

## Adolescent Systemic Hypertension: Late Diagnosis of Coarctation of the Aorta

### About the Authors

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### Abstract

Coarctation of the aorta accounts for 5–7% of all the cases of congenital heart disease, with an estimated incidence of approximately 3 cases per 10,000 births. Coarctation of the aorta typically presents in the neonatal or early childhood period. The less severe coarctation patients may have subtle clinical findings such as elevated upper limb blood pressure, diminished femoral pulses, and a systolic ejection murmur that often transmits to the back. This case demonstrates that coarctation can be seen in the otherwise healthy adolescent population.

### Key words

congenital heart defects, coarctation

Coarctation of the aorta accounts for 5–7% of all the cases of congenital heart disease, with an estimated incidence of approximately 3 cases per 10,000 births.<sup>1</sup> First described repairs of this lesion were in 1944, and since then surgical and nonsurgical techniques have developed.

The morbidity and mortality rates are low for patients undergoing treatment, for both surgical or catheter interventions, though long-term follow-up is required for complications.

Today the diagnosis is often made prenatally with the advent of fetal echocardiography; however, approximately 30% of neonates with coarctation remain undiagnosed upon discharge after delivery.<sup>2</sup> This cardiac defect generally results in left ventricular pressure overload and the patient presentation often varies with the severity of the left ventricular outflow tract obstruction. Additionally, coarctation may be associated with other cardiac defects, as well as chromosomal abnormalities such as Turner syndrome.<sup>3</sup>

### Case Description

A 14-year-old boy was referred to our community pediatric cardiology outpatient clinic for an incidental finding of systemic hypertension that was noted by the patient's family physician on routine evaluation. The patient was completely asymptomatic, with no visual changes, no headaches, and had a normal activity profile by history. He had an unremarkable past medical history and also had a family history of late-onset hypertension.

On examination, he was not dysmorphic, not in distress, was somewhat anxious, and was warm and well perfused. There was no evidence of cyanosis or clubbing. His heart rate was 80 beats per minute and regular with a respiratory rate of 20 breaths per minute. Peripheral upper limb pulses were easily palpable. Femoral and pedal pulses were decreased bilaterally, while radial pulses were notably prominent in the right and left arms. There was the presence of a brachial femoral pulse delay. The blood pressures in the right and left arm were elevated at 154/70. The blood pressure in the right leg using a proper sized cuff was 80/58. The chest was clear with good air entry bilaterally.

On cardiac examination, the precordium was quiet. The apex was somewhat prominent but was normally placed. There was a normal first and normally split-second heart sound with no additional heart sounds. There was a harsh sounding mid-pitched 2/6 systolic ejection murmur best heard at the right and left upper sternal border, radiating toward the neck but not appreciated in the back, nor in the left or right scapular area. There was no gallop and no diastolic component to the murmur.

Abdominal exam was normal with no hepatosplenomegaly. An electrocardiogram performed at presentation showed normal sinus rhythm, normal intervals and demonstrated a frontal QRS axis of 90 degrees. The increased QRS voltages in V5 and V6 were consistent with left ventricular hypertrophy, and these voltages

were accompanied by normal T waves.

An echocardiogram was performed. The situs was normal and there was levocardia. The subcostal images showed a blunted abdominal aortic Doppler pattern with diastolic runoff, both of which are the typical features seen in coarctation of the aorta. The parasternal short and long axis views of the echocardiogram showed normal ventricular function and moderate concentric left ventricular hypertrophy, with normal subaortic, aortic valve and supravalve aortic anatomy. There was no intracardiac shunt defined. The suprasternal images showed colour flow acceleration in the post-ductal region. Careful imaging of the arch showed a normal sized ascending aorta and transverse arch, measuring 11 mm. There was a distal discrete coarctation of the aorta measuring 5 mm at the isthmus. Using colour flow Doppler, the turbulent flow was again noted in this region, and the continuous flow Doppler showed flow acceleration and a diastolic tail with a peak systolic gradient of 70 mmHg.

The family and patient were informed of the findings and the choices for intervention. The patient was preoperatively started on a cardio-selective beta blocker and the patient was subsequently presented to a surgical centre for semi-urgent coarctation repair. The surgical repair was an end-to-end anastomosis of the aorta and the patient had postoperative hypertension that required management with antihypertensive therapies. The

patient is now followed at regular intervals to observe for resolution of the left ventricular hypertrophy and to monitor the healing and growth of the aorta, and to monitor for possible complications.

## Discussion

Coarctation of the aorta typically presents in the neonatal or early childhood period. The severe coarctation patients are duct dependent and can become acutely unwell when the ductus closes. The less severe coarctation patients may have subtle clinical findings such as elevated upper limb blood pressure, diminished femoral pulses, and a systolic ejection murmur that often transmits to the back.

This case demonstrates that coarctation can be seen in the otherwise healthy adolescent population. The patient presented with no symptoms but had systemic upper limb hypertension and diminished femoral pulses with a brachial femoral delay, and a prominent precordial systolic murmur.

The late diagnosis of adolescents and adults with coarctation of the aorta may be due to the fact that collateral circulation to the lower body developed and the first symptom may be mistaken as isolated increased blood pressure. It is crucial that a proper diagnosis occurs with appropriate investigation and management to follow. A complete clinical exam and assessment is required including a four-limb blood pressure assessment. Echocardiography and an ECG are appropriate investigations and they must be performed in a

centre with experience in diagnosing congenital heart disease.

When the diagnosis is missed or left untreated, coarctation of the aorta can result in late aortic aneurysm formation, and/or premature coronary and cerebrovascular disease.<sup>3</sup> More specifically, some of the complications of coarctation of the aorta are: aortic dissection, thoracic aortic aneurysm, infective endocarditis, endocardial fibroelastosis, cerebral aneurysm

rupture, impaired left ventricular systolic/diastolic function progressing to congestive cardiac failure among others.<sup>3</sup>

### Conclusion

This case demonstrates that coarctation can be seen in the otherwise healthy adolescent population. It is recommended that patients with repaired and unrepaired coarctation obtain follow-up throughout their lifetime by a cardiologist, with specific attention to baseline and

exercise-induced hypertension.<sup>4</sup> Modifications of various surgical techniques have led to low mortality and morbidity rates, and recent additions of transcatheter balloon angioplasty and endovascular stent placement have expanded treatment options.<sup>1</sup> Hypertension is common in postoperative patients with aortic coarctation, even in the presence of no residual coarctation, which requires appropriate follow-up and treatment.

## Common Echocardiography Features of Coarctation of the Aorta Image Comparison of Normal versus the Case Study Patient

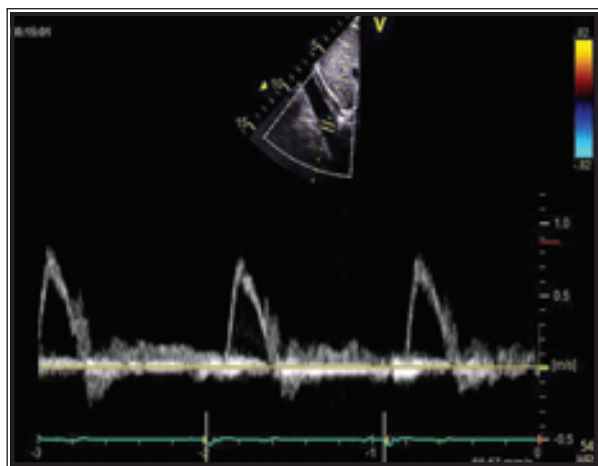


Figure 1A. Normal abdominal aortic flow.

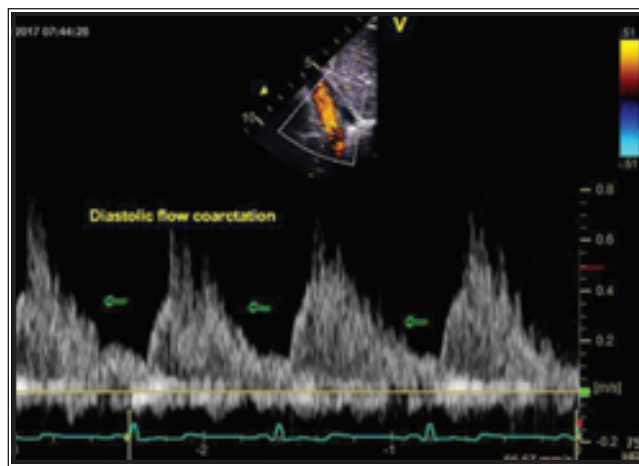


Figure 1B. Abnormal abdominal aortic flow (diastolic runoff).

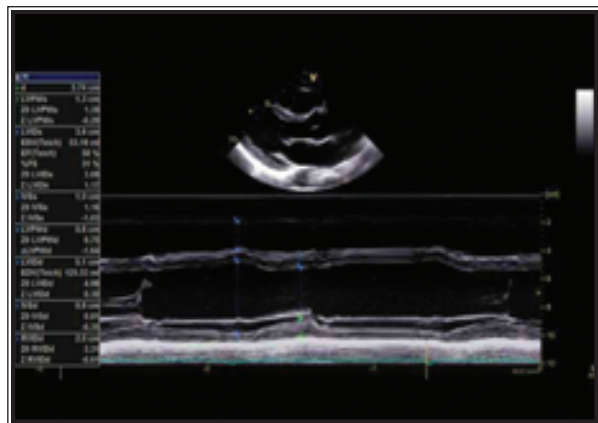


Figure 2A. Normal Left Ventricular (LV) wall thickness.

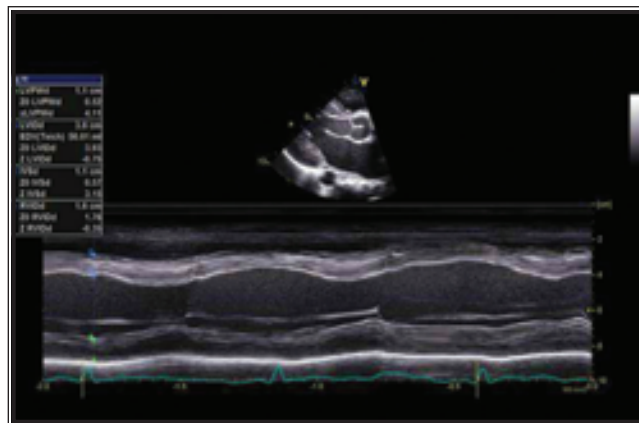


Figure 2B. Abnormal LV wall thickness (concentric LVH).

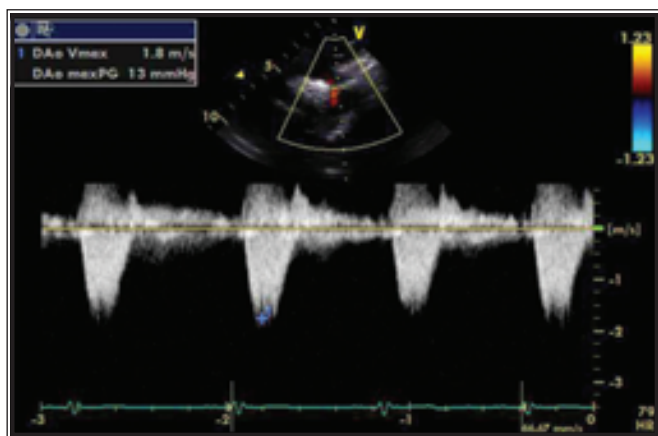


Figure 3A. Normal flow pattern in descending aorta.  
Normal peak gradient = 13 mmHg.

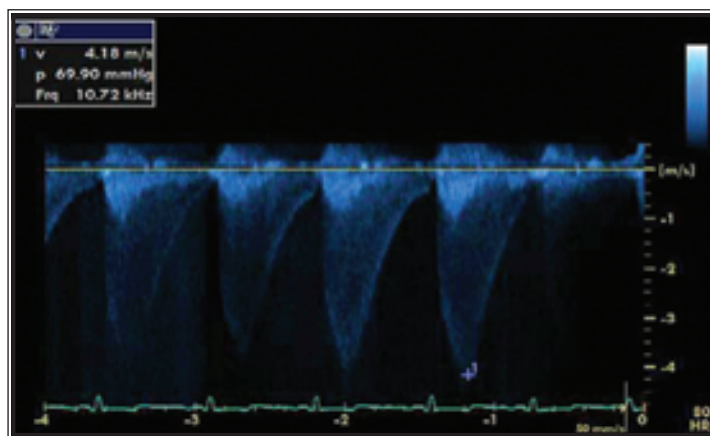


Figure 3B. Abnormal flow pattern in descending aorta.  
Significant increase in peak gradient = 70 mmHg.

## References

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