Heart transplantation in primary amyloidosis

Transplante cardíaco em amiloidose primária

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Abstract
Cardiac amyloidosis is a disease that highly compromises the survival expectancy after the beginning of the symptomatic phase, usually with sudden death as the final event. The aggression to other organs, although, can make heart transplantation a disputable form of treatment taking into consideration the shortage of organ donors. The aim is to report the evolution with a survival of seven years after heart transplantation and in fair condition of a patient with amyloidosis. One year after the heart transplantation, the patient was referred to renal transplantation also in consequence of the disease aggression. The patient evolution was favorable compared to three other patients also from our service, who died early after the diagnosis. Even considering the multi-systemic nature of amyloidosis, we can accept that in selected patients the heart transplantation is justified, taking into account the very ill prognosis of the disease.


Resumo
A amiloidose cardíaca é doença altamente limitante da sobrevida, por morte súbita na maioria dos pacientes. Pela agressão contra outros órgãos, particularmente rins e sistema nervoso central, o transplante cardíaco tem sido opção questionável, face à escassez de órgãos. O objetivo é relatar a evolução, com sobrevivência de 7 anos, da paciente após transplante cardíaco por amiloidose, em boas condições. Um ano após o transplante cardíaco, houve indicação de transplante renal, também pela agressão da doença. Esta paciente contrasta com outros três pacientes de nosso serviço que foram a óbito, ainda na fase de avaliação. Apesar de sua natureza multisistêmica, a amiloidose cardíaca pode, em pacientes selecionados, justificar o transplante cardíaco, pela gravidade do seu potencial evolutivo após o início dos sintomas.

CASE REPORT

Patient, V.A.C., 49 years-old, was referred to our service, presenting heart dysfunction class III/IV (NYHA). The Doppler-echocardiogram performed revealed, normal size of the right and left ventricles; ejection fraction of the left ventricle was 53%, with probable biventricular amyloidal infiltration, including the ventricular septum, interfering with the myocardial complacence, compatible with the amyloidal deposit disease; important tricuspid insufficiency and minimal pericardial effusion (Figure 1). This finding was confirmed by cardiac magnetic resonance that evidenced compromising of the biventricular systolic function probably as a result of the deposit disease.

On August 3, 2001, it was performed a myocardial biopsy that revealed cardiac amyloidosis. Due to the unfavorable evolution, characteristic of the primary cardiac amyloidosis, it was indicated the heart transplantation (Figures 2 and 3).

After performing protocol for heart transplantation (normal laboratory examination, negative criss-cross match, pulmonary gradient of 6 mmHg), the patient was accepted for the heart transplantation procedure. On August 31, 2001, she suffered cardiopulmonary arrest, being performed the cardiopulmonary resuscitation maneuvers (CPR) successfully and given priority for heart transplantation.

Fig. 1 – Echocardiogram evidenced deposit disease (observe the ventricular septum)
On September 24, 2001, it was performed orthotopic heart transplantation, without intercurrences, however, being kept under peritoneal dialysis between September 19 and November 16, 2001.

The immunosuppression applied was oral cyclosporine 70 mg, every 12 hours, and mofetil micofenofate 500 mg, every 12 hours, applying 1 g of methylprednisolone at the end of the heart transplantation.

The myocardial biopsies performed on October 24, November 9 and December 16, 2001 revealed zero degree. The renal function kept progressively declining, being confirmed by renal biopsy performed on October 31, 2001, the presence of renal amyloidosis, being indicated for transplantation by the nephrology group.

The evolution after the renal transplantation, which was performed on April 8, 2002; was positive when the immunosuppression threefold scheme was applied, adding prednisone in low doses of 0.1 mg/kg to cyclosporine and to mofetil micofenolate.

After 11 months from the cardiac transplantation, the patient was interned due to tachycardia and fever to be confirmed. It was performed a Doppler-echocardiogram that revealed left ventricle with normal function, size and segment contraction, mild tricuspid insufficiency, normal aorta and right chambers, with no further abnormalities. The cardiac biopsy demonstrated zero degree, eliminating rejection from the graft, maintaining the same scheme of immunosuppression.

It was diagnosed bronchopneumonia by the thorax X-Ray and clinical examination, being performed the adequate therapy.

No biopsy performed revealed any evidence of amyloidosis that could imply aggression rejection to the implanted organ (Figure 4).

DISCUSSION

In the literature review, there is an insufficiency of series with a significant number of cases that could establish a reliable pattern for the dubious and difficult referral of transplantation for cardiac amyloidosis. The larger series found was at the Harefield Hospital, England, in which, out of 10 operated cases, only one patient achieved late survival [9]. All other issues on the subject refer to isolate cases, however, there are reports that state the possibility of treatment for the amyloidosis disease as a real clinical alternative, which brings new expectations for these patients [1,3-8].

In the present case there was also found renal aggravation and we were able to preserve the kidneys function at acceptable levels, reducing the cyclosporine dosage. Nearly a year later, a renal transplantation was required; however, it is worth mentioning the fact that no cardiac biopsy suggested any degree of cardiac rejection,
even considering the immunosupresor scheme attenuated by the difficult clinical characteristics that the patient presented.

Other three cases of cardiac amyloidosis evaluated at our service, died right after the diagnosis, still at the stage of diagnostic investigation for heart transplantation.

In the literature, we find different opinions regarding the opportunity for heart transplantation as a consequence of cardiac amyloidosis, however, due to the fair 4-year evolution of our patient, we could assume that young patients suffering limited amyloidosis aggression to the heart (or heart and kidneys) can be candidates for heart transplantation until there are larger series of patients that could definitely clarify this difficult issue.

Also, favorable to this policy, there is the fact that the clinical therapy for this deposit disease has been attempted with reasonably initial success [2,6,9].

REFERENCES


