Cerebral air embolism during endoscopic retrograde cholangiopancreatography: treatment with therapeutic hypothermia

Cerebral air embolism (CAE) during endoscopic retrograde cholangiopancreatography (ERCP) is an uncommon complication, but of the nine previously reported cases, seven had fatal outcomes and one was left with severe hemiparesis [1–3].

A 36-year-old man who was admitted with gallstone pancreatitis underwent two unsuccessful ERCPs and a successful percutaneous transhepatic cholangiogram. At subsequent ERCP for stent removal 5 days later, he suddenly became unresponsive with left conjugate eye deviation. Computed tomography (CT) of the brain confirmed CAE (Fig. 1 a, b, arrowheads), which had completely resolved on imaging 24 hours later (Fig. 1 c). Due to a lack of facilities, hyperbaric oxygen (HBO) therapy was not administered and he underwent therapeutic hypothermia for 24 hours. Subsequent examination revealed quadraparesis, which was worse on the left side. CT chest and transthoracic echocardiography were normal. Magnetic resonance imaging of the brain confirmed areas of acute ischemia involving middle and posterior cerebral arteries bilaterally.

If embolism is suspected, immediate high flow oxygen and volume expansion should be initiated and the patient placed in the Trendelenburg position. Based on previous case series, early treatment with HBO has been recommended to improve outcomes [7]. HBO was unavailable for the current case and our patient underwent therapeutic hypothermia, which has been shown to improve outcomes in patients after global ischemia following cardiac arrest [8, 9]. The first case of its use in a patient with CAE has been reported with good outcomes [10]. Focal neurological deficits during ERCP should alert physicians to the possibility of CAE. HBO remains the recommended treatment. Therapeutic hypothermia may have improved the prognosis for our patient, but further studies are needed.

Competing interests: None

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References


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