblique view and intraprocedural transthoracic echocardiography. The patient's status quickly improved after administration of inotropes and intravenous fluids and the symptoms subsided; the procedure was completed

without further complications. After obtaining a post-procedure 12-lead ECG, ST-segment elevation myocardial infarction was confirmed (Figure 1A). Emergency coronary angiography showed critical stenosis of the left anterior descending artery with compromised distal flow, of the diagonal branch, and significant stenosis of the circumflex artery. Angioplasty of the left anterior descending artery and the diagonal branch was performed using two drug-eluting stents; the patient was scheduled for elective circumflex artery angioplasty before discharge.

Due to the complicated pacemaker implantation course and the ECG suggesting epicardial pacing, suspicion of direct injury to the coronary artery was raised. After careful re-evaluation of coronary angiography, a direct left anterior descending artery perforation by the ventricular lead helix was confirmed (Figure 1B, D; Supplementary material, Video S1–S3). The lead was replaced without further complications, and scheduled angioplasty was carried out as planned. No significant pericardial effusion was present on control echocardiography following the procedure. After follow-up, the patient was discharged home.

Myocardial infarction due to coronary artery injury is a rare complication of cardiac electronic device implantation [1]. There were only several recorded cases of left anterior descending artery injury caused by a ventricular lead [2–5]. In the presented case, the patient developed symptoms of acute myocardial infarction due to inadvertent malposition of the

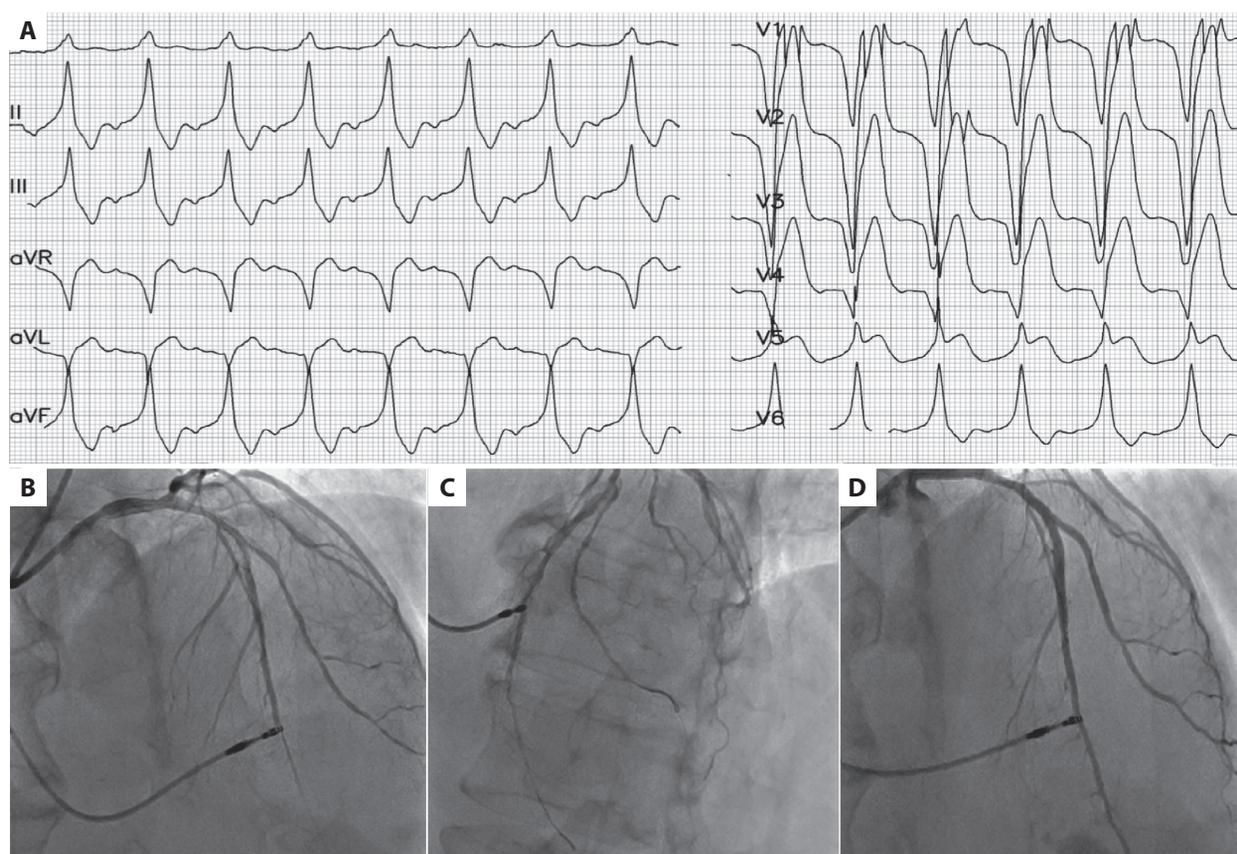


Figure 1. A. ST-segment elevation myocardial infarction in bipolar paced evolutions fulfilling Sgarbossa Criteria — concordant ST-segment elevation >1 mm in lead V5, discordant ST-segment elevation >5 mm in leads V2–V4. Atypical QRS morphology suggesting possible epicardial pacing. B. Coronary angiography revealing left anterior descending artery perforation by the ventricular lead helix with TIMI grade 1 flow beyond the injury point, RAO 19°, CRA 35° view. C. LAO 33°, CRA 25° view. D. Control angiography after coronary stenting RAO 15°, CRA 36° view. Abbreviations: CRA, cranial angle; LAO, left anterior oblique; RAO, right anterior oblique

ventricular lead in the right ventricle antero-septal junction leading to coronary artery perforation by the lead helix, and he required urgent revascularization and lead replacement. Routine use of 12-lead ECG and right anterior oblique (RAO) imaging during implantation should be considered to avoid this high-risk pseudo-septal position and potential complications. Utilization of novel imaging algorithms such as iterative metal artifact reduction for computed tomography might be helpful for better evaluation of the perforated leads [6].

Supplementary material

Supplementary material is available at https://journals.viamedica.pl/kardiologia_polska.

Article information

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