A 61-year-old female underwent implantation of a Heartmate II left ventricular assist device (LVAD; Thoratec Corporation, Pleasanton, CA) for end-stage nonischemic cardiomyopathy. Six months later, she presented with chest pain and worsening heart failure symptoms. Computed tomography angiography revealed a large subxiphoid pseudoaneurysm with peripheral thrombus exerting a mass effect on the heart (Figures 1 and 2). Further evaluation by ultrasoundography with anterior chest transducer placement confirmed a 13-cm pseudoaneurysm with multiple connections to the LVAD outflow Dacron graft (Figure 3). She was afebrile and had no physical or laboratory evidence of infection. Because of extensive comorbidities, including morbid obesity, restrictive lung disease, and chronic renal insufficiency, open repair via repeat sternotomy was considered risk-prohibitive, and an endovascular repair was pursued.

Off-label use of a Gore Excluder (W.L. Gore and Associates, Flagstaff, AZ) iliac limb stent graft (16 mm proximal diameter, 18 mm distal diameter×9.5 cm length) was considered the best commercially available device to attempt endovascular repair. This device was chosen because of the appropriate size match to the Dacron LVAD outflow graft and the short nose of the delivery catheter, which would permit advancement close to the LVAD pump mechanism. Because of a delivery catheter shaft length of only 55 cm, a left axillary artery approach was chosen for device delivery. The left axillary artery was exposed via an infraclavicular incision. An 8 mm Dacron conduit was sewn end-to-side to this artery and brought out through a separate stab incision on the lateral chest to minimize the angle of entry for the wires and sheaths, given patient obesity. Initial attempts at retrograde entry into the LVAD outflow tract from the ascending aorta proved difficult because of high LVAD flow. As such, the decision was
made to temporarily turn off the LVAD, after full systemic heparinization to an activated clotting time of greater than 300, which the patient tolerated hemodynamically. An arteriogram of the ascending aorta/arch was then performed, and the location of the distal anastomosis of the LVAD outflow graft identified (Figure 4A) and successfully cannulated using a Cobra-2 catheter (AngioDynamics, Latham, NY), followed by an Amplatz superstiff wire with a 1-cm floppy tip (Cook Medical, Bloomington, IN) that passed into the LVAD outflow graft and down to above the pump portion of the LVAD. An 18-French Gore dry-seal sheath was passed into the LVAD outflow graft and down to above the pump portion of the LVAD. An 18-French Gore dry-seal sheath was passed into the LVAD outflow graft and down to above the pump portion of the LVAD. An 18-French Gore dry-seal sheath was passed into the LVAD outflow graft and down to above the pump portion of the LVAD. An 18-French Gore dry-seal sheath was passed into the LVAD outflow graft and down to above the pump portion of the LVAD.

Figure 3. A, Sagittal ultrasonographic view of the anterior chest demonstrating a 13×9 cm fluid collection (demarcated by + symbols) surrounding the outflow tract (red arrow) from the left ventricular apex (yellow arrow) to the left ventricular assist device (LVAD). B, Sagittal Doppler view demonstrating swirling flow within the fluid collection consistent with pseudoaneurysm.

Figure 4. A, Initial angiography run demonstrating the large pseudoaneurysm (red arrow) at the base of the outflow graft (yellow arrow; ascending aorta indicated by green arrow). B, Fluoroscopy demonstrating wires (yellow arrow) in the left ventricular assist device (LVAD) outflow graft extending into the LVAD apparatus (red arrow). C, Early image of completion angiography run demonstrating contrast in the upper part of LVAD outflow graft within the newly placed endograft (blue arrow). D, Later image of completion run demonstrating good flow through the endograft (yellow arrow) and absence of the blush seen previously within the pseudoaneurysm (red arrow).

Discussion

Pseudoaneurysms associated with LVADs are rare, with prior reports of occurrence at the left ventricular apex, as well as the anastomosis of the outflow graft to the ascending aorta.1 Pseudoaneurysm of the LVAD outflow graft, thought to be secondary to graft contact with a sternal wire causing erosion of the graft, was reported in a patient with a Novacor N100 LVAD; this pseudoaneurysm required open repair under deep hypothermia and circulatory arrest.2 Additionally, endovascular repair of a fistula between the outflow graft of a Heartmate II and a portion of the right bronchial tree, with access from the right common carotid artery, has been described.3

In the present case, pseudoaneurysm formation could have resulted from prosthetic graft damage during implantation or contact with the sternal wires, as previously described. Additionally, detachment of the bend relief device (Figure 6), which overlies the LVAD outflow graft, could have caused outflow graft damage and pseudoaneurysm formation. To this latter possibility, a recent FDA warning was issued regarding concerns of the bend relief device causing graft obstruction and detachment from the LVAD.4 The endovascular repair strategy described herein represents the second placement...
of an endovascular stent graft within an LVAD circuit, and the first endovascular repair of an LVAD outflow graft pseudoaneurysm to our knowledge. Potential complications of this repair strategy include endograft infection, potential for LVAD-related thrombus, especially given the temporary cessation of device flow (albeit during a period of full systemic heparinization), damage to the pump mechanism from catheters or wires, wire or catheter entrapment, and endoleak.

Lifelong surveillance follow-up imaging is therefore recommended, similar to other endovascular repair procedures. Nonetheless, the endovascular strategy presented seems to represent a novel, safe, and effective treatment for LVAD outflow tract pseudoaneurysm that avoids a highly morbid open operation in a compromised patient population.

Sources of Funding

Salary support was provided by a Thoracic Surgery Foundation for Research and Education Research Fellowship (to N.D.A.).

Disclosures

Dr Hughes is a paid consultant for W.L. Gore and Associates and Terumo Medical. Dr Milano is a paid consultant for Thoratec Corporation. Dr Rogers is a paid consultant for Thoratec Corporation.

References


**Key Words:** aneurysm • cardiomyopathy • ventricular assist device
Endovascular Stent Grafting of a Left Ventricular Assist Device Outflow Graft Pseudoaneurysm
Asvin M. Ganapathi, Nicholas D. Andersen, Deyanira J. Prastein, Zubair A. Hashmi, Joseph G. Rogers, Carmelo A. Milano, Richard L. McCann and G. Chad Hughes

Circ Heart Fail. 2013;6:e16-e18
doi: 10.1161/CIRCHEARTFAILURE.112.971861
Circulation: Heart Failure is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
Copyright © 2013 American Heart Association, Inc. All rights reserved.
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:
http://circheartfailure.ahajournals.org/content/6/1/e16

Permissions: Requests for permissions to reproduce figures, tables, or portions of articles originally published in Circulation: Heart Failure can be obtained via RightsLink, a service of the Copyright Clearance Center, not the Editorial Office. Once the online version of the published article for which permission is being requested is located, click Request Permissions in the middle column of the Web page under Services. Further information about this process is available in the Permissions and Rights Question and Answer document.

Reprints: Information about reprints can be found online at:
http://www.lww.com/reprints

Subscriptions: Information about subscribing to Circulation: Heart Failure is online at:
http://circheartfailure.ahajournals.org//subscriptions/