A 45-year-old male presented with 2 days of nausea, sweating, and abdominal pain. Examination revealed tachycardia, hypertension, diaphoresis, widespread crepitations, and diffuse abdominal tenderness. Profound hypotension developed, despite intravenous fluids, and was treated with noradrenaline and dobutamine; hypoxia required endotracheal intubation, followed by chest radiograph, which demonstrated extensive pulmonary edema. Echocardiography revealed severe global left ventricular systolic impairment, with an estimated ejection fraction of only 10% (Data Supplement Movies I and II). The patient was transferred to our hospital for the consideration of intraaortic balloon counterpulsation or left ventricular assist device support or both. An intraaortic balloon pump was inserted, and inotropic support was changed to adrenaline with modest improvement. Recurrent atrial fibrillation and worsening pulmonary edema indicated that the patient was unlikely to survive with conservative treatment; yet, the risks of conventional surgical resection without autonomic blockade were considered prohibitive. The only option for a successful outcome was to provide the patient with an artificial circulation and remove the tumor. Femoro/femoral bypass was rejected as this form of support would be unable to provide for the potential need for very high flow rates. The patient underwent cardiopulmonary bypass following a midline sternotomy. The heart was left beating, and moderate hypothermia was achieved. Laparotomy confirmed a large tumor adherent to a left sided inferior vena cava. It was removed without complication while the patient was maintained on bypass by using a phenolamine and esmolol infusion throughout (Figure 2). The patient was weaned from cardiopulmonary bypass with adrenaline support without complications, and the feeling his head was going to explode, which usually occurred when bending over to lace his boots in the morning. Histology of the tumor confirmed a paraganglioma with extensive ischemic necrosis.

Discussion

Phaeochromocytoma are rare catecholamine-producing tumors, typically presenting with headache, sweating, palpitation, and hypertension. Eighty-five percent arise from the adrenals, and when they arise outside the adrenals, they are termed paragangliomas. Recognized cardiovascular complications include sudden death, myocardial infarction, heart failure, hypertensive encephalopathy, and cardiogenic shock including fatal cardiomyopathy. The mechanism underlying the impaired ventricular function is unclear and may be because of a tachycardia-related cardiomyopathy, ventricular hypertrophy as a result of systemic hypertension, or a direct effect of catecholamines on cardiac myocytes. Following diagnosis, the challenge is to stabilize the patient with autonomic blockade to allow safe surgical removal of the tumor. Given the presenting symptom of abdominal pain with hypertension and diaphoresis on arrival followed by cardiogenic shock, it is likely that the acute event was infarction of part of the phaeochromocytoma, as suggested on histology with a surge in catecholamine levels and acute left ventricular stunning.

Phaeochromocytoma should be considered in patients presenting with heart failure and cardiogenic shock and no other obvious diagnosis. Removal of the tumor may lead to rapid reversal of catecholamine-induced cardiomyopathy. Extracorporeal membrane oxygenation or left ventricular assist...
devices have been used to support surgery. We report the use of cardiopulmonary bypass to facilitate surgical removal in a critically ill patient with severe cardiac dysfunction.

Disclosures

None.

References


Figure 1. Computed tomography of the abdomen showing a mass overlying and compressing a left-sided inferior vena cava measuring 7.8 cm in diameter. An artifact from the intraaortic balloon pump in the aorta was noted.
Figure 2. Operative specimen.
What a Headache: Rare Neuroendocrine Indication for Cardiopulmonary Bypass for Severe Left Ventricular Dysfunction and Shock
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Circ Heart Fail. 2008;1:143-145
doi: 10.1161/CIRCHEARTFAILURE.108.766865
Circulation: Heart Failure is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
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Print ISSN: 1941-3289. Online ISSN: 1941-3297

The online version of this article, along with updated information and services, is located on the World Wide Web at:
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