Ipertensione nefrovascolare ed edema polmonare acuto «flash»

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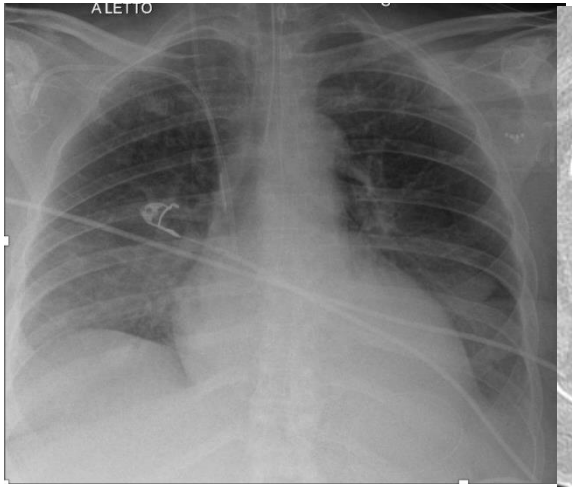
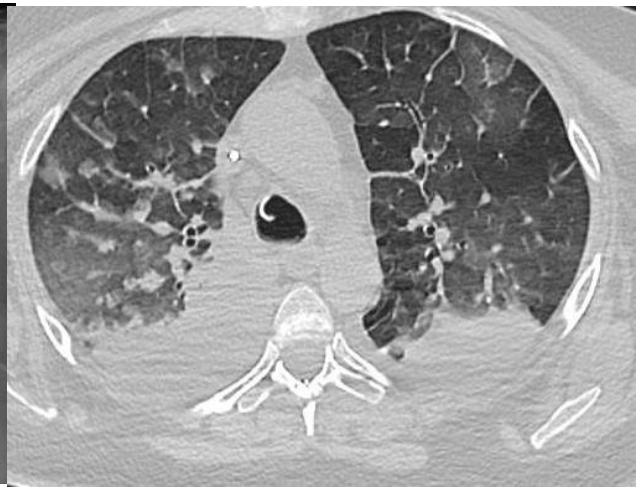
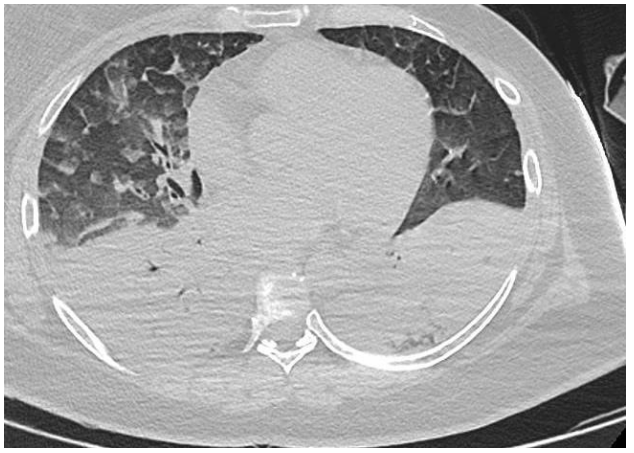
- Donna 46 aa, fumatrice, obesa
- 39 aa carcinoma mammario: mastectomia, RT, CT, examestane, triptorelina
- 40 aa (2017) ipertensione arteriosa (candesartan 16 mg, amiloride 5 mg/HCT 50 mg)

- 8/1/2023 in DEA dispnea e tosse da 1 h
  - PA 220/160 mmHg, FC 130 bpm, SpO2 60% AA
  - PH 7, PaCo2 76 mmHg, PaO2 69 mmHg

- ECG tachicardia sinusale FC 130/min, scarsa progressione R V1-V4, atipie diffuse recupero
- ECO fast VS con ipocinesia diffusa, FE ispettiva 25-30%, VCI 22 mm
- Consulenza cardiologica EPA iperteso in CMP non nota precedentemente
- Nitrati e furosemide ev. IOT. Ricovero in UTI







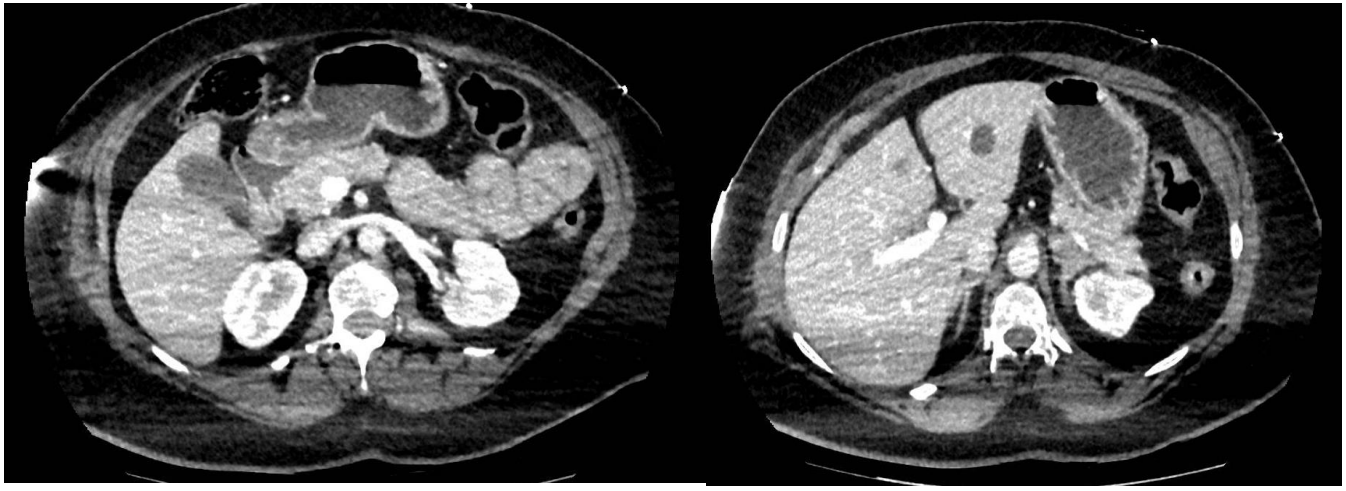
Infarto lacunare insulare dx

Estesi addensamenti parenchimali coinvolgenti entrambi i lobi polmonari inferiori con broncogramma aereo.

Sfumati addensamenti parenchimali a vetro smerigliato lobi superiori e lobo medio.

Minima falda di versamento pleurico in sede postero-basale.

Surrene sinistro lievemente ingrandito per possibile iperplasia



Ricovero in UTI

- Furosemide 125 mg ev, clonidina 150 mcg ev poi 2,5 mg cerotto, acetazolamide 250 mg, amlodipina 10 mg, ramipril 5 mg, carvedilolo 25 mg x2, nitroglicerina 10 mg. Ceftriaxone e azitromicina

- Creatinina 1.1 mg/dl→2,59 mg/dl→ 0,74 mg/dl il 14/1. PCT elevata fino a 8.33 mg/dl, GB 20000 mm3, ACR 26 mg/g, K 3.4 meq/l

UTI

- Valori pressori stabilizzatisi 150/90 mmHg
- Estubata il 12/1 (4 giorni)

Eccoardiogramma in UTI 12/1

VD non dilatato, IT lieve, VS non dilatato IVS concentrica SIV 14 mm, PP10 mm, FE preservata senza deficit maggiori di cinetica, FE > 50%, diastole di II grado, VCI dilatata 22 mm, non collassabile.

Trasferita in AC 14/1

- Svezzamento da O2

Dimessa il 20/1 con candesartan 16 mg, amlodipina 10 mg, idroclorotiazide 12,5 mg, doxazosina 2 mg

PA in dimissione 150/100 mmHg, FC 75 bpm

26/1 prima visita ambulatorio ipertensione

- PA 135/90 mmHg, FC 109 bpm (al domicilio PA 140/100)
- Sostituita idroclorotiazide con spironolattone (EGA estemporanea in visita K 3.3 mEq/l)
- Sostituita doxazosina con nebivololo
- Richiesti:
  - ED arterie renali
  - Studio surrenalico
  - ED TSA e RMN encefalo (pregresso infarto lacunare)

4/2/2023 in DEA (dispnea e tosse)

SO2 85% in AA → MV 50%, PA 170/120 mmHg, FC 100 bpm, T 37.6°C

EGA AA ph 7,47, pCO2 38 mmHg, pO2 45 mmHg, HCO3 37.5 mmol/l, lattati 0.9 Na 139 ,K 3,7 meq/l

ECO torace sindrome interstiziale basale bilaterale con minima falda di versamento pleurico

MV 60%, steroide, furosemide, → 2 h SpO2 95% in CN 2l/min PA 125/80 mmHg

Ricovero in Medicina-Nefrologia

- TSH 1.24 microlU/ml, cortisolemia 12 microg/dl
- Normetanefrine 1378-1512 pmol/l (vn ‹ 600)
- PET FDG negativa
- Saturimetria notturna OSAS moderato severo, indicato monitoraggio cardiorespiratorio notturno

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CURRENT OPINION

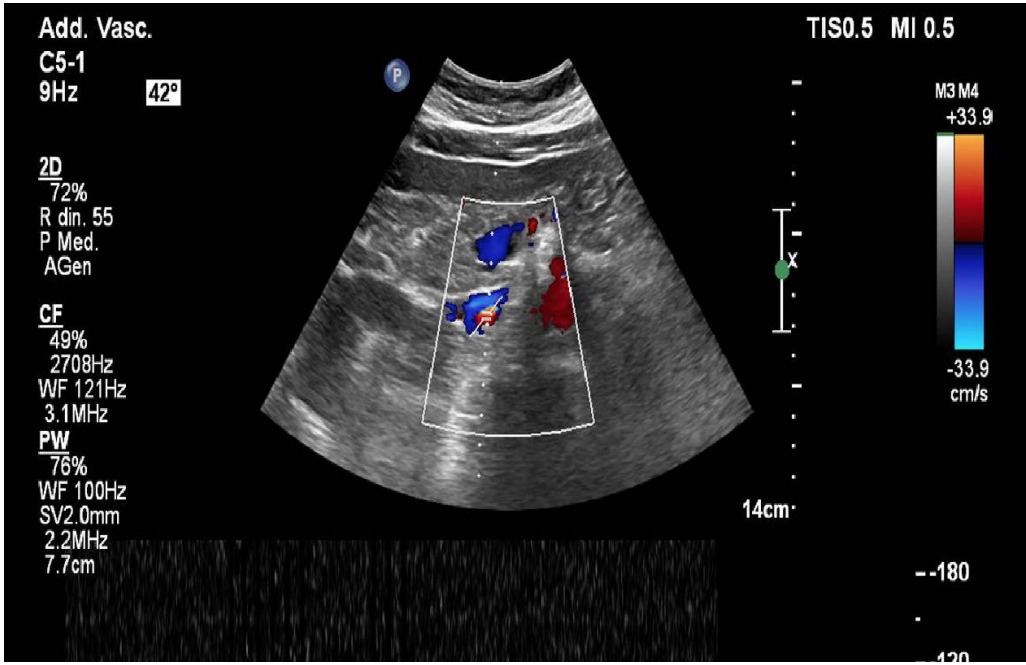
Flash pulmonary oedema and bilateral renal artery stenosis: the Pickering Syndrome†

Franz H. Messerli[1]*, Sripal Bangalore[2], Harikrishna Makani[1], Stefano F. Rimoldi[3], Yves Allemann[3], Christopher J. White[4], Stephen Textor[5], and Peter Sleight[6]

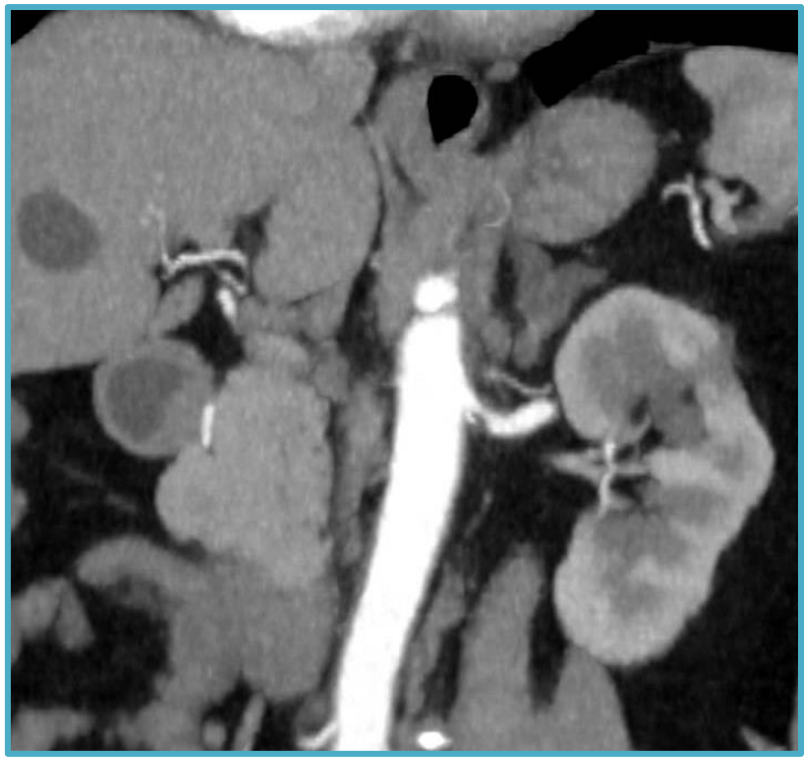
- Edema polmonare acuto + polmonite
- Insufficienza respiratoria con sovraccarico polmonare (sindrome interstiziale bilaterale) a rapida risoluzione
- Ipertensione «resistente»
- Insufficienza renale acuta

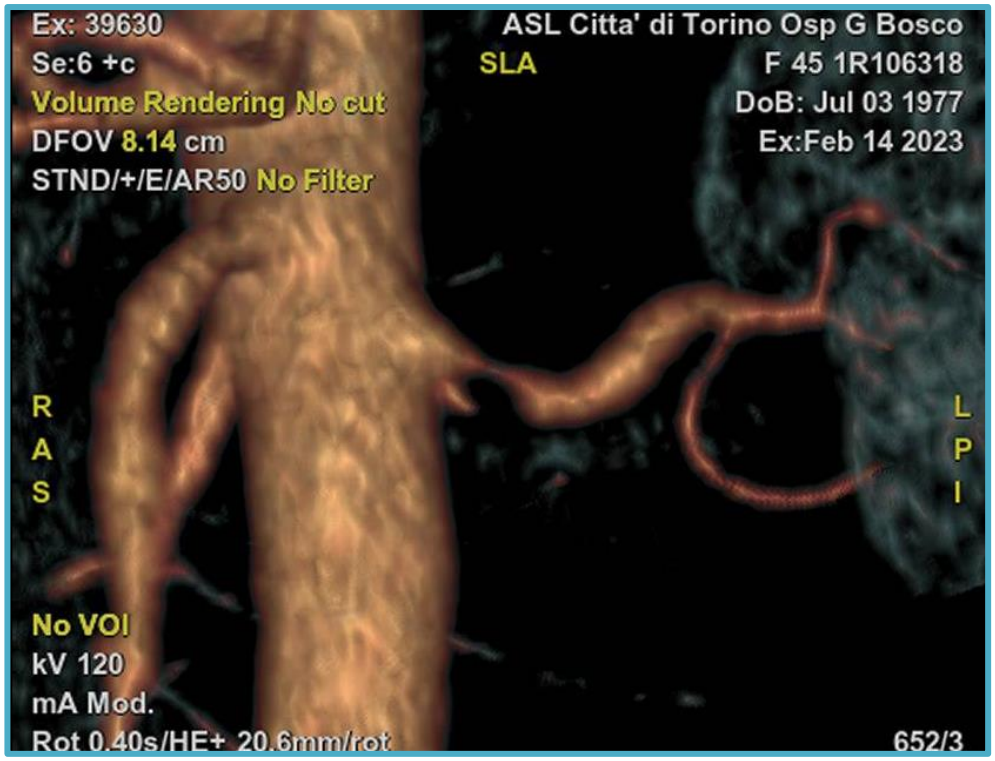
9/2 Ecodoppler arterie renali

Turbolenze di flusso fino a 34 m/s arteria renale sinistra- terzo medio con IR 0,55



Angio-TC 14/2/2023





(A) Atherosclerotic renovascular disease

Prevalence:
6–14%[a]

Suggestive symptoms, signs and findings

Resistant hypertension
Flash pulmonary edema
Rapidly declining kidney function
Acute renal function degradation on ACEi or ARB
Generalized atherosclerosis[b]

1st choice screening test

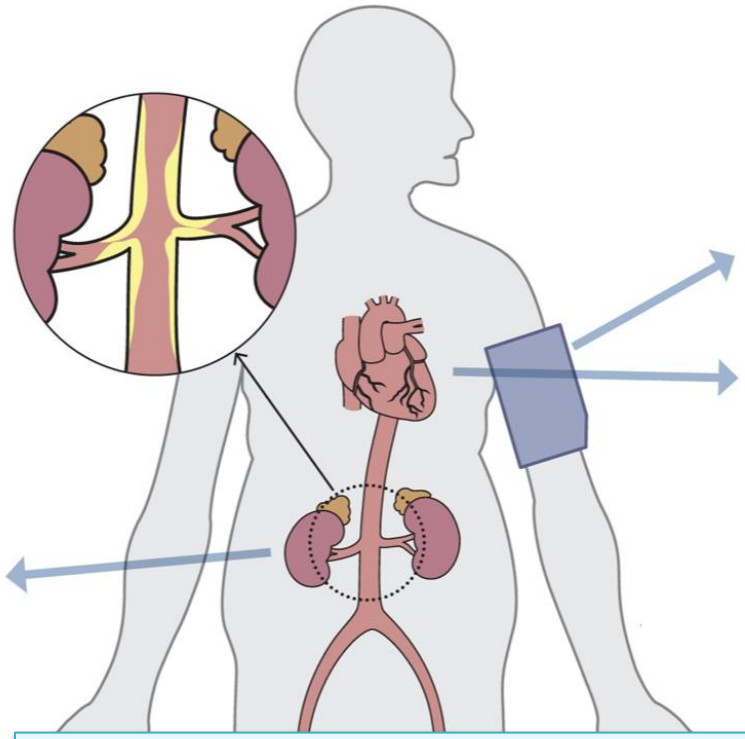
Renal artery duplex ultrasound; otherwise angio-CT or angio-MR

Further work-up

Angio-CT or angio-MR
Invasive catheter angiography

Treatment[c,d]

Antihypertensive treatment
Strict control of CV risk factors
Revascularization (selected cases)



Cardiovascular phenotype

24h ABPM – resistant hypertension, frequent non-dipping

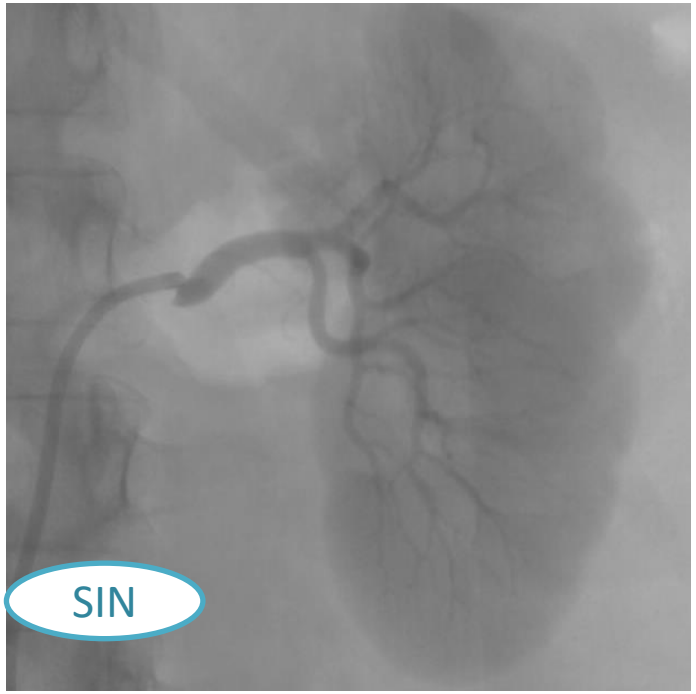
- LVH
- Decreased diastolic function
- Decreased systolic function

Increased CV Risk and mortality

Renal artery stenting in addition to medical therapy is associated with renal and CV benefits in patients presenting with high-risk ARVD phenotypes:

1) resistant hypertension
2) recurrent pulmonary edema
3) heart failure and
4) deterioration of kidney function.

2023 ESH guideines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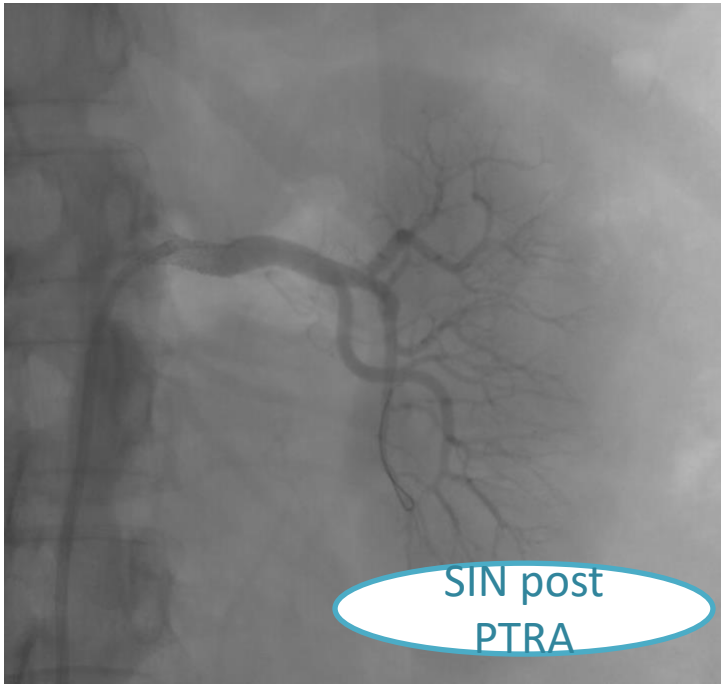
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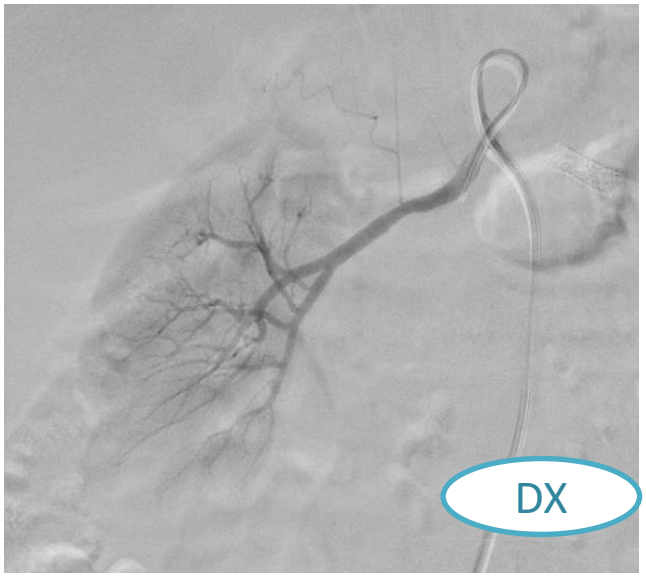
PTRA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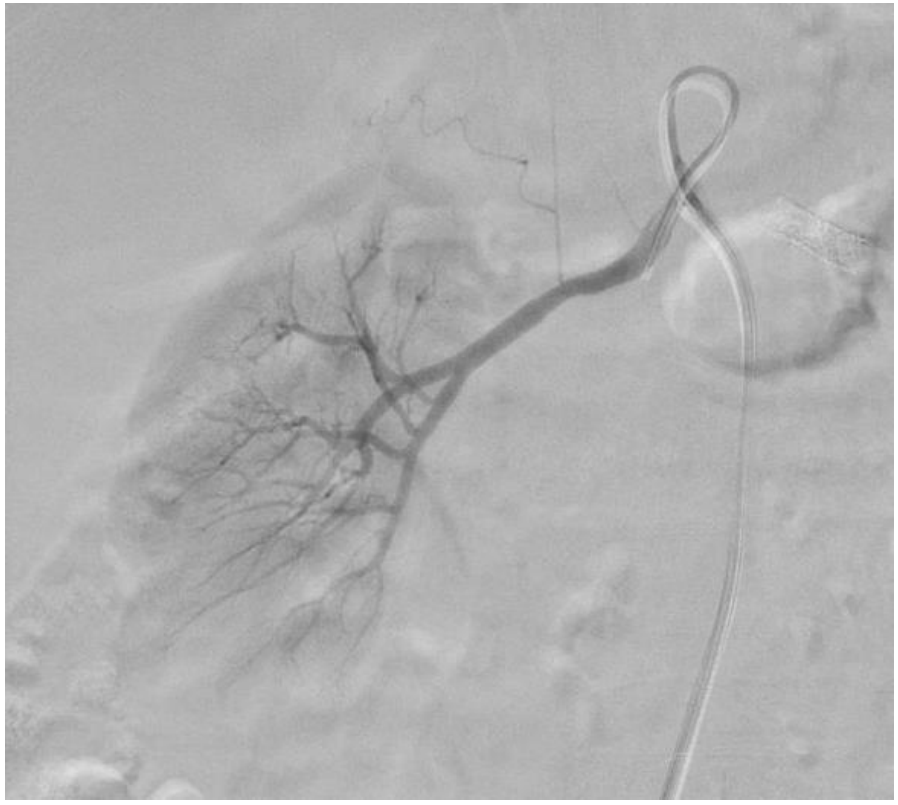
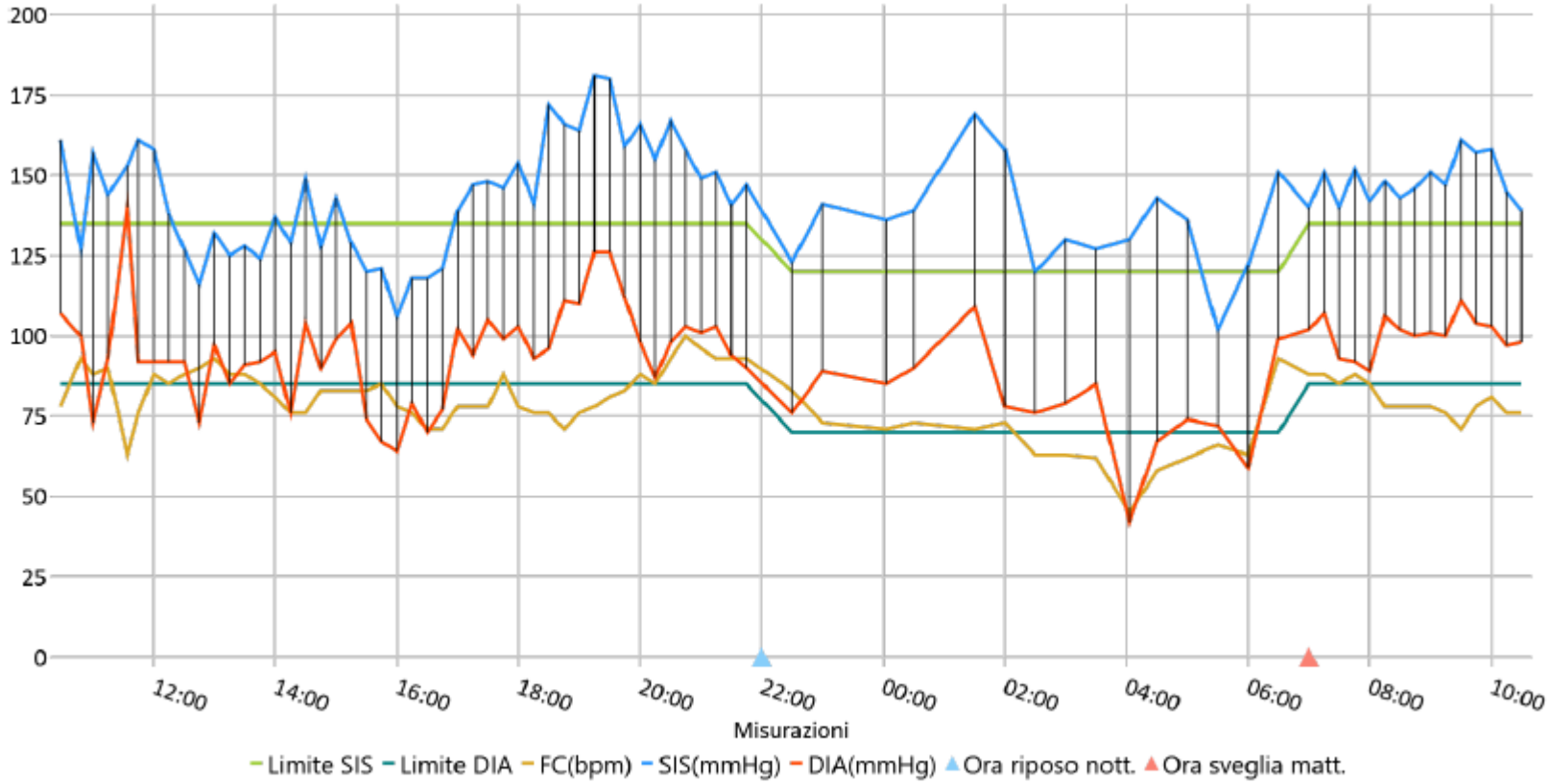


Visita ambulatoriale 18/9

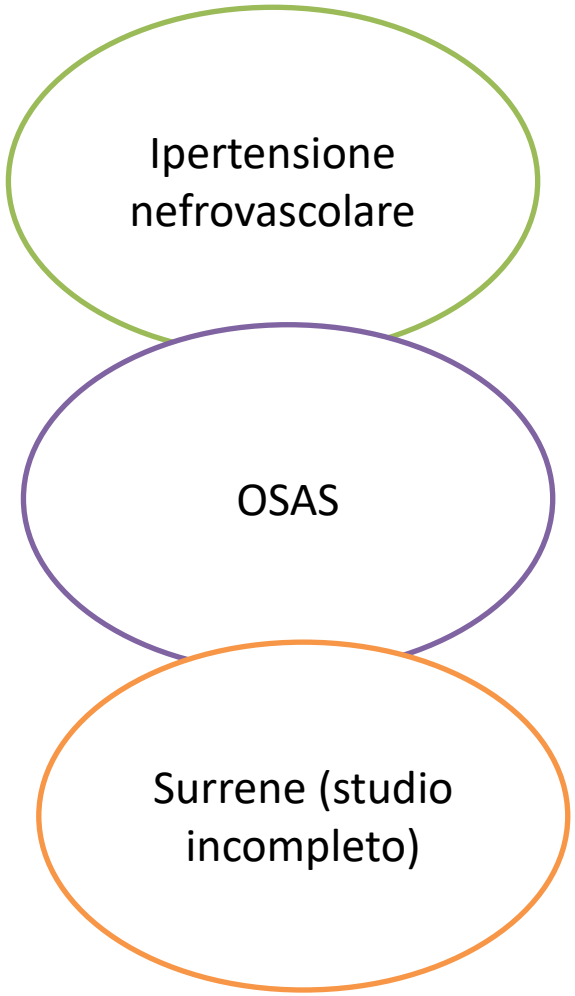
PA 134/93 mmHg
FC 90 bpm



24 h 142/92 mmhg G 144/96 mmHg N 135/78 mmHg

amlodipina 10 mg,
nebivololo 2,5 mg

candesartan 16 mg
potassio canreonato 50 mg/butizide 5 mg



EPA in stenosi monolaterale arteria renale (scompenso diastolico? polmonite concomitante?

Patogenesi aterosclerosi (fumo, altro? Inibitore dell'aromatasi? Triptorelina?)