CASE REPORT

Spontaneous closure of an acquired ventricular septal defect

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Ventricular septal defect (VSD) is a rare but serious complication of acute myocardial infarction requiring early surgical intervention. A patient with acquired VSD that spontaneously closed over three months is presented. The literature on spontaneous closure of acquired VSDs is also reviewed.

CASE REPORT

A 66 year old man was admitted after a syncopal episode associated with a right sided weakness. There was no precipitating chest pain or aura. He had undergone cystoscopy and biopsy for dysuria three weeks before admission. He was a smoker of 40 packet years with no pre-existing cardiovascular symptoms or history. He denied a history of hypertension and his lipid profile was normal.

Physical examination revealed a pulse of 100 beats/min, regular. The blood pressure was 100/65 mm Hg and there was a harsh systolic murmur at the left sternal edge. The chest was clear and there was no peripheral oedema. Neurological examination revealed an ataxic gait with right upper limb weakness grade 4/5. The lower limbs were normal and the plantar reflexes equivocal.

Investigations

The electrocardiogram showed sinus rhythm 100 beats/min, left axis deviation, ST elevation, and T wave inversion in the anteroseptal leads. The chest radiograph was normal. Serum creatine kinase fraction peak was 1085 IU/l (normal range up to 175 IU/l) with raised aspartate transaminase 68 IU/l (normal range up to 40 IU/l). Transthoracic echocardiography (fig 1) revealed ventricular septal aneurysm with a small rupture of the distal septum causing a VSD with left-to-right shunting. Towards the left ventricular apex there was laminated thrombus. Computed tomography of the brain showed a hypodense area within the left cerebellar hemisphere compatible with recent infarction. A diagnosis of a recent anteroseptal myocardial infarction complicated by a VSD, laminated left ventricular thrombus, and cerebellar embolisation was made.

Management

Early closure of the VSD was not undertaken as he had severe chronic obstructive airways disease, and the defect was small and causing no haemodynamic decompensation. Therefore, it was decided to observe him closely. He was anticoagulated with warfarin and started on an angiotensin converting enzyme inhibitor (ACEI). He remained haemodynamically well and was discharged home on day 7. Three weeks later auscultation of the heart continued to reveal a soft pansystolic murmur and echocardiography showed no change in his

Figure 1  [A] Transthoracic echocardiogram in the apical four chamber view illustrating the left ventricle with the interventricular septum in the centre, the left ventricular lateral wall on the right of the figure, with the right ventricle on the left and the apex of the heart towards the top of the figure. The VSD is shown towards the apex with the red colour map demonstrating left-to-right blood flow across the interventricular septum. A laminated thrombus (arrow) is shown at the apex. (B) Apical two chamber view (inset) with a close-up in the main figure demonstrating the VSD in the apical anterior segment.

Abbreviations: ACEI, angiotensin converting enzyme inhibitor; VSD, ventricular septal defect
Vogel JH, Cummings RG, Reimer KA, Califf R, et al. Spontaneous closure of acquired VSD after blunt trauma has been reported.

To our knowledge, this is the first reported case of spontaneous closure of an acquired VSD arising from an anterior myocardial infarction.

REFERENCES

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