

Aortic extraction of a migrated Watchman® device☆



Extracción aórtica de dispositivo Watchman® migrado

Non-valvular atrial fibrillation (NVAF) is the most common arrhythmia in our setting. Its most serious complication is cardioembolic stroke due to the disability and mortality involved. The standard treatment for this arrhythmia is anticoagulation with vitamin K antagonists and oral anticoagulants (OAC), although the main disadvantage

of these drugs is the increased risk of hemorrhage. More than 90% of thrombi of the left atrium are located inside the left atrial appendage (LAA), which has led to the creation of devices that close it to prevent cardioembolic risk. Percutaneous closure of the LAA is still a technique in its early stages, and its indication is currently reserved for

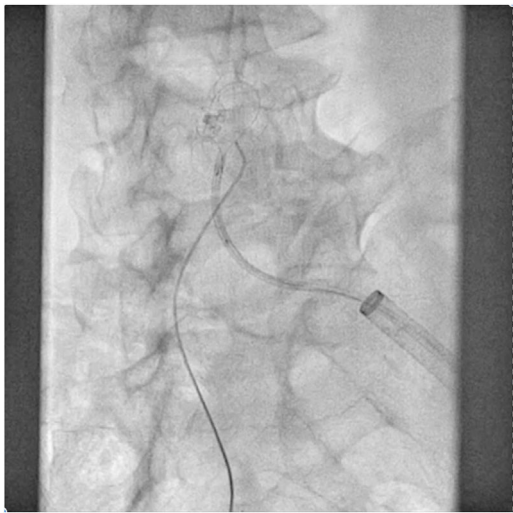


Fig. 1 – Aortography.

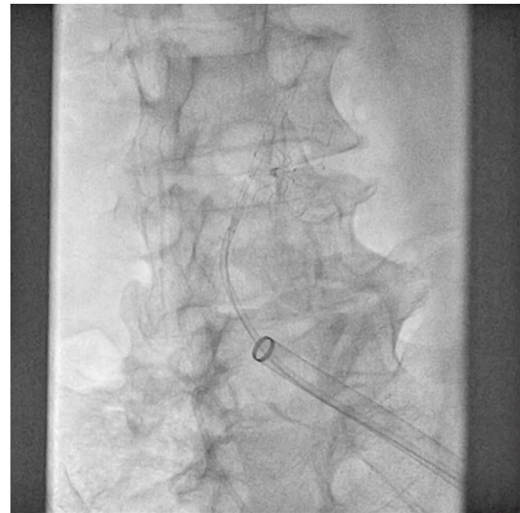


Fig. 3 – Capture attempt through the left femoral.



Fig. 2 – Capture attempt with loop and guidewire through the right femoral.

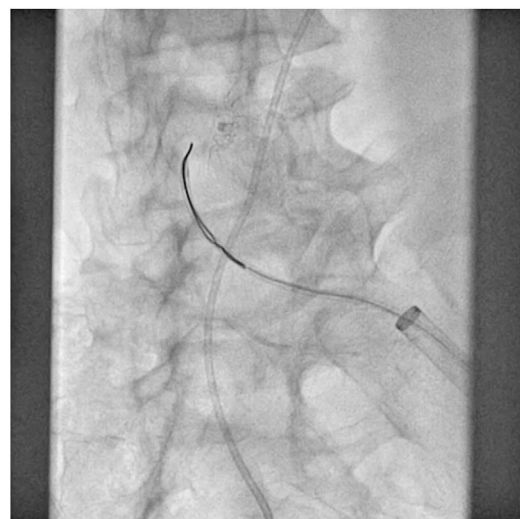


Fig. 4 – Capture attempt through the left femoral.

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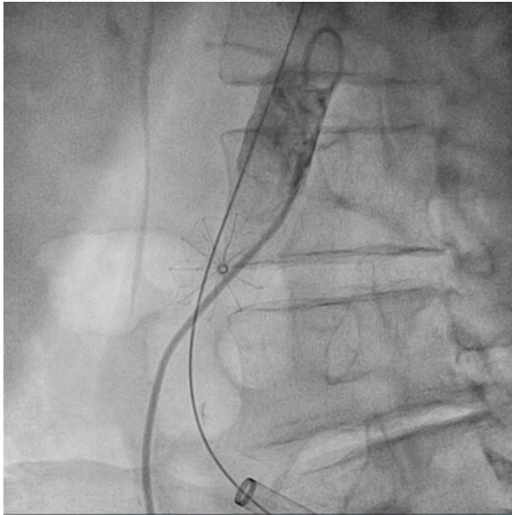


Fig. 5 - Dissection of the abdominal aorta and right common iliac artery.

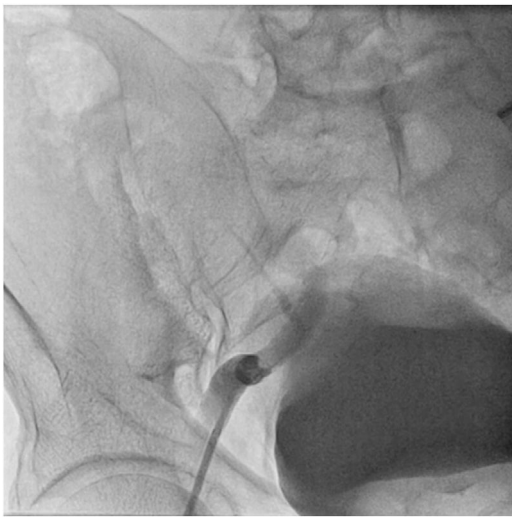


Fig. 6 - Dissection of the abdominal aorta and right common iliac artery.



Fig. 7 - Arteriotomy with extraction of the device and closure of the defect with correction of the dissection using a bovine pericardial patch.

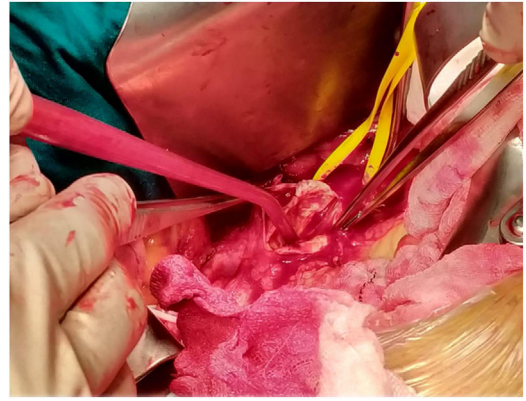


Fig. 8 - Arteriotomy with extraction of the device and closure of the defect with correction of the dissection using a bovine pericardial patch.

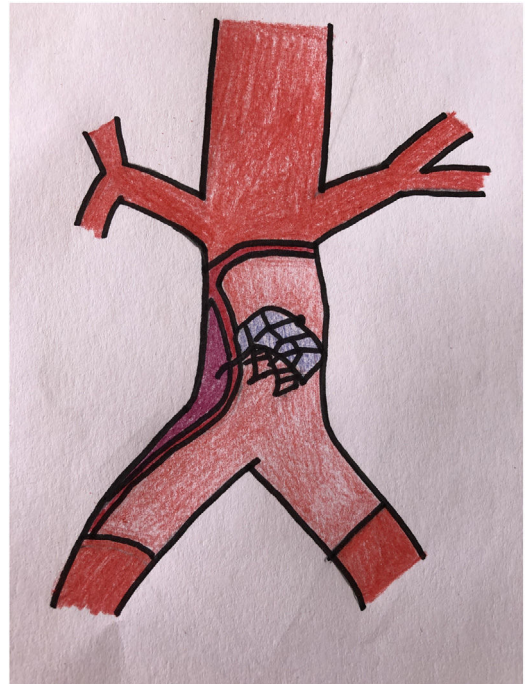


Fig. 9 - Arteriotomy with extraction of the device and closure of the defect with correction of the dissection using a bovine pericardial patch.

patients with NVAF and contraindications to anticoagulant therapy.

Our patient is a 67-year-old male, hypertensive, and ex-smoker with NVAF but no structural heart disease and a high risk for embolism, treated with Edoxaban®. He presented an intraparenchymal hematoma in the left hemisphere as a complication, so a Watchman® left atrial appendage closure device was implanted. During the follow-up transesophageal echocardiogram performed one month later when the patient was completely asymptomatic, migration of the device was observed. Computed tomography was performed, and the device was found in the infrarenal abdominal aorta.

The patient was transferred to the hemodynamic unit, where we attempted to extract the device. Different 10-mm, 25-mm and 30-mm loop catheters were used, as well as manufactured loops with long and short guidewires, in an attempt to mobilize the device using different types of vascular access (bifemoral access 6 and 18 Fr, and radial 6 Fr) (Figs. 1–4). As a complication, abdominal aortic dissection occurred with extension to the right common iliac artery (Figs. 5 and 6) and total loss flow in the ipsilateral lower extremity with signs and symptoms of acute arterial ischemia. The patient was immediately transferred to the angiology and vascular surgery operating room. Infrarenal abdominal aorta dissection was performed via midline laparotomy with longitudinal aortotomy at the site of the foreign body, where the migrated device was observed to be anchored to the intima-media of the arterial wall. This was extracted, and the aortotomy was then closed with a bovine pericardial patch at the dissection to correct the defect (Figs. 7–9). The patient left the operating room with bilateral pedal pulse and excellent distal perfusion.

Given the difficulty to remove the device endovascularly, and due to the complication that occurred during the procedure, extraction by open surgery could be considered a first treatment option.

It is possible that the sinus rhythm ‘jumps’ that the patient experienced were the cause of the migration of the device, which should lead us to consider another possible therapeutic option, such as the implantation of a pacemaker.

Conflict of interests

The authors have no conflict of interests to declare.

Appendix A. Supplementary data

Supplementary data associated with this article can be found, in the online version, at [doi:10.1016/j.cireng.2021.02.009](https://doi.org/10.1016/j.cireng.2021.02.009).

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Surgical treatment of recurrent medullary thyroid carcinoma in a hospital with a high incidence of medullary carcinoma associated with MEN syndrome[☆]



Tratamiento quirúrgico del carcinoma medular de tiroides recidivado en un centro con alta incidencia de carcinoma medular asociado al síndrome de MEN

Medullary thyroid carcinoma (MTC) is a rare tumor that is sporadic in most series (more than 75% of cases). However, in areas where there is a concentration of patients with multiple endocrine neoplasia (MEN) syndrome, familial tumors may be more common.^{1–3} Surgery is the only potentially curative treatment option for these tumors, but the recurrence rate is high (30%-65% in most series), even despite adequate radical surgical technique.^{1,4} For the management of recurrent MTC, surgery is the most effective treatment and the only potentially

curative one. However, there is no consensus on when it should be done, or which surgical technique is best.⁵ As a general rule, surgery seems to be more effective for local recurrence, while the treatment of choice for disseminated disease is palliative medicine.⁵ The objective of this study is to evaluate the results of surgical treatment in recurrent cervical MTC.

Our study population included patients with MTC who were treated surgically, met the criteria for cure, but who later presented tumor recurrence during follow-up. The patient

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