

CAS CLINIQUE

HTP

B. ESSAYAGH

Dr RENARD – Sce Pr HABIB



**Assistance Publique
Hôpitaux de Marseille**

CONTEXTE

- F 63 ans sans ATCD
- NYHA III + asthénie depuis 1 an
- Constantes normales
- B2 Normal, poumons claires
- Dilatation VD sans HTP majeure (PAPs= 40 mmHg)
- Pas d'EP à l'angioTDM

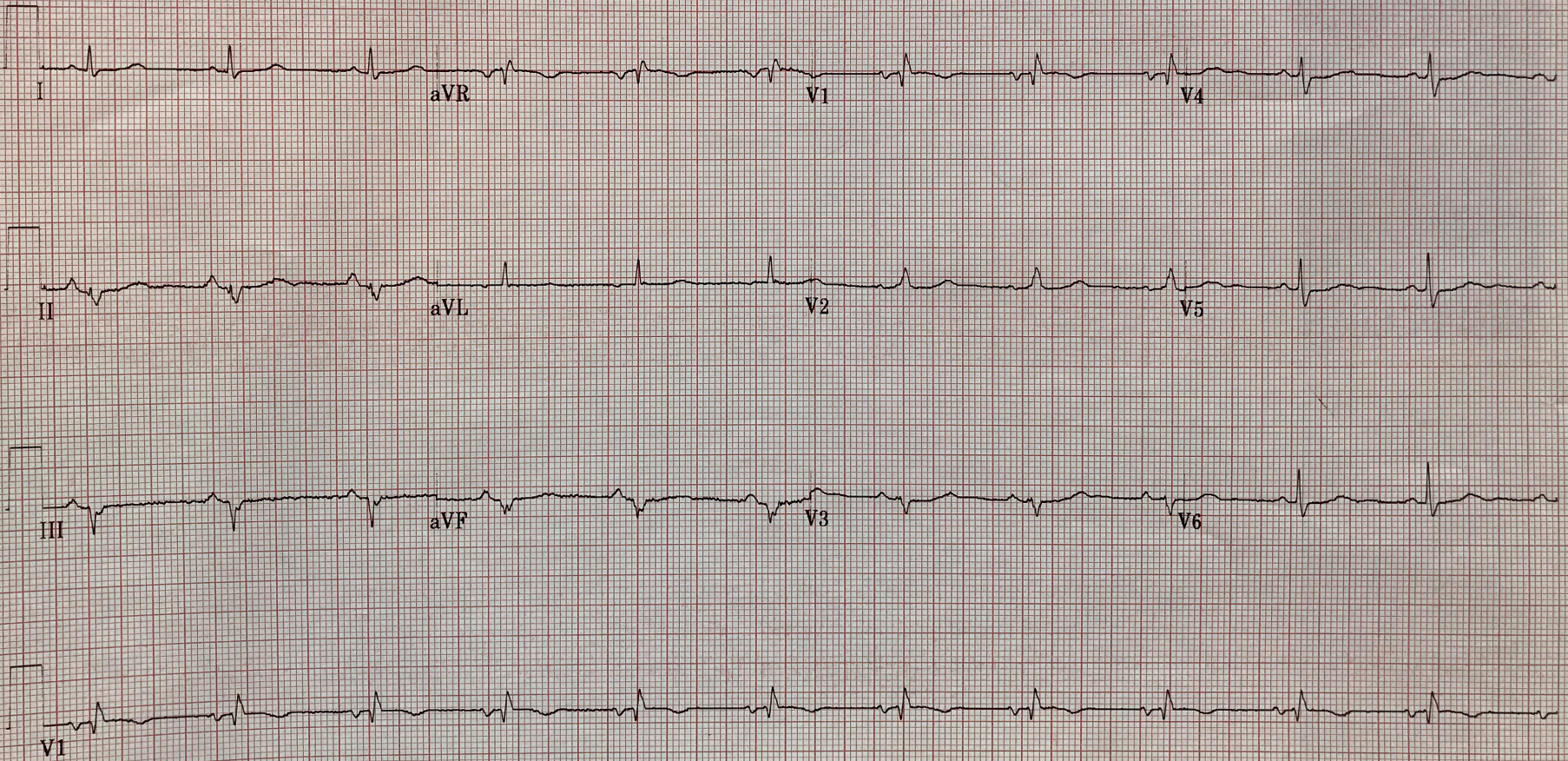
Fréq. ventr. 68 bpm
Intervalle PR 130 ms
Durée QRS 98 ms
QT/QTc 438/465 ms
Axes P-R-T 64 -41 54



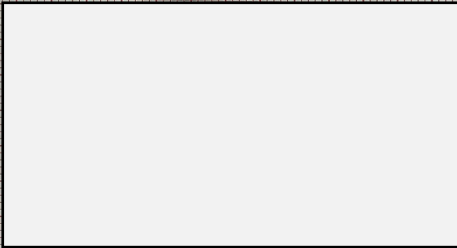
Indications:

PATIENT #001 22.NOV.16
HEUR FREQ SP02
11:00:16 68B ---
SYS DIA MOY
PR 118 / 74 93 mmHg

Non validé



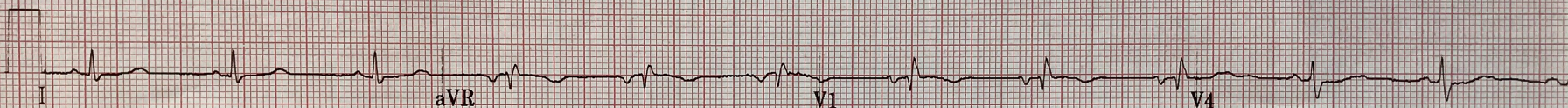
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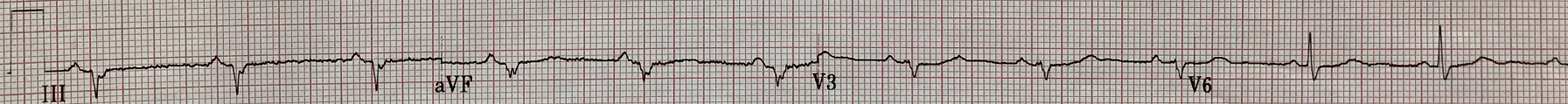
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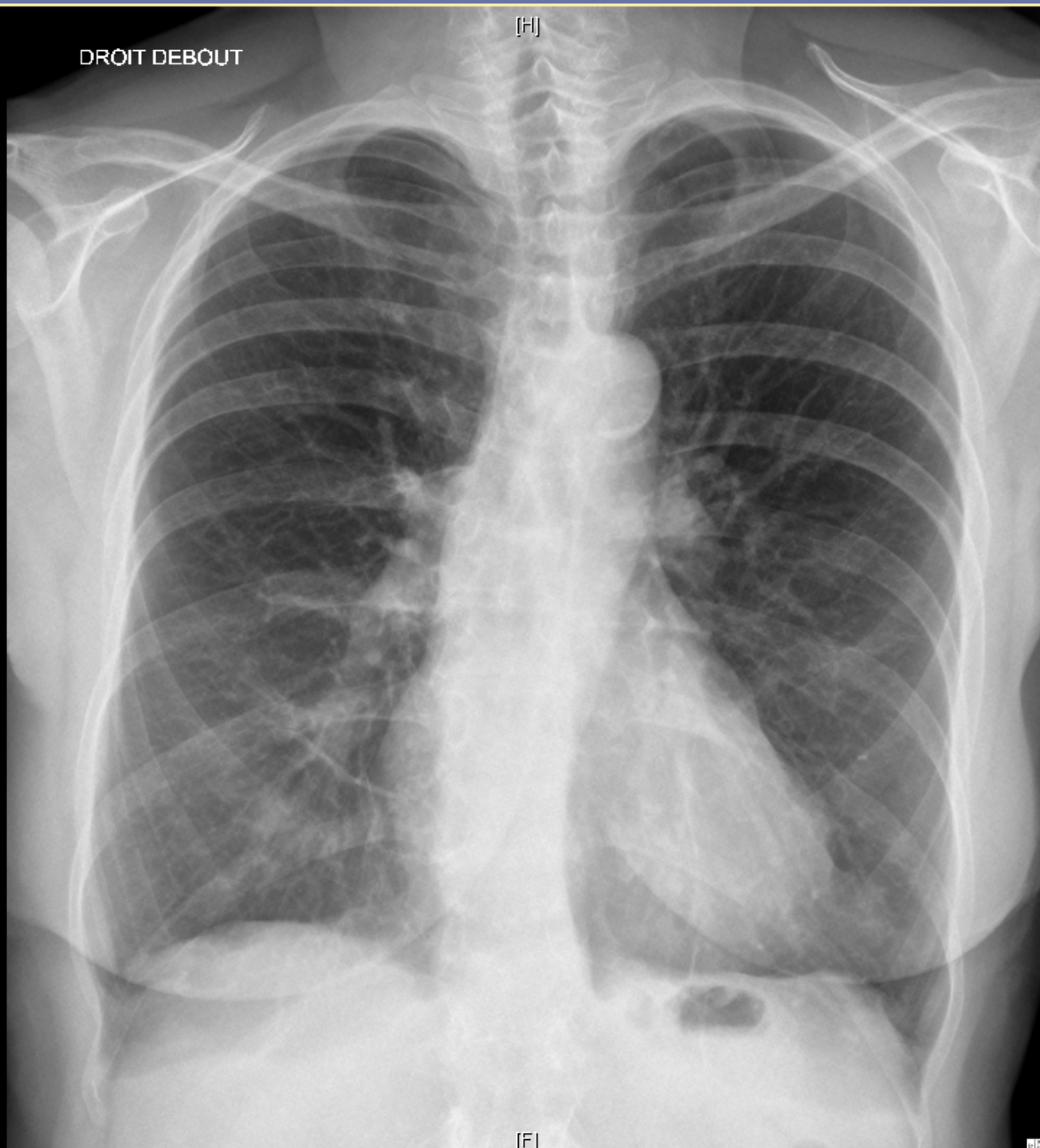


Axe gauche + aspect de BBD



DROIT DEBOUT

[H]

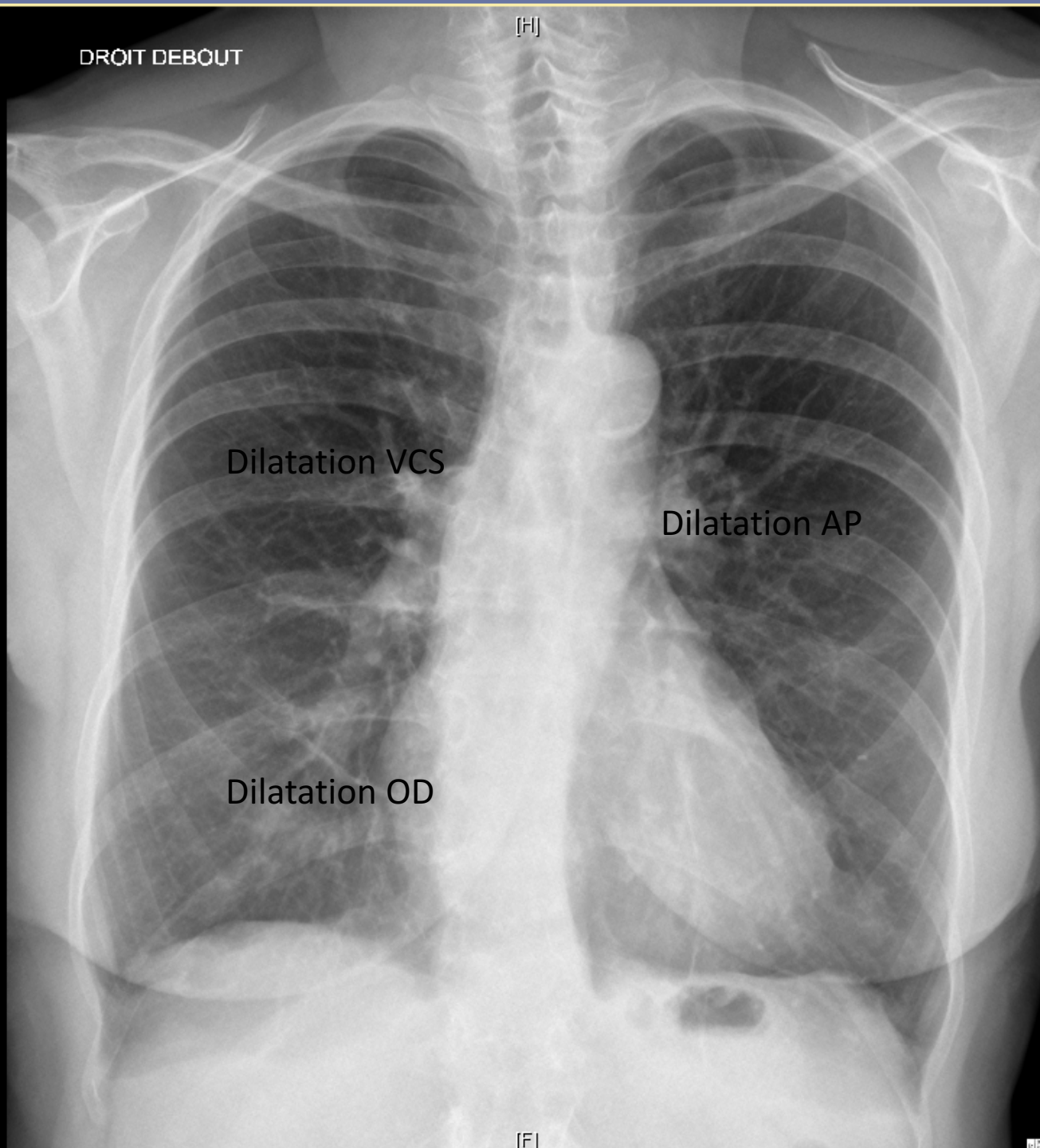


[F]

RF

DROIT DEBOUT

[H]



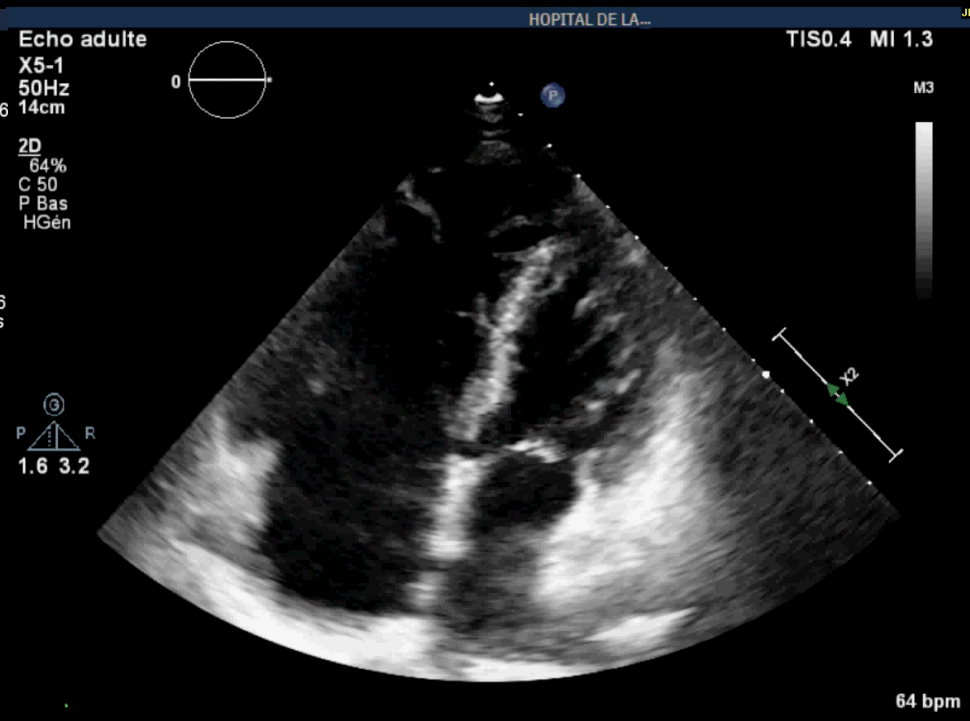
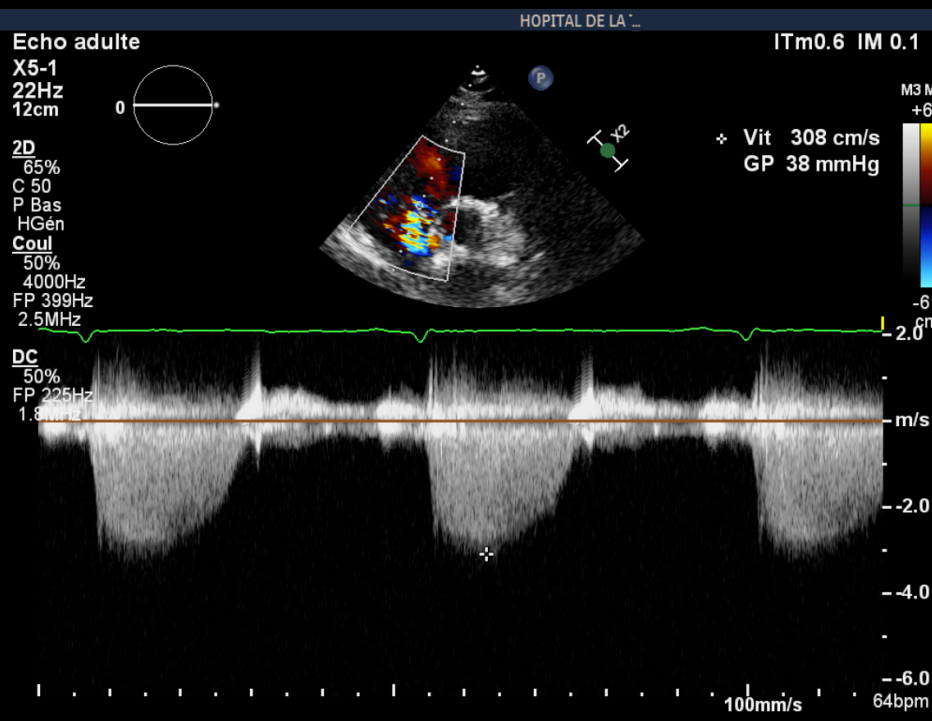
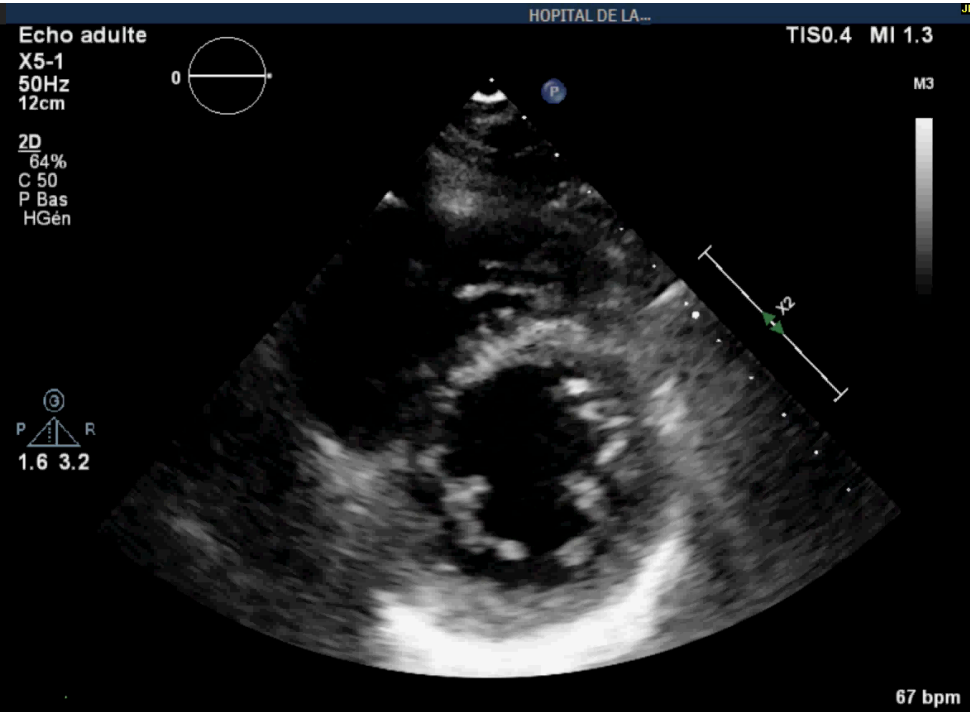
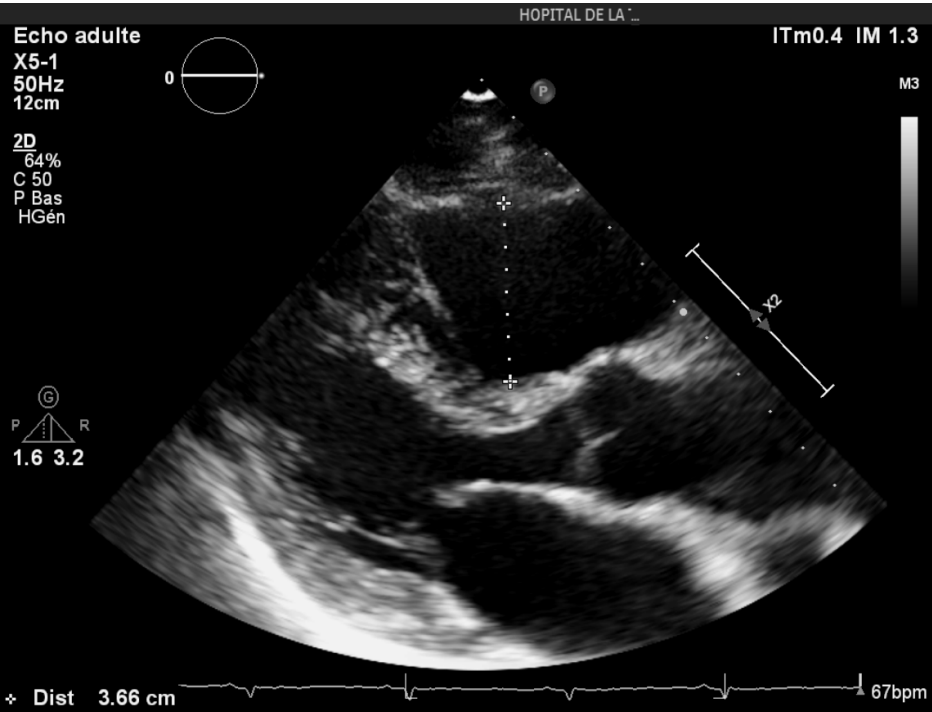
Dilatation VCS

Dilatation AP

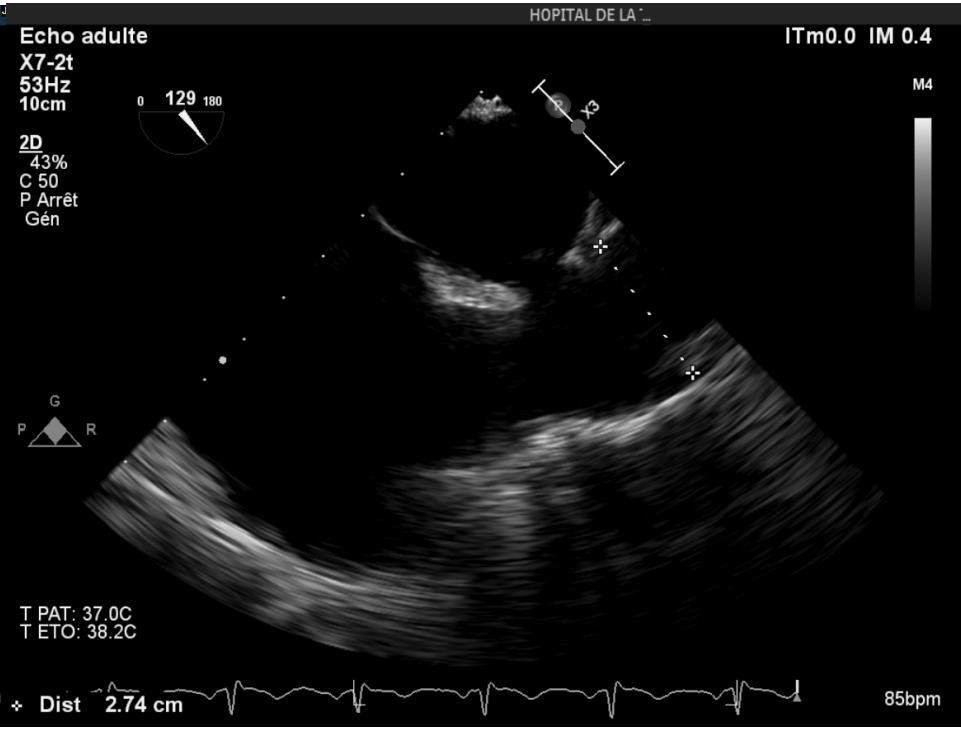
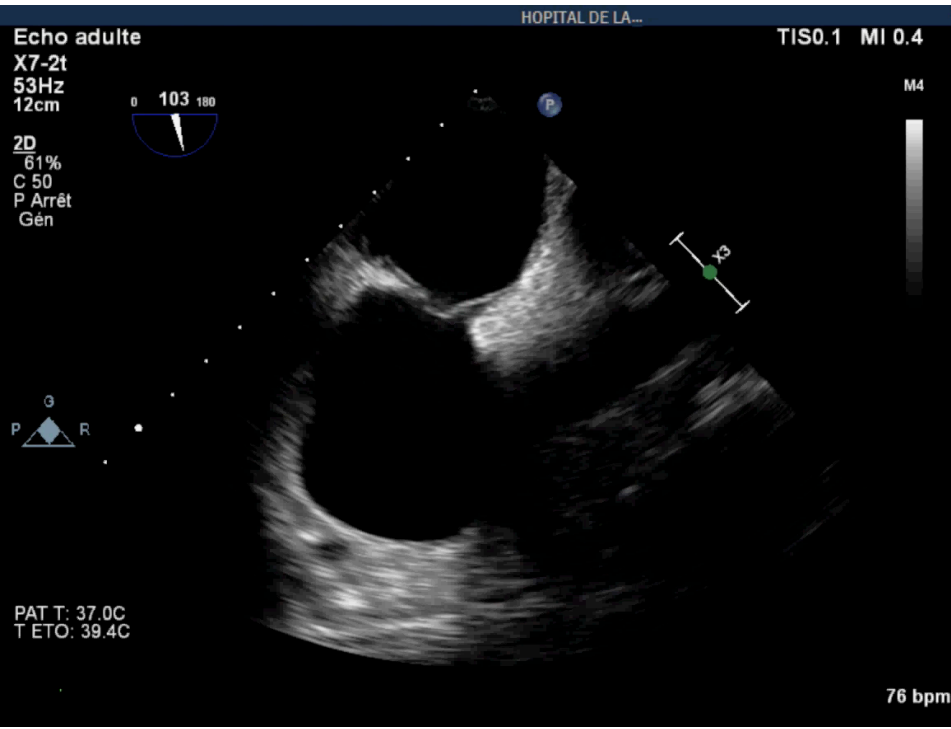
Dilatation OD

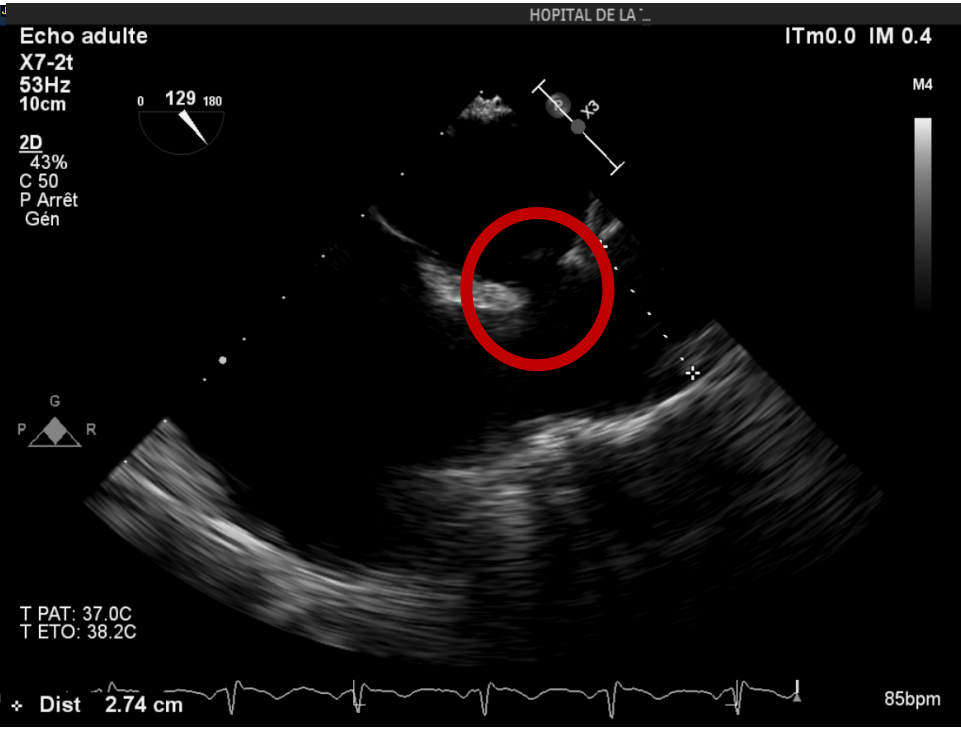
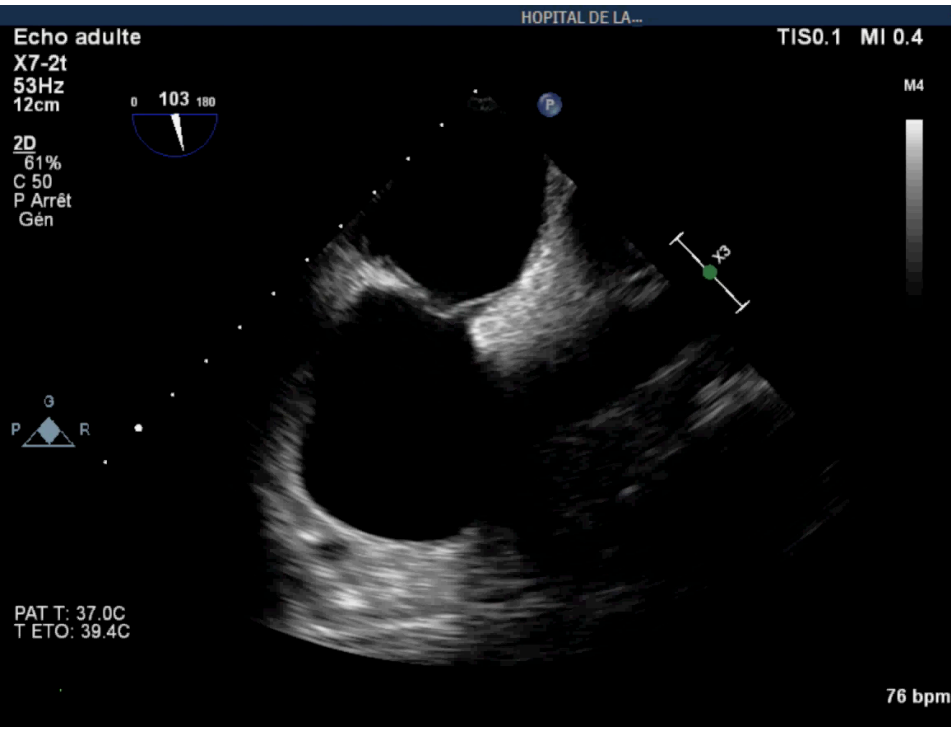
[F]

RF



DIAGNOSTIQUE ?

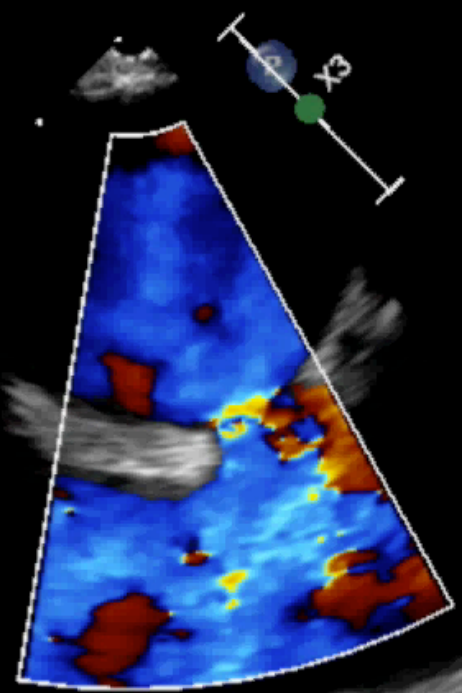




Echo adulte

X7-2t
24Hz
10cm

2D
48%
C 50
P Arrêt
Gén
Coul
48%
6838Hz
FP 615Hz
4.4MHz



PAT T: 37.0C
T ETO: 38.2C

85 bpm

Echo adulte

X7-2t

15Hz

10cm

xPlane

50%

50%

50dB

P Arrêt

Gén

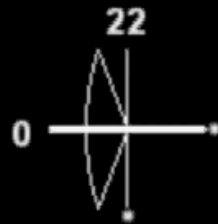
Coul

48%

6838Hz

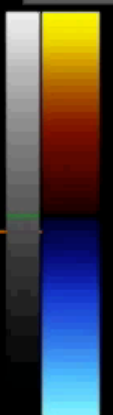
FP 615Hz

4.4MHz



M4 M4

+59.3

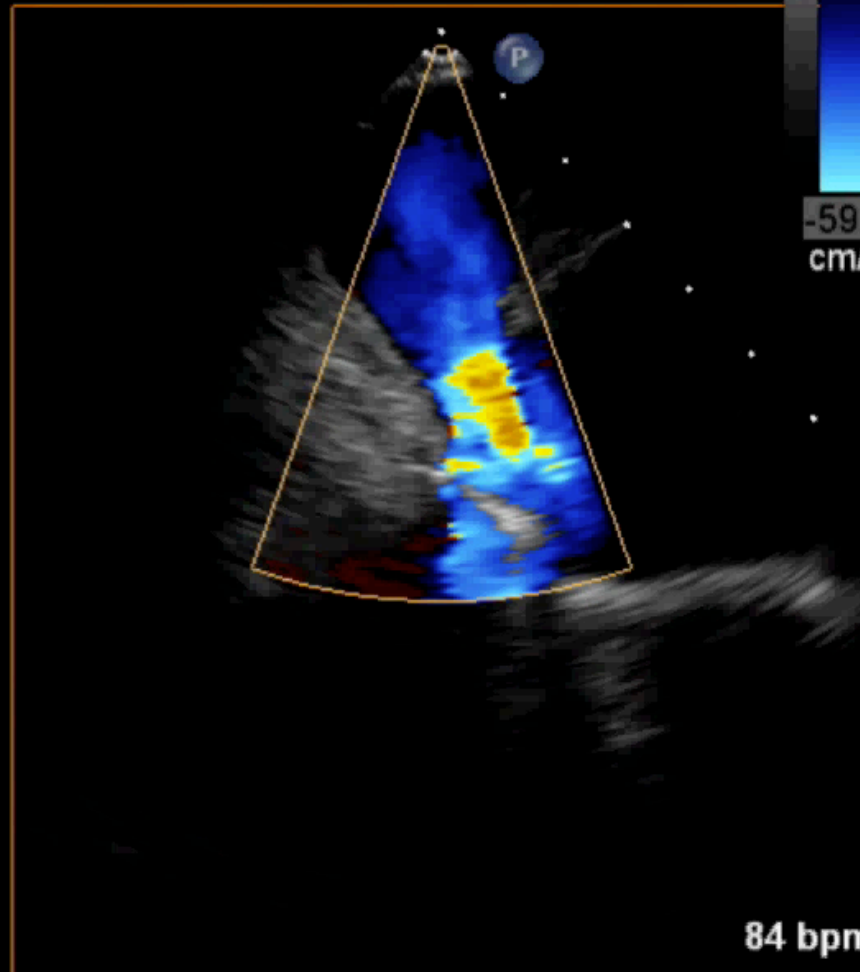
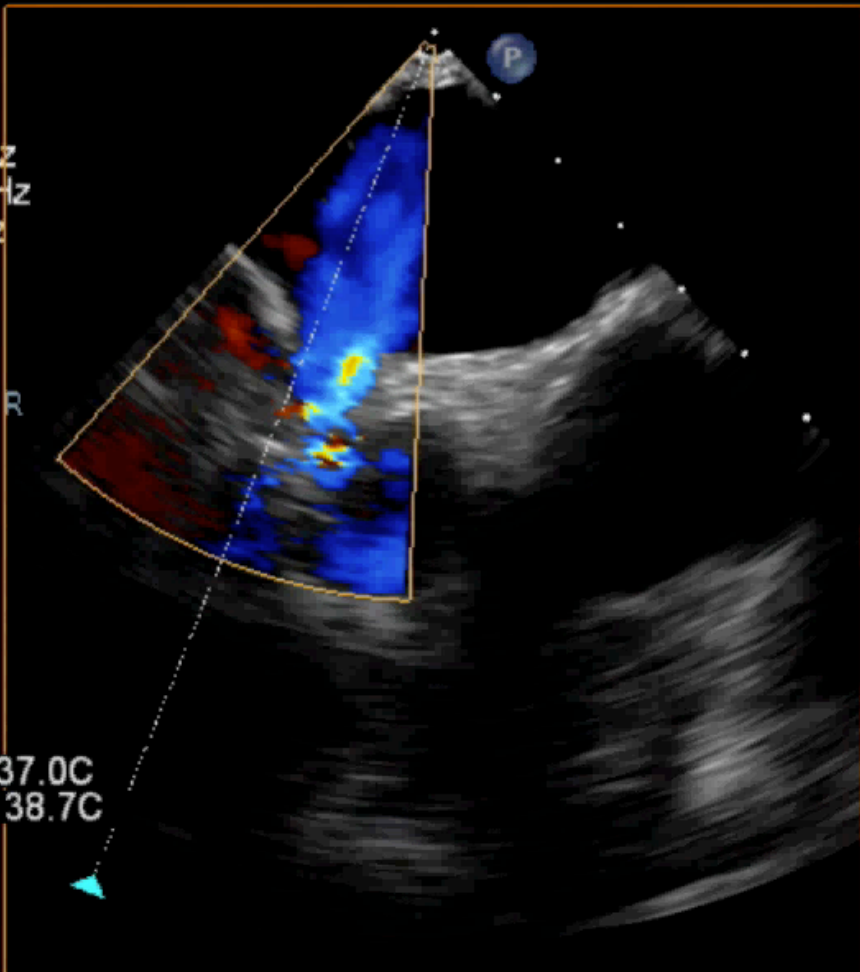


-59.3

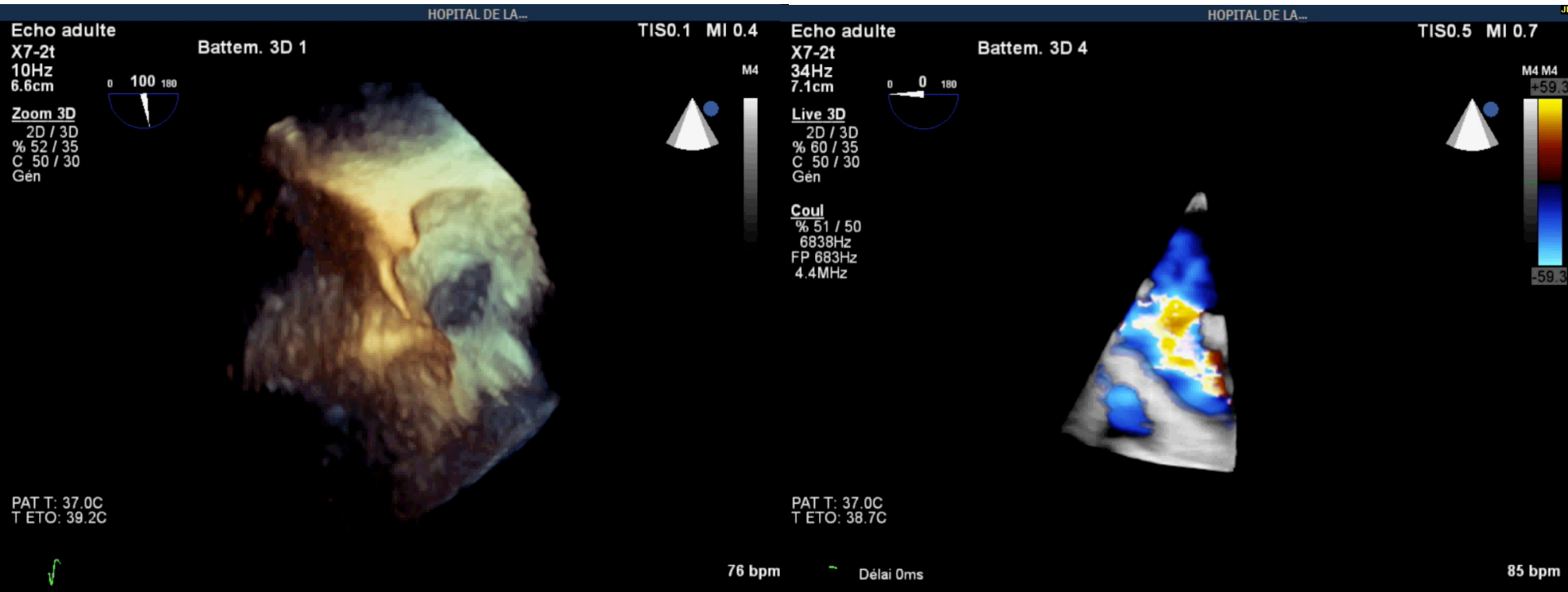
cm/s



PAT T: 37.0C
T ETO: 38.7C



84 bpm



CCL: CIA SINUS VENOSUS
=> Rechercher le **RVPA** associé



European Heart Journal (2010) **31**, 2915–2957
doi:10.1093/eurheartj/ehq249

ESC GUIDELINES



ESC Guidelines for the management of grown-up congenital heart disease (new version 2010)



European Heart Journal (2016) **37**, 67–119
doi:10.1093/eurheartj/ehv317

ESC/ERS GUIDELINES



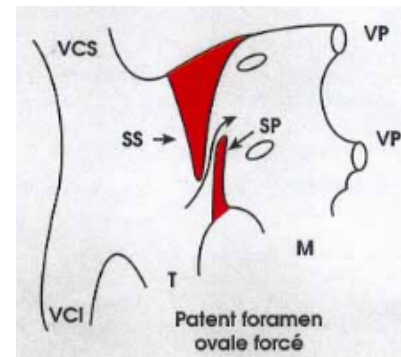
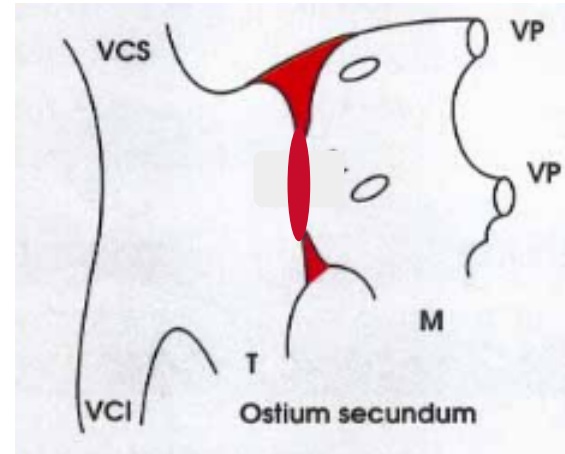
2015 ESC/ERS Guidelines for the diagnosis and treatment of pulmonary hypertension

Les CIA

- 10% des cardiopathies congénitales
- Prévalence : 5/10 000 naissances
- Prépondérance féminine (2/1)
- Découverte : 30% après 18 ans

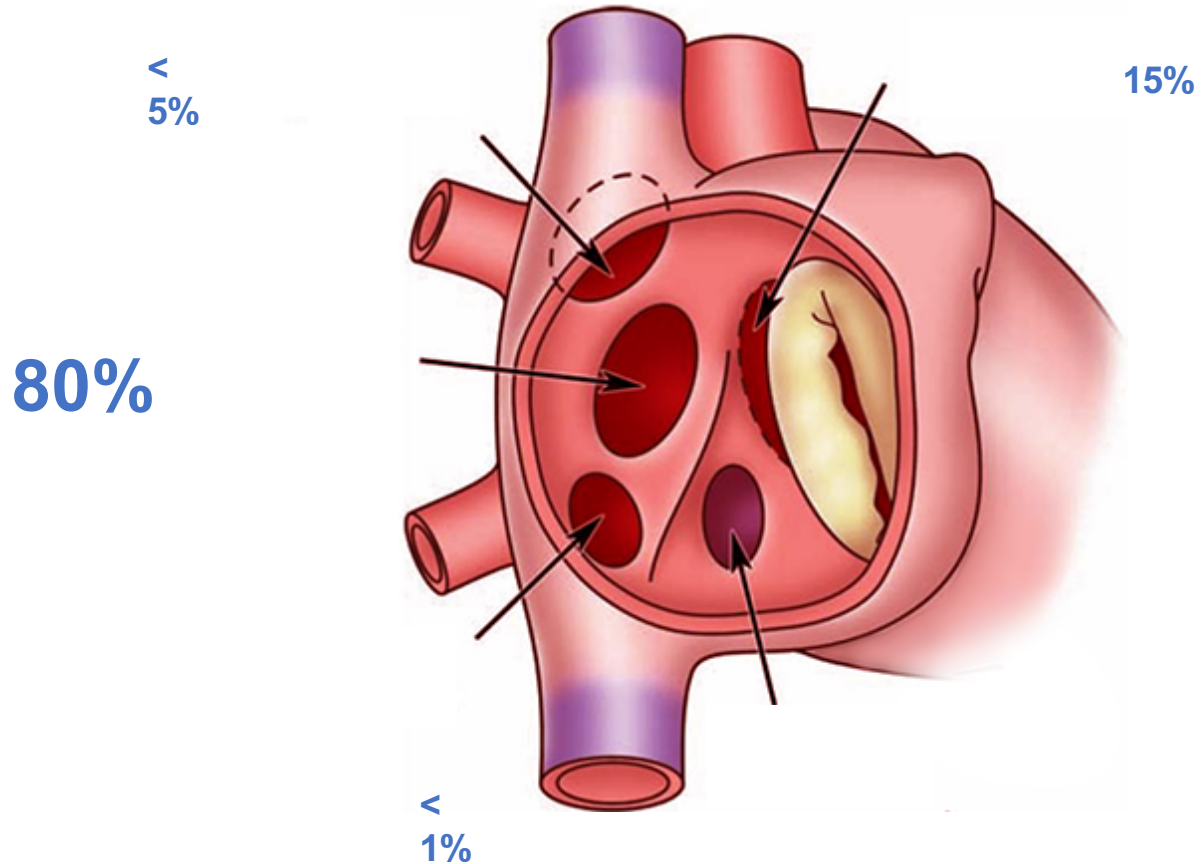
Les CIA

- Défect
- Shunt gauche- droit permanent



FOP

CIA : Types anatomiques

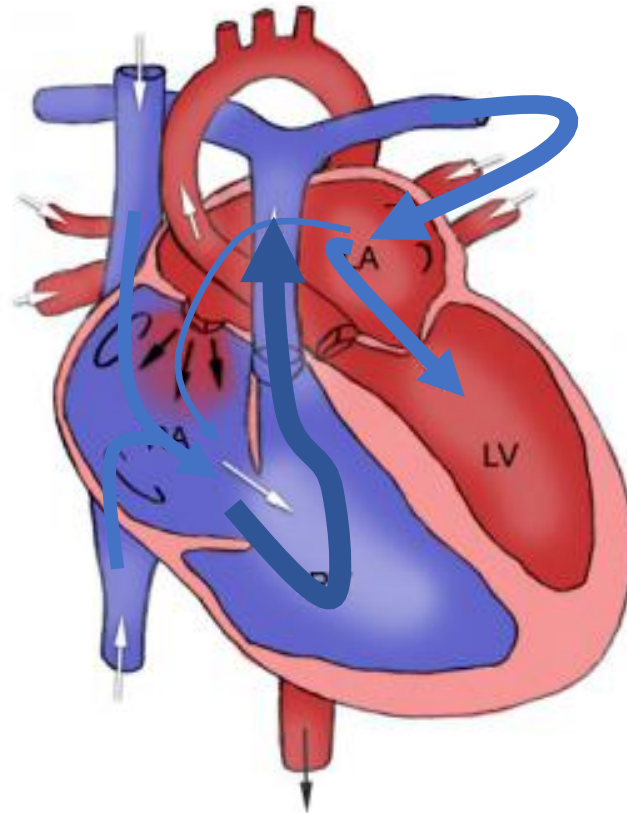


Physiopathologie de la CIA

- Importance du shunt à l'étage atrial dépend :
 - Taille du defect ++
 - Gradient de pression OG / OD
 - Compliance VD et VG
- « Significative » si :
 - diamètre > 10 mm (20 mm)
 - dilatation VD et AP +++

Physiopathologie de la CIA

- Surcharge volumique cardiaque droite avec Hyperdébit chronique dans circuit pulmonaire



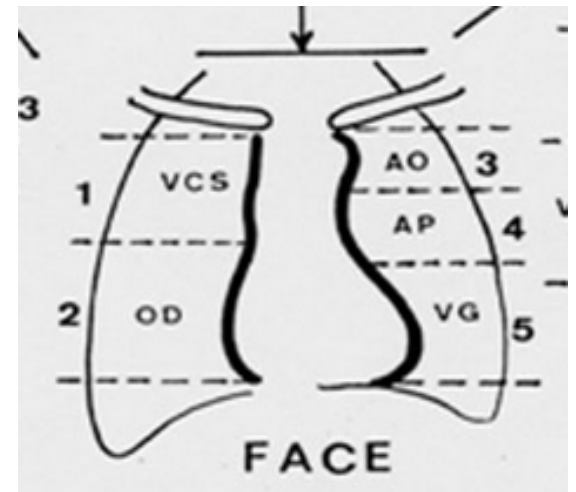
Découverte d'une CIA

- **Examen clinique :**
 - paucisymptomatique ++
 - souffle systolique pulmonaire
 - dyspnée, palpitation

- **Complications :**
 - Tachycardie supra-ventriculaire (Gatzoulis et al. N Engl 1999)
 - AIT / AVC
 - insuffisance cardiaque droite / HT(A)P (tardive)

Bilan paraclinique- CIA

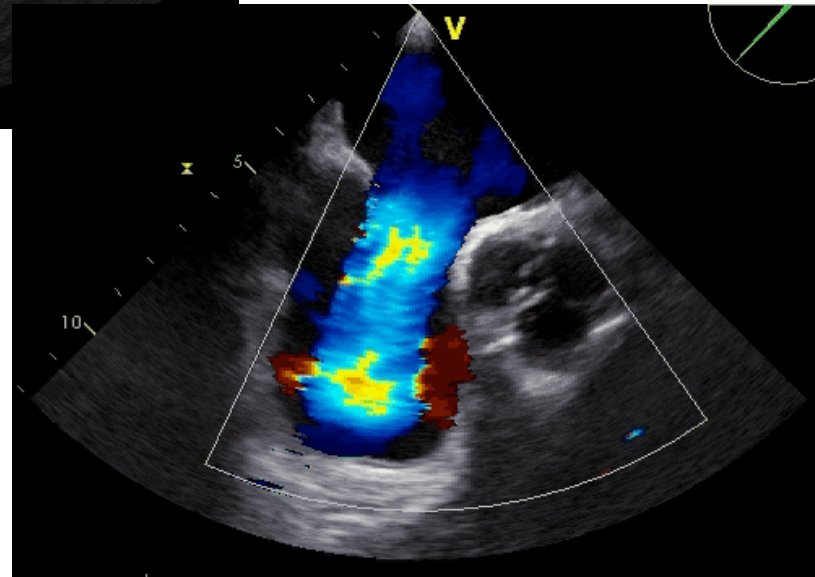
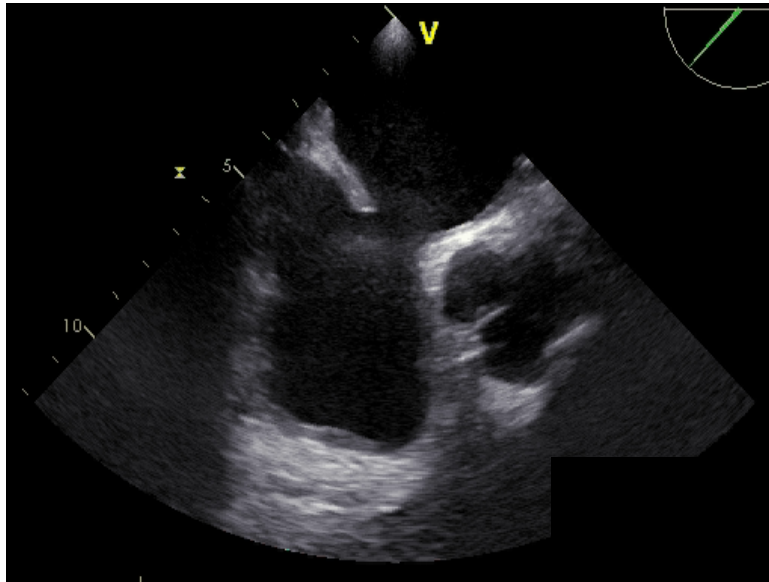
- **ECG** : BBD incomplet, surcharge droite, TSV
- **Thorax**: Cardiomégalie, dilatation AP / OD, hyper-vascularisation pulmonaire,
- **ETT** :
 - dilatation cavités droites
 - visualisation du defect
 - Elévation des PAPs



Bilan paraclinique- CIA

- ETO
- Examens de 2^{nde} intention :
 - Scanner Cardiaque : visualisation defect (CIA hautes +)
 - IRM cardiaque : dysfonction VD
 - Cathétérisme droit : bilan hémodynamique précis en cas d'HTP

ETO



Prise en charge : fermeture

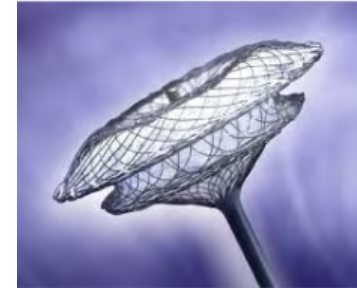
Table 3 Indications for intervention in atrial septal defect

Indications	Class ^a	Level ^b
Patients with significant shunt (signs of RV volume overload) and PVR <5 WU should undergo ASD closure regardless of symptoms	I	B ²⁶
Device closure is the method of choice for secundum ASD closure when applicable	I	C
All ASDs regardless of size in patients with suspicion of paradoxical embolism (exclusion of other causes) should be considered for intervention	IIa	C
Patients with PVR ≥5 WU but <2/3 SVR or PAP <2/3 systemic pressure (baseline or when challenged with vasodilators, preferably nitric oxide, or after targeted PAH therapy) and evidence of net L–R shunt (Qp:Qs >1.5) may be considered for intervention	IIb	C
ASD closure must be avoided in patients with Eisenmenger physiology	III	C

† ESC Guidelines for the management of grown-up congenital heart disease (new version 2010)

Prise en charge : fermeture

- Fermeture percutanée

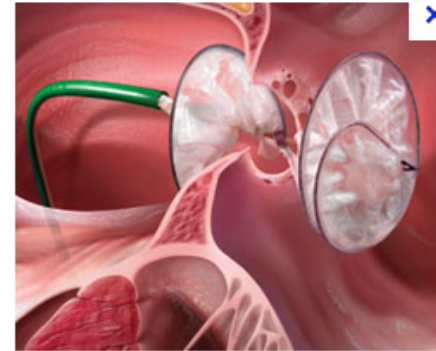


- Fermeture chirurgicale



Prise en charge : fermeture percutanée

- CIA type ostium secundum ++
 - 80% seront éligibles



- Limites :
 - Taille > 40 mm
 - Forme complexe / berges
 - Si autre anomalie associée (IM, RVPA)

Suivi après fermeture

- Aspirine 100 mg/j pendant au moins 6 mois

- Suivi au long cours : variable
 - Âge lors de la fermeture
 - Existence d'un retentissement
 - Persistance shunt résiduel