Paradoxical embolism in a boy with cystic fibrosis and a stroke

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Abstract
An 11 year old boy with cystic fibrosis suffered a stroke, producing right sided weakness. Four years previously a totally implantable venous access device (Port-a-Cath) had been inserted. Magnetic resonance angiography revealed a filling defect in the left middle cerebral artery. Transoesophageal echocardiography demonstrated a thrombus attached to the tip of the Port-a-Cath and also the presence of a patent foramen ovale. After an initial period of anticoagulation the defect was closed using a septal occlusion device introduced via a cardiac catheter. The boy's neurological signs completely resolved and he remains free from further thromboembolic episodes. Whilst pulmonary embolism has been described before in relation to a totally implantable venous access device, this is believed to be the first description of a paradoxical embolism in relation to such a device.

Keywords: cystic fibrosis; paradoxical embolism; catheterisation

An 11 year old boy with cystic fibrosis was admitted to hospital with sudden onset of confusion and slurred speech. On examination he was found to have a right-sided hemiparesis, expressive and receptive dysphasia. He had originally presented at the age of two days with a meconium ileus and was subsequently found to be homozygous for the AF508 deletion. A sweat test performed at the age of four months confirmed the diagnosis of cystic fibrosis. Since the age of four he had required many hospital admissions for intravenous antibiotic therapy. In February 1992 a Port-a-Cath was inserted via the right internal jugular vein and secured to the anterior chest wall. His lung function was considerably compromised with a forced expiratory volume in one second (FEV1) of 0.63 l (35% predicted) and a forced vital capacity (FVC) of 0.98 l (49% predicted).

A computed tomographic (CT) brain scan performed on the day after admission revealed a poorly defined area of low attenuation in the left temporoparietal region which was suggestive of ischaemia in the territory of the left middle cerebral artery. Magnetic resonance angiography confirmed recent ischaemia in this region with evidence of an embolus in the left middle cerebral artery. A transthoracic echocardiogram was performed which showed an unusual Ebstein’s-like deformity of the tricuspid valve; the proximal part of the septal leaflet of the tricuspid valve was displaced apically with a point of attachment in the mid body of the right ventricle. Mild tricuspid regurgitation was also seen but no other abnormalities were apparent.

Ebstein’s anomaly is associated with abnormal intra-atrial connections and therefore a transoesophageal echocardiogram was arranged. This was performed under general anaesthesia and demonstrated a small patent foramen ovale, the anterior border abutting the posterior aspect of the ascending aorta. The Port-a-Cath was seen in the right atrium and was noted to impinge against the tricuspid valve during the cardiac cycle. In addition, a large thrombus was seen attached to the tip of the Port-a-Cath in the right atrium.

Despite using intravenous contrast, no right to left shunt was demonstrable during the procedure. Techniques to enhance any right to left shunt such as coughing and the Valsalva manoeuvre were not possible because of the general anaesthetic.

The patient was anticoagulated with warfarin and started on an anti-platelet dose of aspirin. One month later the defect was closed using a 9 mm atrial septal occlusion device introduced via a cardiac catheter (fig 1). By this time the neurological signs had completely resolved and aspirin was discontinued after three months. There have been no further episodes of thromboembolism.

Figure 1 Septal occlusion device clamped across the atrial septum.
Surgery and respiratory muscles

In their review of the effects of surgery on the respiratory muscles Siafakas and co-workers have cited my work incorrectly on two occasions.1 We reported a study of respiratory mechanics after abdominal surgery with measurements of the pressure-volume characteristics of the rib cage and abdomen.2 This report has been cited to support statements on the effects of surgery on gas exchange efficiency of the lung and of general anaesthesia on the thorax. On neither occasion is this citation appropriate. We found evidence that the abdominal muscles were active in patients after abdominal surgery, that this activity was variable, and that it could possibly explain the patterns of movement otherwise considered to represent “diaphragmatic dysfunction”. These observations, along with a short review of the published work on the subject, formed an editorial3 in which I argued that the concept of diaphragmatic dysfunction was outmoded. This work has been cited in support of the effects of laparoscopic cholecystectomy, which is incorrect. Indeed, there is remarkably little direct evidence that the intercostal inspiratory muscles become more active in the patient after surgery. There is also little direct evidence in humans that the diaphragm is the respiratory muscle most affected by surgery.

Many of the changes in the shape of the thorax caused by the induction of anaesthesia can be attributed to a loss of skeletal muscle tone, with a change in the shape of the vertebral column. If this is prevented, then the changes in thoracic dimensions during induction of anaesthesia are small, variable, and do not require the hypothesis of major movements of intravascular volume as indicated in fig 1 of their review.4 This is supported by direct measurements of intravascular volume, which do not show these shifts.5

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4 Spens HJ, Drummond GB, Wrath PK. Changes in chest wall compartment volumes on induction of anaesthesia with etomidate, propofol, and thiopentone. Br J Anaesth 1996;76:569–73

AUTHORS’ REPLY We wish to thank Dr Drummond for pointing out the incorrect citation of his work in our recent review.1 We apologise for this, especially for quoting his editorial2 for the effects of laparoscopic cholecystectomy on the respiratory muscles. However, we have extensively discussed the semantics of the term “diaphragmatic dysfunction” in the methodological part of our review, sharing some of Dr Drummond’s views.3 Furthermore, we have cited the work of Dr Drummond and colleagues in the general discussion of the function of respiratory muscles during surgery, arguing that respiratory muscle dysfunction, in the general sense of the term, could influence functional residual capacity. We believe that this is in agreement with Dr Drummond’s findings that upper abdominal surgery alters the relative activity of respiratory muscles (including the abdominal muscles) leading to changes in the rib cage abdominal configuration (fig 1, Nimmo and Drummond).4 Similarly, we have cited his work to support the argument that general anaesthesia causes volume displacement between the thoracic and abdominal cavities. Dr Drummond...
argues that this could be due to the loss of skeletal muscle tone. We have no objection to this since the respiratory muscles are skeletal muscles too. Furthermore, the changes seen in the pattern of breathing after upper abdominal surgery and the relative contributions of the rib cage and abdomen during quiet breathing have been attributed by most investigators to dysfunction of the diaphragm. Dr Drummond's experiments offer another explanation, pointing out the role of the abdominal muscles (the major respiratory muscles). Our own experiments have shown that upper abdominal surgery impairs the global strength of the inspiratory and expiratory muscles to produce maximum pressure. It is well known that the major contributor to the maximum inspiratory pressure (MIP) is the pressure produced by the diaphragm. Thus, it is logical to suggest that, if MIP is reduced after surgery, this is primarily due to diaphragmatic dysfunction. We believe that the above differences may be due to the different experimental conditions (quiet breathing versus maximum static pressures).

A further theoretical but serious consideration is that of re-expansion pulmonary oedema (REPE). This has been associated with excessively negative pleural pressures after removal of air or fluid from the pleural space. The study concludes that an ideal postoperative drainage system will “allow the maintenance of a negative intrapleural pressure, even in the presence of an air leak”. In our view a negative pleural pressure in this situation would only serve to encourage the egress of more air from the damaged lung surface into the pleural cavity, thus worsening the situation. Whilst accepting that the postoperative situation may differ somewhat from that which pertains in a spontaneous pneumothorax because of the presence of fluid/blood in the pleural cavity, we would urge caution before abandoning the standard and well tried technique of drainage of the pleural cavity (underwater seal) in favour of the suggested alternative, at least before data from larger, controlled clinical trials become available.

Postoperative air leaks

The study by Waller et al did not attempt to compare the clinical benefit, cost effectiveness, or relative convenience of the two alternative chest drainage systems—a flutter valve drainage bag or the conventional underwater seal. Instead it claims that the flutter valve offers a “physiologically more effective” alternative to the underwater system. However, a pneumothorax is a pathological rather than a physiological condition in which it is imperative to remove air from the pleural cavity. In this situation the pleural pressures will be higher than in the normal physiological state and, indeed, air will only exit the pleural cavity via a chest drain when the pleural pressure exceeds atmospheric pressure. Any drainage system for a pneumothorax that renders the pleural pressure more negative (relative to the atmospheric pressure) will therefore reduce the exit of air, other than by more forcible expiration, and reduce its effectiveness.

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Aspergillus fumigatus: re-invention of the wheel

The paper by Murayama et al contains the unwary statement that their study may have been the first to demonstrate the suppressive effects of Aspergillus products on antifungal host defences by both human alveolar macrophages and PMNs. A search for Aspergillus in the eThomus website would have saved both them and your referees from accepting this. In a series of papers published in the 1980s Maura Robertson and I showed this in animal and human cells, demonstrated the paradoxical effect of complement and, perhaps importantly, showed that the substance produced by the spores had similar effects on soil protozoa, thus explaining the biological paradox as to why an organism that gains access from colonising animal lungs should have developed such exquisite antiphagocytic properties. Some of this work was summarised in our paper published in the Lancet in 1989. These effects are discussed in at least one well known textbook of respiratory disease.1

It is to be hoped that the “wheel reinventing” tendency of authors who search the literature back only five years and the short memory or ignorance of referees may be alleviated by use of your new web site.

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AUTHORS’ REPLY
We thank the editors for the opportunity to respond to the concerns raised by Professor Seaton. His group 4 and Drs Mullbacher, Eichner et al in Australia 5 are pioneers in studies of the antiphagocytic activity of Aspergillus derived products and they have done some excellent work. We cited some of their original articles in our previous paper.1 Professor Seaton et al have shown that spores and spore diffusates of A fumigatus inhibit phagocytosis of antibody coated radiolabelled sheep red blood cells by mouse peritoneal exudate cells.2 They have also performed experiments using human cells and have shown that spore diffusates of A fumigatus reduce the migration of human polymorphonuclear leukocytes and decrease the capacity of mouse peritoneal exudate cells to spread on glass.3 They have measured the ability of human pulmonary macrophages to bind and kill A fumigatus spores and have examined the effects on killing of heat labile serum components.4 However, they have not presented data on the suppressive effects of Aspergillus derived products on polymorphonuclear leukocyte mediated damage to A fumigatus.

It has been considered that selective protection against Aspergillus spores by mononuclear phagocytes and against hyphae of Aspergillus by polymorphonuclear phagocytes are critical host defences in humans.5 Since Aspergillus spores enter mainly through the respiratory tract and proliferate in mycelial form in human tissues, our study has focused on interactions between Aspergillus spores and human alveolar macrophages, and also between Aspergillus hyphae and human polymorphonuclear leukocytes. In our study we showed that A fumigatus culture filtrate suppressed not only human polymorphonuclear leukocyte mediated A fumigatus hyphal damage but also inhibition of spore germination of A fumigatus by human alveolar macrophages, and suggested that A fumigatus produces a variety of substances, some of which may suppress antifungal (anti-A. fumigatus) activity of human alveolar macrophages and polymorphonuclear leukocytes. To our knowledge, our study is the first to demonstrate the suppressive effects of Aspergillus derived products on human polymorphonuclear leukocyte mediated hyphal damage of Aspergillus and also on inhibition of spore germination of Aspergillus by human alveolar macrophages.

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Aspergillus fumigatus: re-invention of the wheel

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