



Hybrid Stenting Procedure for Aortic Coarctation in a Very Low Birth Weight Newborn

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Herein, we present the case of a very low birth weight newborn with severe aortic coarctation which worsened despite treatment with prostaglandins. Coarctation stenting is a feasible alternative treatment choice to avoid the higher morbidity and mortality risks associated with the surgical repair.^{1,2,3}

A premature newborn (gestational age, 28 weeks) weighing 1,100 grams was referred to our center with absent femoral pulses and high blood pressure for his age recorded in the upper extremities. Echocardiography revealed significant coarctation of the aorta, a bicuspid aortic valve, and patent ductus arteriosus. The 4 mm segment of the isthmus was only 1.5 mm (Z score: -4). The left ventricle was spherical and hypertrophic (Z score: > 2), and its function was normal at the time (EF: 74%) (Figure 1). PGE1 was administered palliatively prior to performing surgery. Two weeks later, the infant developed oliguria, feeding intolerance, and mild abdominal distention. An emergency intervention was planned.

In a catheterization laboratory, our pediatric cardiovascular surgeon performed a right carotid artery cut-down technique, using a 5-Fr sheath (Glidesheath Slender Introducer; Terumo Corporation, Japan) advanced over a 0.014" coronary guidewire. An angiogram was obtained by injecting a radio-opaque dye into the hand via the introducer sheath; it demonstrated the coarctation area. The isthmus region, distal arcus, and segment distal to the coarctation were 4, 2.45, and 5.3 mm, respectively (Figure 2). Thus, a 4.5/9 mm coronary stent (Alvimedica Ephesos™ II;) was implanted in the coarctation area. The mounted coronary stent was positioned via a 0.014" coronary guidewire over the isthmus, just distal to the left subclavian artery. An angiogram confirmed the accurate positioning of the stent, and the balloon was inflated up to just above the nominal pressure, dilating the stent to approximately 4 mm (Figure 2). The procedure was performed in 20 minutes, and the fluoroscopy time was 240 s. After the carotid artery was repaired, the procedure

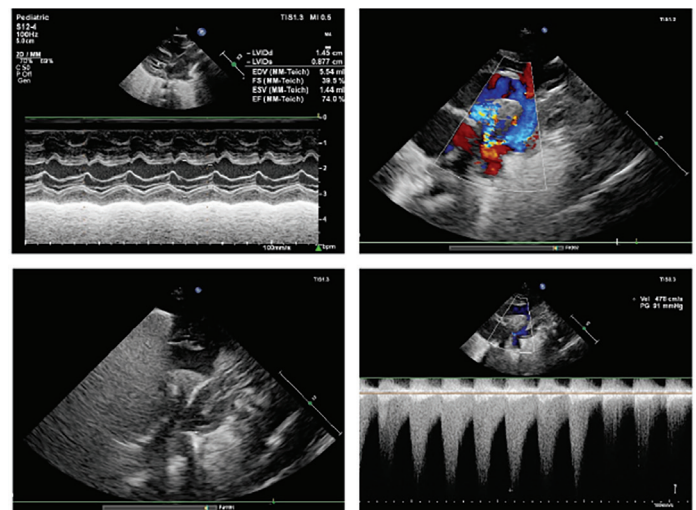


FIG. 1. Echocardiography showed left ventricular dilatation and hypertrophy (upper left), severe narrowing of the distal transverse aorta and retrograde flow in the patent ductus arteriosus (upper right), severe coarctation of the aorta (2D image, lower left), and a very high-pressure gradient (95 mmHg from proximal to distal sites of the coarctation; lower right).

was completed without any complications. Postoperatively, the patient's symptoms of poor feeding and oliguria had diminished; the infant was transported back to the NICU. Six months after being discharged, the infant electively underwent coarctation repair surgery.

Coarctation stenting is preferred over surgery for palliation in very low birth weight infants because of the high mortality and morbidity rates. The early and late follow-up results encourage the

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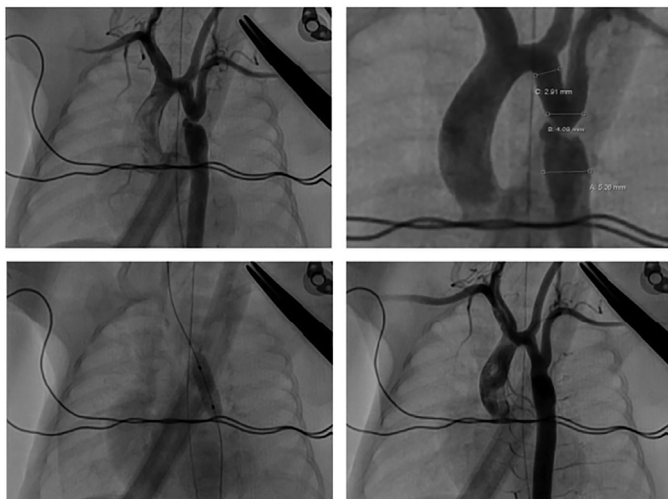


FIG. 2. Angiogram showing the coarctated site in the left oblique plane (upper left), measurements of the transverse and distal aorta (upper right), inflation of the coronary stent over a balloon in the correct position (lower left), and flow to the distal aorta (lower right).

application of coarctation stenting in carefully selected cases. Stent implantation using hybrid approaches should be considered in premature babies to avoid vascular complications.

Informed Consent: Informed consent was obtained from the patient's parents.

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