

PULMONARY EMBOLISM POST SHOULDER ARTHROSCOPY- A POTENTIAL SILENT KILLER

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Introduction: There are only few reports and preventive guidelines on pulmonary embolism (PE) after arthroscopic shoulder surgery; with its incidence of 0.01-0.21%.[1] We report a patient who developed PE 4 days after arthroscopic shoulder surgery.

Discussion: Patient is a 55yrs old gentleman with underlying IHD done stenting previously, and now on single antiplatelet. He also has underlying metabolic syndrome and severe OSA. Patient is right hand dominant, has a BMI of 27.6 and works as a teacher. He was diagnosed with left acromioclavicular arthropathy, long head biceps tendon tendinopathy and left supraspinatus partial tear which was confirmed with MRI. After unsatisfactory conservative management patient agreed for surgery. He underwent Arthroscopic Subacromial Decompression of Left Shoulder and Long Head of Bicep Tendon Tenotomy + Mumford' Procedure under general anesthesia. Intra-operatively there were no complications, procedure done in right lateral decubitus position using skin traction with operation time of 142 minutes. Post operatively well and ambulating the day after surgery. On day 4 post-operatively patient developed temperature of 39.5°C and type 1 respiratory failure. Patient had no chest pain. Provisional diagnosis was HAP however PE was suspected in view of normal chest radiographs. CTPA done showed acute right upper lobe pulmonary artery embolism. Patient was treated with fondaparinux and discharged with Rivaroxaban. He was discharged on day seven post operatively. Thrombophilia screening (Protein C, Protein S & antithrombin activity) was normal. Patient is currently well and shoulder symptoms improved.

Conclusion: No current guidelines recommend VTE prophylaxis in shoulder arthroscopy.[2] However in the presence of cardiac disease extra caution is necessary in regards to the development of PE. Serial D-dimer measurements can be used in the perioperative period for detecting DVT/PE.[2] Doppler ultrasound of the upper and lower extremities should be considered for DVT, and a CTPA should be ordered to evaluate for PE whenever necessary.