Rev Port Cardiol. 2014;33(9):563.e1–563.e4

Revista Portuguesa de Cardiologia
Portuguese Journal of Cardiology
www.revportcardiol.org

CASE REPORT

Severe aortic stenosis: Forgotten associations☆

Ana Rita Godinho[a,*], Sandra Amorim[a], Manuel Campelo[a], Elisabete Martins[a], Elisa Lopez Rodriguez[b], Rosa Coelho[c], Guilherme Macedo[c], Maria Júlia Maciel[a]

[a] *Serviço de Cardiologia, Hospital de São João, Porto, Portugal*
[b] *Serviço de Cirurgia Torácica, Hospital de São João, Porto, Portugal*
[c] *Serviço de Gastroenterologia, Hospital de São João, Porto, Portugal*

Received 23 January 2014; accepted 2 February 2014
Available online 6 September 2014

KEYWORDS
Severe aortic stenosis;
Gastrointestinal bleeding;
Angiodysplasia;
Heyde syndrome;
Pulmonary hypertension

Abstract The authors present the case of a 68-year-old man with predominantly right heart failure in the context of severe aortic stenosis associated with pulmonary hypertension. Anemia was diagnosed which, after endoscopic study, was considered to be secondary to angiodysplasia and a diagnosis of Heyde syndrome was made. After valve replacement surgery the patient's heart failure improved and hemoglobin levels stabilized.

We present this case to show the need to recognize less common associations of severe aortic stenosis, in order to provide immediate and appropriate treatment.

PALAVRAS-CHAVE
Estenose aórtica grave;
Hemorragia gastrointestinal;
Angiodisplasias;
Síndrome de Heyde;
Hipertensão pulmonar

Estenose aórtica grave: associações esquecidas

Resumo Os autores apresentam um caso clínico de um homem de 68 anos com clínica de insuficiência cardíaca predominantemente direita, no contexto de estenose aórtica grave associada a hipertensão pulmonar. Concomitantemente, foi diagnosticada anemia que, após estudo endoscópico, se concluiu ser secundária a angiodisplasias intestinais, tendo sido feito o diagnóstico de síndrome de Heyde.

Após cirurgia de substituição valvular houve resolução do quadro, com melhoria dos sintomas de insuficiência cardíaca prévia e estabilização dos valores de hemoglobina.

☆ Please cite this article as: Godinho AR, Amorim S, Campelo M, et al. Estenose aórtica grave: associações esquecidas. Rev Port Cardiol. 2014;33:563.e1–563.e4.
* Corresponding author.
E-mail address: rita_biscaia_godinho@hotmail.com (A.R. Godinho).

Com este caso pretende-se mostrar a necessidade do conhecimento de associações menos frequentes na estenose aórtica grave para uma atuação terapêutica imediata e adequada.

Case report

A 68-year-old man with type 2 diabetes (medicated with metformin and vildagliptin) and dyslipidemia (medicated with statins and fenofibrate) as cardiovascular risk factors, and a history of alcohol abuse (100 g/day), had been diagnosed with iron deficiency anemia a year previously that was investigated by endoscopy, which revealed chronic atrophic gastritis.

In March 2013 he began to experience fatigue, dyspnea on moderate and mild exertion, abdominal swelling, lower limb edema and cachexia. He was medicated with furosemide and ivabradine and assessed by a cardiologist four months after symptom onset. On physical examination he was in New York Heart Association (NYHA) class III, with marked weight loss and venous jugular distention; bilateral basal rales on pulmonary auscultation; rhythmic S1 and S2 on cardiac auscultation with a grade III/VI aortic early to mid systolic murmur radiating to the carotids; palpable hepatomegaly 4 cm below the costal margin; moderate ascites and lower limb edema up to the knee. The electrocardiogram showed sinus rhythm and complete right bundle branch block. On the chest X-ray cardiomegaly was visible with right atrial dilatation and bilateral hilar enlargement. Laboratory tests revealed anemia (hemoglobin [Hb] 9.9 g/dl). The echocardiogram showed dilatation of both atria and the right ventricle (RV) (Figure 1), with mild hypertrophy of the ventricular septum; a thickened and calcified aortic valve with significantly limited opening (Figure 2); peak left ventricular (LV)/aortic gradient of 55 mmHg, mean 33 mmHg, and functional aortic valve area of 0.8 cm^2 (0.39 cm^2/m^2); mild to moderate tricuspid regurgitation (Figure 3)

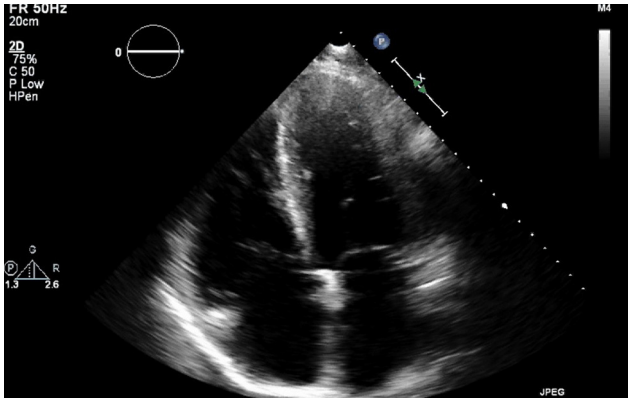

Figure 1 Echocardiography in apical 4-chamber view showing dilatation of both atria and the right ventricle.

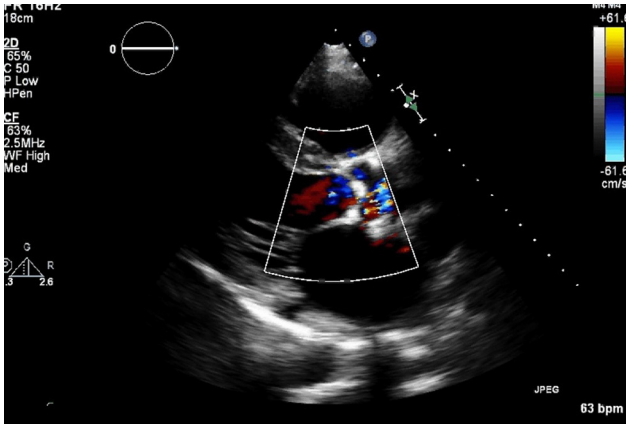

Figure 2 Echocardiography in long-axis parasternal view showing thickened and calcified aortic valve with significantly limited opening.

with pulmonary artery systolic pressure (PASP) of 51 mmHg; mild to moderate LV systolic dysfunction; systolic and diastolic straightening of the ventricular septum; and impaired RV systolic function.

To investigate the signs of pulmonary hypertension (PH) in a patient with severe isolated aortic stenosis (AS), spirometry was performed, which was normal; lung computed tomography showed no sign of pulmonary embolism (PE) or other alterations of the pulmonary parenchyma, while ventilation/perfusion scintigraphy showed a low probability of PE. Abdominal ultrasound revealed moderate ascites, hepatomegaly (19.2 cm), moderate homogeneous

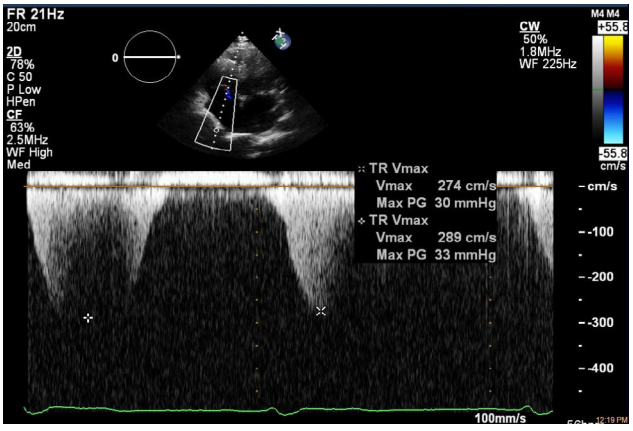

Figure 3 Echocardiography showing mild to moderate tricuspid regurgitation.