CASE REPORT

Pulmonary Artery Aneurysm Associated with Bicuspid Pulmonary Valve

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Abstract:
A 73-year-old Japanese man was admitted with an asymptomatic pulmonary artery aneurysm. However, chest X-ray and contrast-enhanced thoracic computed tomography revealed a protrusion at the second left branch that in fact was a pulmonary artery aneurysm with a diameter of 50 mm. Transesophageal echocardiography showed a bicuspid pulmonary valve, and cardiac catheterization revealed pulmonary stenosis with a pressure gradient of 45 mmHg, but no other heart diseases were noted. An extremely rare pulmonary artery aneurysm associated with an isolated bicuspid pulmonary valve was diagnosed.

Key words: anomaly, congenital heart disease, systolic murmur

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Introduction

Pulmonary artery aneurysms (PAAs) are rare, having been identified in only 8 of 109,571 autopsies. They generally occur in younger persons compared with other types of aneurysms with an equal sex incidence (1, 2).

Several pathologies are related to PAAs, and pulmonary valve stenosis is one cause of PAAs due to dilation after stenosis (3). Although pulmonary valve stenosis is not unusual in terms of congenital heart diseases, isolated bicuspid pulmonary valves without other congenital abnormalities are rare (4).

We herein report an extremely rare PAA with an isolated bicuspid pulmonary valve.

Case report

A 73-year-old Japanese man was admitted with a PAA. Pulmonary emphysema associated with smoking (cigarette 30/day for 35 years) had been pointed out one year before. His family history showed no remarkable disease, including cardiovascular diseases, infectious diseases, and autoimmune diseases. Although a heart murmur had been identified at a medical checkup several years previously, it had not been further assessed. Chest X-ray during a routine medical checkup at 72 years old had shown a round mass in the left middle lung field (Fig. 1A). Contrast-enhanced chest computed tomography (CT) 6 months ago revealed a PAA with a diameter of 50 mm (Fig. 1B). He had had no symptoms, such as dyspnea or chest pain, when he worked as a fisherman.

A physical examination upon admission showed height 155 cm, body weight 56.6 kg, blood pressure 138/75 mmHg, heart rate 74/minute, and oxygen saturation 95% on room air. A Levine grade 3 systolic murmur was heard with normal respiratory sounds, and he had no hepatosplenomegaly and no leg edema. He also had no skin lesions, aphtha, or arachnodactyly. We consulted with an ophthalmologist, who reported no abnormal findings in his eyes, including lens dislocation and uveitis.

Laboratory data were normal, including N-terminal pro brain natriuretic peptide (NT-pro BNP) 45.8 pg/mL, C-reactive protein 0.09 mg/dL, anti-nuclear antibody <20, β-D-glucan 5.4 pg/mL (normal <20), and the T-SPOT test (-). Electrocardiography findings were normal without right heart overload. Transthoracic echocardiography (TTE) showed a normal left ventricular systolic function, no rightsided cardiac overload, pulmonary valve stenosis with mosaic flow in the pulmonary valve, and peak systolic velocity of transpulmonary flow of 3.4 m/s, indicating a mean systolic pressure gradient in the transpulmonary valve of 45
mmHg. Transesophageal echocardiography (TEE) confirmed these findings and revealed systolic doming of the pulmonary valve in the long-axis view, no pulmonary valve calcification, and a bicuspid pulmonary valve in the short axis (Fig. 2). Planimetry showed that the area of the pulmonary valve was 1.7 cm², but cardiac shunt diseases were undetectable.

The PAA findings on contrast-enhanced CT were the same as those from six months earlier (Fig. 3A, B). Pulmonary ventilation perfusion scintigraphy did not reveal a pul-

Figure 1. Chest radiography findings one year ago and contrast-enhanced chest computed tomography findings six months ago. (A) Chest radiography shows protrusion of the left second branch. (B) Contrast-enhanced chest computed tomography shows pulmonary artery aneurysm with a diameter of 50 mm (arrow).

Figure 2. Pulmonary valve views and transesophageal echocardiography findings. The long-axis view of the pulmonary valve in the diastolic (A) and systolic (B) phases. The short-axis view of the pulmonary valve in the diastolic (C) and systolic (D) phases.
monary artery embolism. Cardiac catheterization showed normal systolic, diastolic, and mean pulmonary artery pressures of 31, 11, and 18 mmHg, respectively, and the peak-to-peak pressure gradient from the pulmonary artery to the right ventricle was 45 mmHg. Right ventriculography showed systolic pulmonary valve doming and jet flow to the pulmonary artery with the PAA (Fig. 4). The blood gas sampling test showed no O₂ step-up in the heart. Other data of these patients. Three of the patients, including our own, were women, 2 were men, and 4 patients were asymptomatic at the time of the PAA diagnosis. The age of the reported patients ranged from 55-73 years, 5 were women, 2 were men, and 4 patients were asymptomatic. The present patient is the second man and the oldest of these patients. Three of the patients, including our own, had been asymptomatic at the time of the PAA diagnosis. Thus, imaging tests including, chest X-ray, TTE, CT, and magnetic resonance imaging (MRI), are important for the diagnosis of PAA.

The diagnosis of a bicuspid pulmonary valve is even more difficult than that of a PAA. The present case was revealed by TEE, although it was unable to be diagnosed by contrast CT because it was not synchronized on electrocardiograms. MRI is one of the most important imaging modalities in such cases, as bicuspid pulmonary valve was diagnosed by MRI in three of these patients.

The mechanisms underlying PAA formation in patients with congenital heart disease are an increased pulmonary
blood flow due to left-right shunt, volume overload due to severe pulmonary valve regurgitation, and dilation after pulmonary valve stenosis (5). A separated post-stenotic flow and increased wall shear stress in a bicuspid pulmonary valve might also play important roles in PAA formation (13). However, PAA develops even when the degree of pulmonary stenosis due to a bicuspid pulmonary valve is mild. Thus, a bicuspid pulmonary valve might also play important roles in PAA formation.

The risk of rupture and dissection of a PAA is lower in patients with a low pulmonary pressure and no pulmonary hypertension or shunt disease than in others (14). The factors associated with an increased risk of rupture and dissection are a pulmonary artery pressure >50 mmHg, diameter >75 mm and expansion >2 mm within one year (15).

The histopathology of PAA associated with an isolated bicuspid pulmonary valve remains unknown, although cystic medial necrosis and elastic fragmentation of the pulmonary artery and aortic walls have been identified in some patients with a bicuspid aortic valve (16). The indications for surgical or catheter treatment for pulmonary valve stenosis are a class I maximum systolic pressure gradient >64 mmHg, class IIa maximum systolic pressure gradient <64 mmHg, symptomatic condition, and right ventricular dysfunction with right-to-left shunt caused by other congenital heart diseases (17, 18).

The PAA and bicuspid pulmonary valve were not treated in the present patient because his pulmonary artery pressure was low, the pulmonary artery diameter was 50 mm and had not expanded over time, the pressure gradient of the pulmonary valve was 45 mmHg, he was asymptomatic, and he had no other congenital heart diseases. His symptoms were monitored, and the pressure gradient of the pulmonary valve and the diameter of the pulmonary artery were respectively assessed by TTE and CT.

In conclusion, the timing of intervention is difficult to determine when PAAs are complicated with a bicuspid pulmonary valve because the condition is very rare.

**The authors state that they have no Conflict of Interest (COI).**

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