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**Clinical vignette**

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**Unusual pacemaker migration**

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A permanent pacemaker was implanted in a girl with complete congenital atrioventricular block at the age of 13 months due to Adams–Stokes attacks. Follow-up revealed adequate pacing system performance, and chest roentgenography at age 4.7 years showed appropriate epicardial lead position and length (A).

Twelve months later, the girl suffered intermittent abdominal pain. Bowel movements and urination were normal, and fever was absent. At the 4th day of illness, the mother noticed a prolapse through the anus. Further examination identified the exteriorized pacemaker (B, C). Cardiac pacing was undisturbed. Laboratory studies demonstrated an increased leukocyte count of 16 700/μL [80% neutrophils (1% band, 79% segmented), 17% lymphocytes, 3% monocytes] and sedimentation rate was 32/72 mm. The abdominal walls were soft.

Exploratory laparotomy revealed an infected pacemaker pocket with broad communication between the pocket and the transverse colon. The infected pocket was separated from the neighbouring structures by adhesions. A colostomy was created. The pacing lead was brought out through the skin, and external transcutaneous pacing was performed.

Sixteen days after admission, the epicardial pacing lead was removed, a transvenous lead was placed via the left subclavian vein, and a new pacemaker was implanted underneath the left pectoralis major muscle. In addition, reanastomosis of the colon was performed.