

Minimally Invasive LVAD Decommissioning as Ultima Ratio for Refractory Gastrointestinal Bleeding After Myocardial Recovery

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Refractory GAVE-associated bleeding persisted despite exhausted therapy. After myocardial recovery, minimally invasive LVAD decommissioning was chosen to stop anticoagulation.

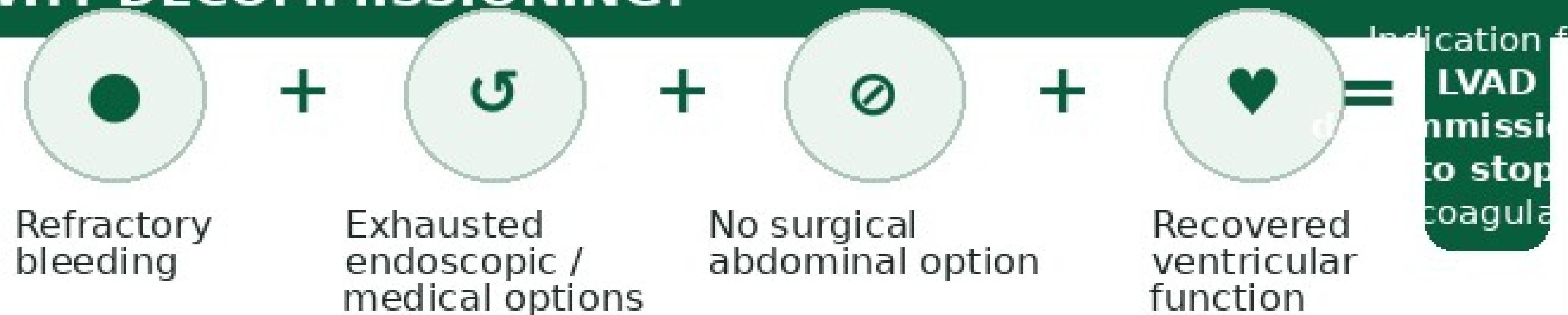
1. BACKGROUND

- Mandatory anticoagulation may perpetuate bleeding in LVAD recipients.
- After ventricular recovery, decommissioning may replace

2. CASE SUMMARY

- 72-year-old patient with prior HeartMate 3 implantation for cardiogenic shock.
- GAVE / angiodysplasia with recurrent severe bleeding and transfusion dependence.
- Endoscopic and medical therapy failed.
- Major additional morbidity: leg amputation for osteomyelitis.
- Gastrectomy was not feasible.
- Serial reassessment showed marked cardiac recovery.

3. WHY DECOMMISSIONING?



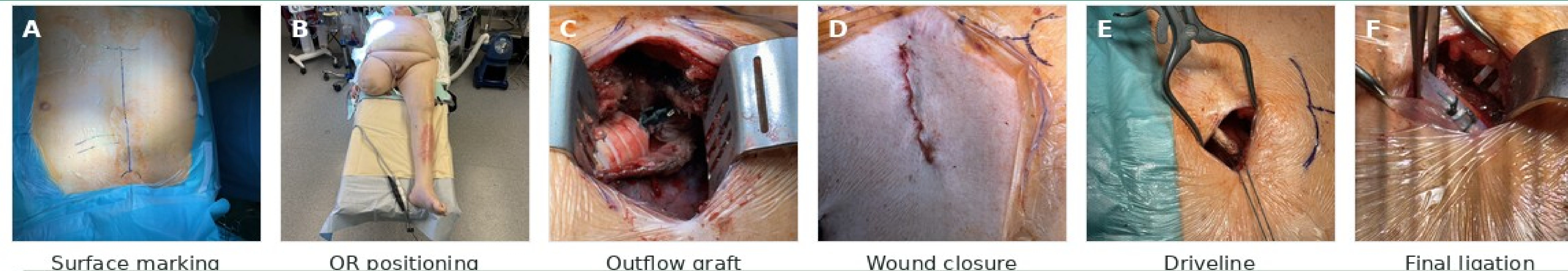
4. MINIMALLY INVASIVE TECHNIQUE

- Single-lung ventilation.
- Left anterior minithoracotomy for outflow-graft exposure and ligation.
- LVAD deactivation after hemostatic control.
- Subxiphoid driveline division with stump fixation.
- Drain placement and layered closure.

KEY CLINICAL FACTS

Age: 72 years
Initial indication: cardiogenic shock
Major complication: recurrent GI bleeding
Additional morbidity: leg amputation

5. OPERATIVE IMAGE SEQUENCE



A surface marking; B positioning; C outflow-graft exposure; D wound after closure; E driveline exposure and ligation; F final ligation / deactivation.

6. RESULTS

- Procedure well tolerated.
- Ventricular function remained preserved.
- Patient remained hemodynamically stable

7. CONCLUSION

- In refractory LVAD-associated gastrointestinal bleeding with recovered ventricular function, minimally invasive decommissioning can be a rescue strategy.
- This approach may reduce bleeding risk when other therapies are exhausted.

When recurrent bleeding becomes the dominant threat and ventricular recovery is convincing, minimally invasive LVAD decommissioning may become the life-preserving final option.