Acute respiratory distress syndrome following straightforward pulmonary vein isolation

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A 65-year-old man, healthy, no allergies, with paroxysmal atrial fibrillation underwent pulmonary vein isolation (PVI) using irrigated radiofrequency ablation (total 1500 mL saline during procedure) under general anaesthetic. The patient was in sinus rhythm with a structurally normal heart. He was therapeutically anticoagulated. Thrombus was excluded by trans-oesophageal echocardiogram. During ablation, the patient developed persistent junctional rhythm. Hours after the uncomplicated procedure he developed marked dyspnoea and pleuritic chest pain with bilateral lung base crackles. Echocardiography showed good left ventricular function and a 1.7 cm pericardial effusion. X-ray revealed pulmonary oedema and bilateral pleural effusions (figure). C-reactive protein was 200, no fever. Electrocardiogram was consistent with pericarditis. The patient was treated with intravenous furosemide, Tazocin, and Clarithromycin and oral non-steroidal anti-inflammatory drugs and non-invasive ventilation. No growth from blood cultures and markers for atypical pneumonia and vasculitis were normal. He recovered and was discharged home after 7 days. Sinus rhythm returned 1 week later. We diagnosed acute respiratory distress syndrome with pericarditis and pleurisy, without evidence of infection or heart failure. Similar cases are described after extensive ablation, but our patient had limited ablation demonstrating a rare complication even after straightforward PVI.

The full-length version of this report can be viewed at: http://www.escardio.org/communities/EHRA/publications/ep-case-reports/Documents/respiratory-distress.pdf.

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