**CASE REPORT**

Treatment with epoprostenol of pulmonary arterial hypertension following mitral valve replacement for mitral stenosis

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Pulmonary hypertension frequently complicates mitral stenosis. Increased pulmonary artery pressure results from raised left atrial pressure, pulmonary arteriolar constriction, and obliterator changes in the pulmonary vascular bed, and usually responds to surgical relief of mitral stenosis. However, severe pulmonary hypertension may persist after surgical treatment of mitral stenosis. We describe a patient whose severe pulmonary hypertension following mitral valve replacement was treated successfully with continuous intravenous epoprostenol.

Epoprostenol was first introduced for the treatment of primary pulmonary hypertension in 1984. Subsequent investigations showed that continuous intravenous administration of epoprostenol provided effective treatment for pulmonary arterial hypertension related to the CREST variant of systemic sclerosis, human immunodeficiency virus infection, and portopulmonary hypertension. These observations expanded the use of epoprostenol to patients with pulmonary arterial hypertension, but the use of epoprostenol to treat pulmonary hypertension associated with surgically corrected mitral stenosis has not been described.

**DISCUSSION**

Pulmonary hypertension is a common complication of severe mitral valve disease. Raised pulmonary artery pressure results initially from increased left atrial pressure, pulmonary arteriolar vasoconstriction, and ultimately oblitterative changes in the pulmonary vascular bed. Wood studied 500 cases of critical mitral stenosis, 12% of whom had extremely high pulmonary vascular resistance (>10 units) and 16% in whom it was moderately high (6–10 units). Injection of 1 mg acetylcholine lowered pulmonary artery pressures in 14 of 16 cases, but in two cases with extremely high pulmonary vascular resistance there was no response, presumably because of oblitterative pulmonary vascular disease.

Mitral valve replacement generally alleviates pulmonary hypertension, but a small subgroup of patients have persistent severe pulmonary hypertension in spite of relief of mitral stenosis by closed valvuloplasty or mitral valve replacement. Other patients with extreme preoperative increases in pulmonary vascular resistance do not survive valvuloplasty or valve replacement because of pulmonary vascular disease. Failure to respond to surgical relief of mitral stenosis often reflects pathological changes in the pulmonary arteries that resemble those seen with other causes of pulmonary arterial hypertension. Excessive thickening of the media and intimal fibrosis of small muscular pulmonary arteries are typical of long standing mitral

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**Table 1** Haemodynamic variables 2 years after mitral valve replacement (baseline) and after long term epoprostenol treatment

| Variable                        | Baseline | Epoprostenol 6 months | Epoprostenol 17 months |
|---------------------------------|----------|-----------------------|------------------------|
| Mean systemic arterial pressure | 83       | 83                    | 90                     |
| (mm Hg)                         |          |                       |                        |
| Mean right atrial pressure      | 12       | 16                    | 16                     |
| (mm Hg)                         |          |                       |                        |
| Mean pulmonary artery pressure  | 65       | 55                    | 57                     |
| (mm Hg)                         |          |                       |                        |
| Cardiac output (l/min)          | 2.2      | 2.9                   | 3.2                    |
| Pulmonary artery occlusion      | 12       | 16                    | 18                     |
| pressure (mm Hg)                |          |                       |                        |
| Left ventricular end diastolic  | 12       | 7                     | –                      |
| pressure (mm Hg)                |          |                       |                        |
| Pulmonary vascular resistance   | 1560     | 1072                  | 999                    |
| (dyne s/cm⁵)                    |          |                       |                        |

*Epoprostenol dose 24 ng/kg/min.
†Epoprostenol dose 26 ng/kg/min.
‡Thrombosis of the anterior leaflet of the St Jude valve led to mild increases in pulmonary artery occlusion pressure at 6 months and 17 months after epoprostenol was started.
Lung Alert

Does a raised pro-BNP level in pleural fluid aid the diagnosis of effusion due to heart failure?

Parcel JM, Vives M, Cao G, et al. Measurement of pro-brain natriuretic peptide in pleural fluid for the diagnosis of pleural effusions due to heart failure. Am J Med 2004;116:417-20.

Plasma levels of B-type natriuretic peptide (BNP) are increased in heart failure. The aim of this study was to assess the usefulness of BNP measurements in pleural fluid from patients with and without heart failure. The pro-BNP concentration was measured in 117 pleural fluid samples taken from patients with heart failure, malignant effusions, tuberculous pleurisy, parapneumonic effusions, hepatic hydrothorax, and effusions secondary to pulmonary embolism. In patients with heart failure the median level of pro-BNP was significantly higher than in all other groups (p<0.001). A pleural fluid BNP concentration of ≥1500 pg/ml had a sensitivity of 91% and specificity of 93% for the diagnosis of cardiac failure and, furthermore, a high pro-BNP level helped to correctly identify those heart failure patients, mostly on diuretics, who were classed as having exudates according to Light's criteria.

There are, however, limitations to the study. It is not reported whether pro-BNP levels were more predictive of heart failure than clinical variables such as a history of myocardial infarction, and it did not compare the pleural pro-BNP concentration with plasma BNP levels. Further studies are required to clarify the clinical usefulness of pleural fluid BNP assay.

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