

Kyphoplasty Induced Cement Pulmonary Embolism

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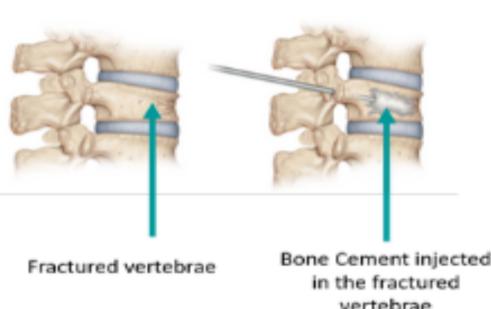
BACKGROUND

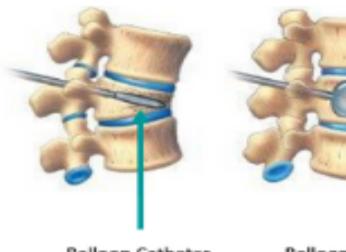
Cement pulmonary embolism (CPE), a rare but potentially life-threatening complication associated with vertebroplasty and kyphoplasty. Occurs when polymethylmethacrylate (PMMA) leaks into the perivertebral veins and subsequently travels to the pulmonary arteries.

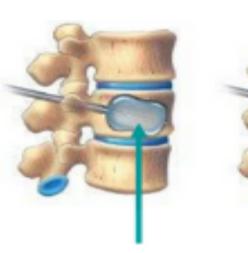
Presentation can range from asymptomatic to dyspnea, chest pain, hypoxemia, and hemodynamic instability. The optimal management strategy remains unclear.

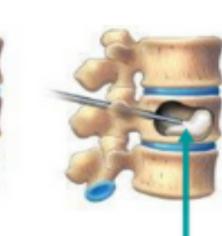
CASE PRESENTATION

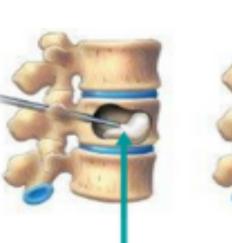
An 83-year-old male with PMHx of HTN and lumbar spondylolisthesis who underwent elective lumbar fusion and kyphoplasty at T10-T11. On postoperative day 3, he developed tachypnea, hypoxemia, and tachycardia. Labs showed hemoglobin 10.3 g/dL, WBC 12.4 x 10^9/L, high sensitive troponin I 156>>139 ng/L, D-dimer 0.77 μg/mL, creatinine 1.21 mg/dL and ESR 42 mm/hr. Chest x-ray showed cardiomegaly, central vascular congestion and trace pleural effusions and basilar atelectasis. Computed tomography angiography (CTA) revealed a small linear hyperdense filling defect in the distal right pulmonary artery. Given its small size and location, the embolus was managed conservatively.

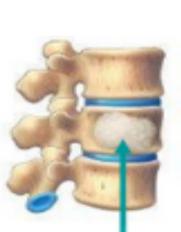






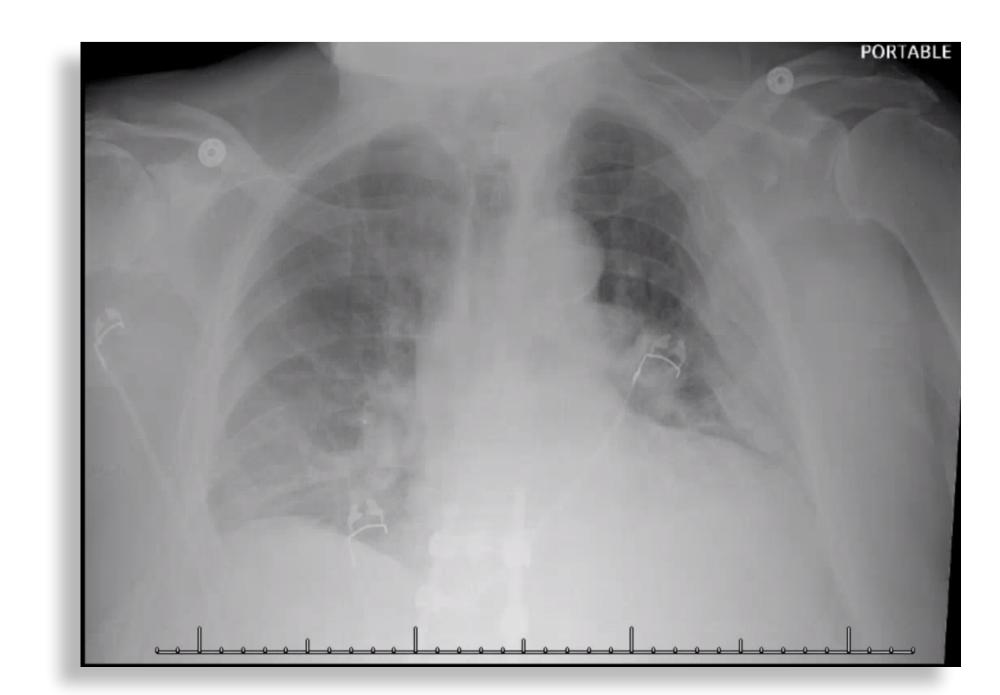


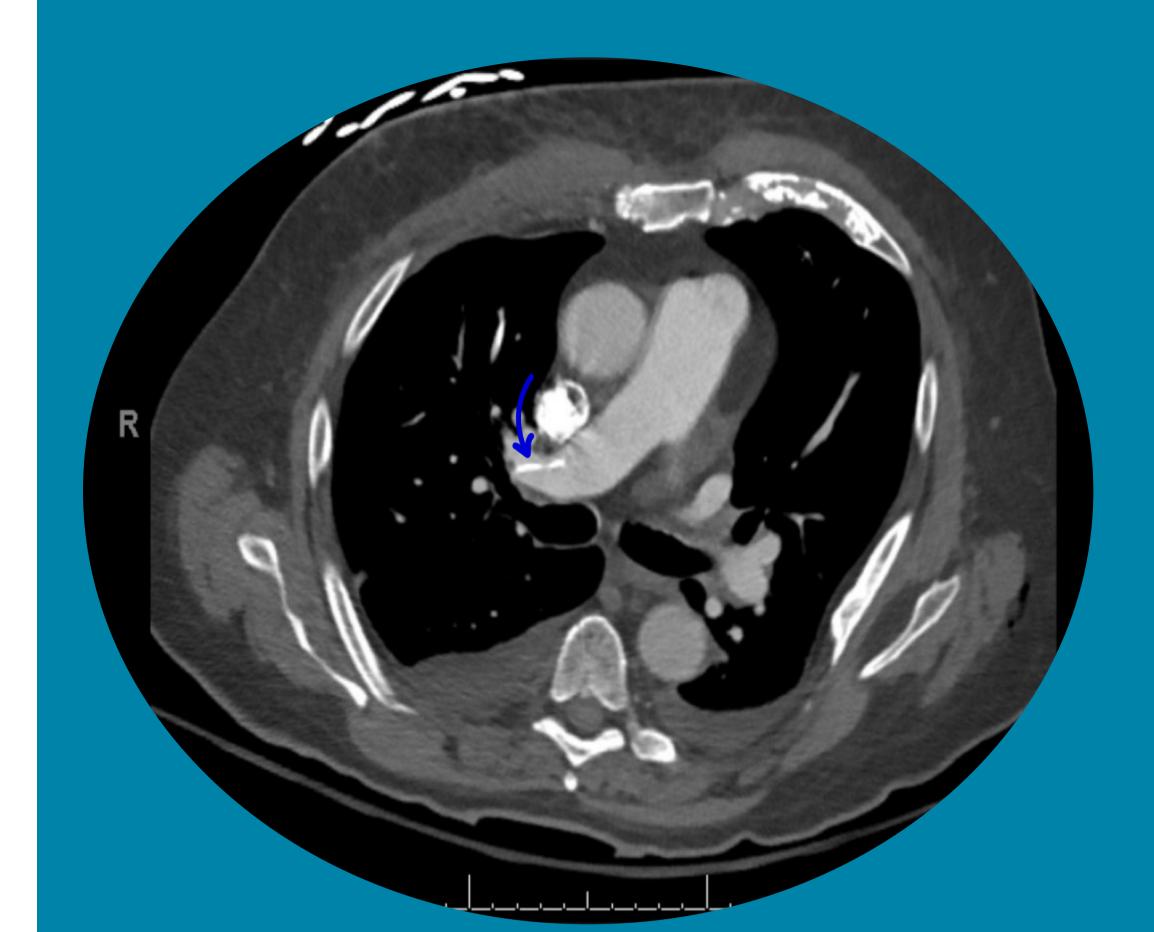




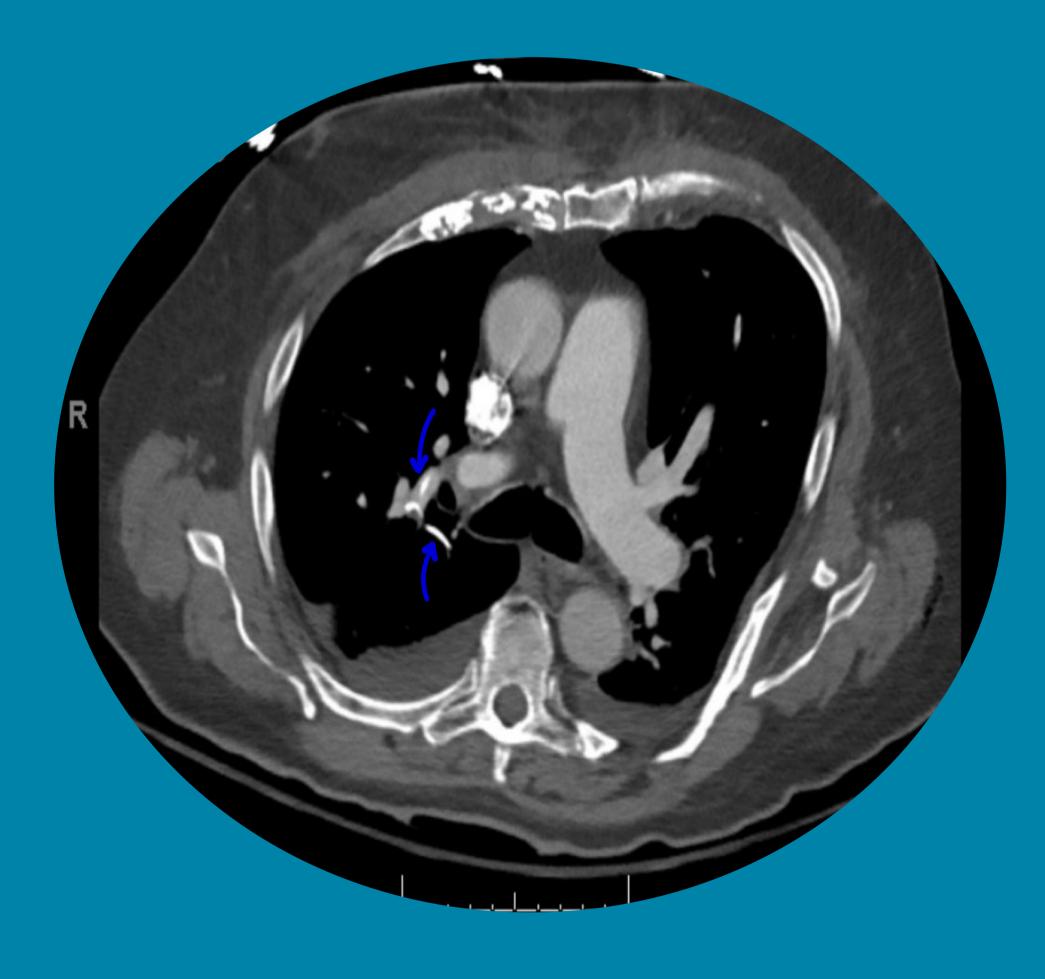
Vertebroplasty

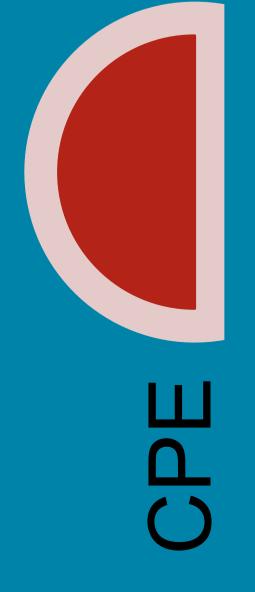
Kyphoplasty





HYPERDENSE FILLING DEFECT in the distal right main pulmonary artery extending into the segmental and subsegmental branch of the right upper lobe





No standardized guidelines exist for managing CPE. Most studies suggest following thrombotic PE guidelines in symptomatic patients given the pro-thrombotic nature of acrylic cement

DISCUSSION

CPE incidence varies from 3.5% to 23%, with vertebroplasty leaks being more common. Although most CPEs are asymptomatic, common symptoms include shortness of breath, tachypnea, tachycardia, chest pain, hemoptysis and hemodynamic instability.

Some studies recommend routine post-procedural chest Xrays. Additionally, symptomatic patients or those with significant cement leakage during the procedure should undergo further evaluation with CT scans.

There is no standardized management protocol for CPE. For symptomatic cases, whether peripheral or central, treatment should follow thrombotic pulmonary embolism guidelines. This includes anticoagulation for both central and peripheral emboli, with surgical intervention or embolectomy reserved for cases involving large central pulmonary emboli.

CONCLUSION

Cement extravasation, though rare, is a recognized complication of vertebroplasty and kyphoplasty that can lead to CPE. While the utility of routine post-procedural imaging remains debated, symptomatic patients should undergo chest CT evaluation. Individualized management is critical, with anticoagulation as the first-line treatment. Surgical intervention may be considered for large, central emboli.

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