Early identification of aortic dissection with pre-hospital ultrasound: a case report

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ABSTRACT

Background: Several studies have demonstrated the feasibility of pre-hospital ultrasound (US) in patients with trauma, cardiac arrest, and respiratory insufficiency. It should be rapid, problem based and the use of specific protocols (focused assessment of sonography for trauma, focused echocardiography in life support, and rapid ultrasound for shock and hypotension) prevents delays.

Case Presentation: We present a case of a 50-year-old man with a syncope while he was working. When the ambulance arrived, he was hemodynamically unstable, indicated dorsal–lumbar pain, an asymmetry of the radial pulses was found, and the electrocardiography did not register any ST segment alterations. A pre-hospital US showed a dilation of the ascendant aorta and a floating flap inside the aortic arch and the abdominal aorta. The computed tomography scan confirmed a dissection from the aortic bulb to the left femoral artery and the patient was transported rapidly to the nearest heart and thoracic surgeries.

Conclusion: The evaluation of the aorta should be considered a new indication of pre-hospital US.

Keywords: Point of care ultrasound, pre-hospital, abdominal aorta, dissection, case report.

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Background

Point of care ultrasound (POCUS) is considered an important diagnostic tool in the Emergency Department.

Current developments in technology, the presence of portable ultrasound (US) machines, the improvement of the quality and resolution of the images, have increased the performance of US also in the pre-hospital setting [1,2].

Several studies have demonstrated the feasibility and accuracy of pre-hospital US, performed either by physicians or paramedics, in many pre-hospital scenarios including land ambulances and helicopters of the Emergency Medical Services [3–6].

Pre-hospital emergency US should be even more focused, rapid, and problem based than in-hospital point of care US, to reduce morbidity and improve outcomes for patients with life-threatening conditions. The integration of focused US with clinical signs improves diagnostic accuracy and provides crucial information to guide the diagnosis, the therapy and to improve the field triage, in order to deliver the patients to the most appropriate destination [7,8].

Many out-of-hospital algorithms have been successfully tested by providers [9], including the focused assessment of sonography for trauma (FAST) and the Extended-FAST [9,10], the focused echocardiography

in life support (FEEL) protocol during cardiopulmonary resuscitation (CPR) [11], the lung ultrasound (LUS) for the evaluation of respiratory insufficiency [2,12] and the rapid ultrasound for shock and hypotension (RUSH) protocol for hemodynamic instability [13]. The study of the abdominal aorta in a patient with abdominal pain and hemodynamic instability could be another important indication of pre-hospital US [2,14].

The evaluation of the aorta is fast, and the dilation of the artery can be easily identified. On the contrary, the diagnosis of a dissection or of a broken aneurysm could be challenging and predicted only by the presence of indirect signs, such as a dilated aorta or the evidence of free fluid in the peritoneum. Nevertheless, when US is closely related to the patient's history and the clinical assessment, diagnostic accuracy can be extremely high [12–15].

This case report analyses the feasibility and usefulness of pre-hospital US for the evaluation of the aorta in a hemodynamically unstable patient.

Case Presentation

We present a case of a 50-year-old man who suddenly lost consciousness while he was working. He remained unconscious for a few minutes and then recovered slowly.

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An advanced life support ambulance arrived within 8 minutes, he was already awake, a bit confused (Glasgow coma scale of 14), he did not remember what had happened and he complained of dizziness and dorsal–lumbar pain.

Bystanders reported that the patient had been well until the syncope. He had hurt his head and back on the floor by falling down, his heart pulse had always been palpable and hadn't had any tonic–clonic movements.

Blood pressure was 80/40, heart rate 105 bpm, oximetry 98%, and the electrocardiography registered a sinus tachycardia without any segment alterations.

Physical examination revealed a small hematoma of the occipital region, a painful cervical column, a spontaneous and intermittent dorsal and lumbar pain, the absence of neurological deficits. The examinations of the heart, lung, and abdomen were completely normal, whereas a slight asymmetry of the radial pulses was found, with the left one weaker than the right one.

A fluid challenge was administered with 500 ml of crystalloid with improvement of blood pressure up to 110/70 and a concomitant reduction of the heart rate (80 bpm). A rapid pre-hospital POCUS was performed according to the RUSH protocol.

The subcostal scan of the heart (the pump) revealed a normal cardiac contractility; a small pericardial effusion was described (Figure 1A), whereas no signs of pleural and peritoneal effusions were found (the tank); finally, the evaluation of the "pipes" showed an abdominal aorta with a normal diameter but with an endovascular floating image (Figure 1B; Video 1). The examination of the thoracic aorta with a sector probe highlighted a dilation of the ascendant aorta (Figure 1C) and a floating flap inside the aortic arch (Figure 1D; Video 2).

The whole pre-hospital US examination lasted less than 5 minutes. The clinical presentation, the asymmetric radial pulses, and the ultra-sonographic finding were consistent with the diagnosis of aortic dissection.

The patient was transported urgently to the emergency department of the nearest district hospital without a heart and thoracic surgery. During the transport, the local radiology was alerted in order to go through a computed tomography (CT) scan as soon as possible.

In the Eemergency Ddepartment, the dorsal and lumbar pain worsened with some episodes of severe hypotension that were responsive to the fluid therapy. The patient underwent CT scan rapidly that confirmed the diagnosis of the aortic dissection which started from the aortic bulb and reached the left femoral artery, involving the celiac tripod, the superior mesenteric artery, and the left renal artery (type A according to Stanford classification) (Figure 2).

The patient was transported by a helicopter of the Emergency Medical Service to the intensive care unit of the nearest hub hospital rapidly where both a heart and a thoracic surgery were available. He underwent emergency surgical correction two times and the outcome was successful.

He was discharged from the hospital after a period of rehabilitation in good condition but with a persistent amnesia of the event.

Figure 1. (A) Subcostal scan shows a small pericardial effusion. (B) Abdominal aorta with an endovascular floating image. (C) Parasternal scan using a sector probe: ascendant aorta dilation of 3.96 cm. (D) Suprasternal scan using a sector probe: aortic arch with a floating flap.





Figure 2. CT scan: Dissection of the thoracic (A - B) and abdominal aorta (C) from the aortic bulb to the left iliac artery (D).

Discussion

There is a lively debate regarding the use of US in the pre-hospital setting. It has been considered a priority for the upcoming years, but the indications are not still clear.

Some articles and reviews have tried to clarify this point, and according to them, we can suggest three major indications: trauma (FAST or EFAST) [9,10], CPR (FEEL protocol) [11], and respiratory insufficiency (LUS) [2,12].

In a recent review, we have also suggested the use of US for the management of aortic aneurysm, since the mortality is extremely high, and it can be reduced only with an early diagnosis and treatment [2,14].

Our case report described a patient with an aortic dissection and we think it is interesting because it clearly described how US can change the diagnostic and therapeutic decision of the emergency physician in the pre-hospital setting. The aortic evaluation was made within a wider approach based on the RUSH protocol and this is another important hint from our case report.

Pre-hospital US must be focused, rapid, and problem based, and the use of specific protocols prevents delays. For example, the FAST is focused on the identification of free fluid in the pericardium, pleura, and peritoneum [9,10]; the FEEL is used in patients with cardiac arrest for no more than 10 seconds during the pulse check to search for reversible causes of cardiac arrest [11]; the RUSH goes rapidly through all the possible causes of shock [13].

Pre-hospital US is time dependent and it should last less than 5 minutes [2,9]. We must always remember that each minute lost dramatically reduces the survival rate in critically ill patients: the probability of death is estimated to increase by 1% for every 3 minutes of delay [9,15]. This is certainly true, but when a rapid pre-hospital approach helps to reach the correct diagnosis or, on the other hand, to exclude life threatening conditions, precious information is obtained to make rapid in-hospital management.

This was the case of our patient: he underwent a CT scan rapidly to confirm dissection of the aorta and he was transported to his final destination within 2 hours. The patient could have been transported directly to the hub hospital, outlining as US can improve also the field triage.

However, the environmental conditions (remote village), the position of the nearest hospital (8 minutes) and the hemodynamic instability suggested to stop at the local emergency department and, after the CT scan, to ask for a helicopter that guaranteed a faster e safer transport.

In our case report, a convex probe was used and we think this is the correct approach since it can give a wider panorama and suits with almost all the scans that are required in the pre-hospital setting. The integration with other probes should be done only if necessary and for specific doubts.

We are aware that the identification of an aortic dissection is often difficult and sometimes impossible also with high performance devices. On the contrary, the visualization of the aorta, in particular the abdominal tract, is rapid and easy, both for physicians and for paramedics [2].

For example, a complete scan of abdominal aorta usually lasts few minutes, sometimes less than 1 minute. So that it should be done in all patients with abdominal pain and hemodynamic instability.

We definitely think that the evaluation of the aorta could be the fourth indication of pre-hospital US.

Acknowledgement

None

List of abbreviations

Cardiopulmonary Resuscitation
Focused Assessment of Sonography for Trauma
Focused Echocardiography in Life support
Lung Ultrasound
Point of Care Ultrasound
Rapid Ultrasound for Shock and Hypotension
Ultrasound

Consent for publication

A written informed consent was signed by the patient before the submission of the article.

Ethical approval

Ethical approval is not required at our institution for the publication of this case report.

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References

- Busch M. Portable ultrasound in pre-hospital emergencies: a feasibility study. Acta Anaesthesiologica Scandinavica 2006; 50:754–8. https://doi. org/10.1111/j.1399-6576.2006.01030.x
- Zanatta M, Benato P, Cianci V. Pre-hospital ultrasound: current indications and future perspectives. Int J Crit Care Emerg Med 2016; 2(2):019. https://doi. org/10.23937/2474-3674/1510019
- Lapostolle F, Petrovic T, Lenoir G, Catineau J, Galinski M, Metzger J, et al. Usefulness of hand-held ultrasound devices in out-of-hospital diagnosis performed by emergency physicians. Am J Emerg Med 2006; 24(2):237–42. https://doi.org/10.1016/j.ajem.2005.07.010
- Heegaard W, Hildebrandt D, Spear D, Chason K, Nelson B, Ho J. Prehospital ultrasound by paramedics: results of field trial. Acad Emerg Med 2010; 17:624–30. https://doi. org/10.1111/j.1553-2712.2010.00755.x
- Plummer D, Heegaard W, Dries D, Reardon R, Pippert G, Frascone RJ. Ultrasound in HEMS: its role in differentiating shock states. Air Med J 2003; 22:33–6. https://doi. org/10.1016/S1067-991X(03)70037-6

- Faizan H, Arshad MD. Point-of-care ultrasound in the prehospital setting. J Emerg Med Serv 2018. Available from: http://www.jems.com/articles/print/volume-43/issue-2/ features/point-of-care-ultrasound-in-the-prehospital-setting.html?c=1
- Jones AE, Tayal VS, Sullivan DM, Kline JA. Randomized, controlled trial of immediate versus delayed goal-directed ultrasound to identify the cause of nontraumatic hypotension in emergency department patients. Crit Care Med 2004; 32(8):1703–8. https://doi.org/10.1097/01. CCM.0000133017.34137.82
- Jensen MB, Sloth E, Larsen KM, Schmidt MB. Transthoracic echocardiography for cardiopulmonary monitoring in intensive care. Eur J Anesthesiol 2004; 21:700–7. https:// doi.org/10.1097/00003643-200409000-00006
- Walcher F, Weinlich M, Conrad G, Schweigkofler U, Breitkreutz R, Kirschning T, et al. Prehospital ultrasound imaging improves management of abdominal trauma. Br J Surg 2006; 93(2):238–42. https://doi.org/10.1002/ bjs.5213
- El Sayed MJ, Zaghrini E. Prehospital emergency ultrasound: a review of current clinical applications, challenges, and future implications. Emerg Med Int 2013; 2013:531674. https://doi.org/10.1155/2013/531674
- Breitkreutz R, Price S, Steiger HV, Seeger FH, Ilper H, Ackermann H, et al. Focused echocardiographic evaluation in life support and peri-resuscitation of emergency patients: a prospective trial. Resuscitation 2010; 81(1):1527–33. https://doi.org/10.1016/j. resuscitation.2010.07.013
- 12. Rempell JS, Noble VE. Using lung ultrasound to differentiate patients in acute dyspnea in the prehospital emergency setting. Crit Care 2011; 15:161. https://doi. org/10.1186/cc10226
- Perera P, Mailhot T, Riley D, Mandavia D. The RUSH exam: rapid ultrasound in SHock in the evaluation of the critically III. Emerg Med Clin North Am 2010; 28:29–56. https://doi.org/10.1016/j.emc.2009.09.010
- 14. Mazur SM, Sharley P. The use of point of care ultrasound by critical care retrieval team to diagnose acute abdominal aortic aneurysm in the field. Emerg Med Australas 2007; 19:71–5. https://doi. org/10.1111/j.1742-6723.2006.00932.x
- Clarke JR, Trooskin SZ, Doshi PJ, Greenwald L, Mode CJ. Time to laparotomy for intra-abdominal bleeding from trauma does affect survival for delays up to 90 minutes. J Trauma 2002; 52:420–5. https://doi. org/10.1097/00005373-200203000-00002

Summary of the case

Patient (gender, age)	1	Male, 50 years old	
Final Diagnosis	2	Aortic dissection: type A according to Stanford classification	
Symptoms	3	Syncope, hypotension, dorsal-lumbar pain, asymmetry of the radial pulses	
Medications (generic)	4	Fluid therapy, Emergency surgical correction of the aortic dissection	
Clinical Procedure	5	Physical assessment, Pre-hospital US according to RUSH protocol, CT scan of the Aorta	
Specialty	6	Emergency medicine, heart and thoracic surgery	