Intracardiac Thrombosis Due to Antiphospholipid Syndrome

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ABSTRACT

Antiphospholipid syndrome (APS) is an autoimmune disease characterised by arterial and venous thrombosis. Recurrent thrombosis and pregnancy losses are important in its diagnosis. Due to the risk of recurrence of thrombosis, long-term anticoagulant treatment may be required. Here, we present the case of a patient who suffered from intracardiac thrombosis due to APS. At present, treatment for significant thrombotic events in patients with APS, such as the aforementioned intracardiac thrombosis, is generally lifelong.

Key Words: Antiphospholipid syndrome; intracardiac thrombosis

Antifosfolipid Sendromuna Bağlı Olarak Gelişen İntrakardiyak Tromboz

ÖZET

Antifosfolipid Sendrom (AFS) arteryal ve venöz trombozlar ile karakterize otoimmün bir hastalıktır. AFS tanısında tekrarlayan trombotik olaylar ve gebelik kayıpları önemli bir yer tutar. Tekrarlayıcı tromboz riski nedeniyle uzun dönemli antikoagülan tedavi gerelebilmektedir. Sunduğumuz olgu bildiriminde AFS'ye bağlı intrakardiyak trombozdan etkilenen bir kadın hastayı paylaştık. İntrakardiak tromboz gibi AFS'ye bağlı ciddi komplikasyonlar yaşayan hastalarda güncel yaklaşım yaşam boyu antikoagülan kullanımını desteklemektedir.

Anahtar Kelimeler: Antifosfolipid sendrom; intrakardiyak tromboz

INTRODUCTION

Antiphospholipid syndrome (APS) is an autoimmune disease characterised by arterial and venous thrombosis. Recurrent thrombosis and pregnancy losses are important in its diagnosis. Due to the risk of recurrence of thrombosis, long-term anticoagulant treatment may be required. The most frequent cardiac complications of APS are valve disorders. Here, we present the case of a patient who suffered from intracardiac thrombosis due to APS.

CASE REPORT

A 38-year-old female patient was being followed up in the internal medicine service due to thrombocytopenia. She was referred to the cardiology department because of dyspnea and peripheral edema. Her medical history was unremarkable. She had bilateral jugular vein distention on physical examination and grade III systolic murmur at the right sternal border. She was normotensive, and her heart rate was 92 beats per minute (bpm). Electrocardiography showed right ventricular hypertrophy and P pulmonale. Transthoracic echocardiography revealed severe tricuspid regurgitation, dilated right heart chambers, high pulmonary arterial pressure, and thrombus attached to septal and anterior leaflets of the tricuspid valve (Figure 1). On chest X-Ray, increased cardiothoracic ratio and dilated pulmonary conus were detected. Her laboratory tests demonstrated that platelet count was 21.000/μL, anticardiolipin IgM-, and anticardiolipin IgG+. She was diagnosed with APS, and steroid therapy was initiated. However, she did not respond to the steroid therapy; therefore, cyclosporine was initiated. She could not be operated on due to low platelet levels and increased pulmonary arterial pressure. Her medical condition and dyspnea were getting worse, so thrombolytic therapy (streptokinase) was administered. After thrombolytic administration, the size of the thrombus reduced and pulmonary arterial pressure decreased dramatically. She was discharged from the hospital with oral anticoagulation (warfarin) therapy, and she is currently being followed up in our clinic.

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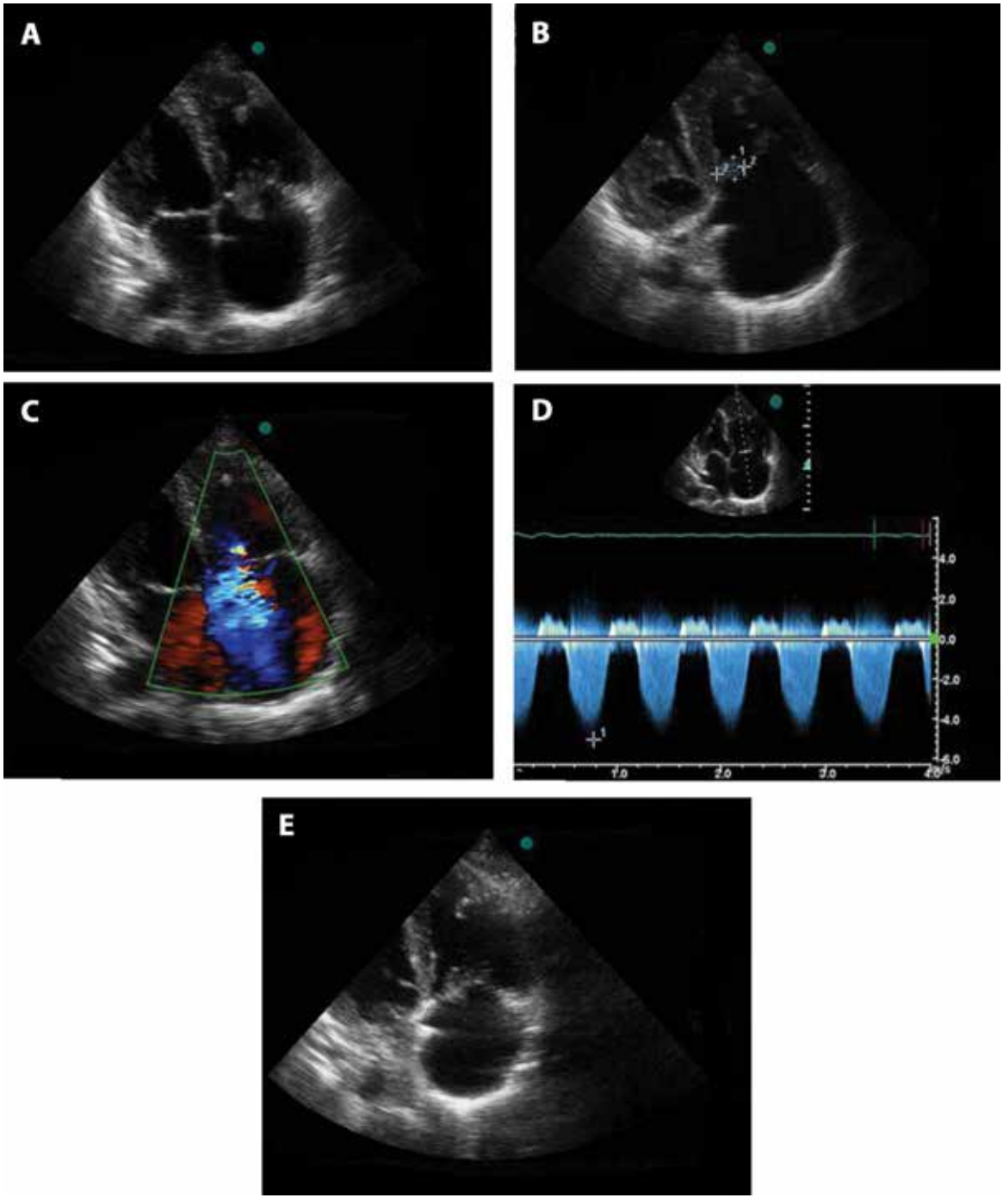

Figure 1. Echocardiographic images showing severe tricuspid regurgitation, dilated right heart chambers, high pulmonary arterial pressure, and thrombus attached to septal and anterior leaflets of the tricuspid valve.

DISCUSSION

In 2003, Soltesz et al. demonstrated that existence of lupus anticoagulant was generally associated with venous thrombosis and existence of anticardiolipin antibody was commonly associated with carotid, peripheral and coronary artery stenosis[1]. At present, the treatment of APS includes full anticoagulation with intravenous or subcutaneous heparin followed by warfarin therapy. Based on the most recent evidence, a reasonable target for the international normalised ratio (INR) is 2.0-3.0 for venous thrombosis and 3.0 for arterial thrombosis. Patients with recurrent thrombotic events, while well maintained on the above regimens, may require an INR of 3.0-4.0. For severe or refractory cases, a combination of warfarin and aspirin may be used. Treatment for significant thrombotic events in patients with APS, such as the aforementioned intracardiac thrombosis, is generally lifelong.

REFERENCE

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