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Pacemaker Lead Displacement Presenting with Atrial Flutter

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Pacemaker lead dislodgement can trigger a malfunction in the pacing systems. Early displacements (within 6 weeks) most commonly affect the atrial leads (3.8%). Lead malposition or dislodgement is the most common reason for the loss of capture after pacemaker insertion. Lead dislodgement can also present with dizziness, syncope or arrhythmia. A 67 years old female presented to the ED for palpitations and shortness of breath. She recently (4 weeks ago) had a dual-chamber pacemaker insertion for symptomatic bradycardia. Her vital signs were: BP 112/91 mmHg, heart rate 139 beats/minute, respiratory rate 18 breaths/minute, and pulse oxygen saturation was 96% on room air. EKG (Fig. A) showed Atrial Flutter 2:1. CT angiography was negative for pulmonary embolism however, it showed one of the pacemaker leads terminating in the plane of IVC at the level of the hepatic dome. When compared to the prior imaging the lead appeared to terminate in the plane of the right atrium. Initially, HR was controlled with Amiodarone. The next day, the patient was taken to the OR and the dislodged atrial lead was repositioned to the lateral atrial wall that led to the resolution of her symptoms. Repeat EKG showed sinus rhythm. Dislodgement evident on imaging is called macro-dislodgement. Data is limited on the exact etiology of macro/micro dislodgement. Once identified, treatment for early dislodgements requires re-intervention to reposition the displaced lead however, surgical intervention to reposition the lead in late (>6 weeks) dislodgement is usually not feasible due to endocardial fibrosis of distal end of the lead.

Biography

Dr Mohammed Usman, the corresponding author has published more than 22 papers in reputed journals with 445 citations and has been serving as an interventional cardiologist at Monmouth Medical Center.

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