BRIEF REPORTS

Pulmonary Thromboembolism after Fontan Operation
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The fatal outcome in an eleven-year-old girl, one month after an extra-cardiac Fontan operation is reported. She was diagnosed with tricuspid atresia and had a Blalock Taussig shunt and a bidirectional Glenn procedure. The Fontan operation was performed using a Dacron conduit, fenestrated with a 6 mm Goretex® tube. The first week after the operation she received low molecular weight heparin, then it was stopped and aspirin was started. One month after surgery she was admitted to the hospital because of sudden cyanosis, dyspnea, chest pain and syncope. A diagnosis of left pulmonary artery thrombosis without right to left shunt across the fenestrated tube was made. She was carried to the cardiac catheterization laboratory where a mechanical lysis of the thrombi was attempted. A local infusion of rtPA was started without improvement and she died 3 hours later.

Key words: Fontan procedure. Thrombus. Fibrinolysis.

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Tromboembolismo pulmonar tras operación de Fontan

Se describe la evolución fatal de una niña de 11 años, un mes después de haber sido sometida a una operación de Fontan. Diagnósticada de atresia tricúspide se le realizó, previamente a la corrección, una fistula de Blalock-Taussig y un Glenn bidireccional. La operación de Fontan se completó con un conducto extracardíaco de Dacron, fenestrado con un tubo de Goretex® de 6 mm. Tras la cirugía, la primera semana recibió heparina de bajo peso molecular y, a continuación, aspirina. Al mes de la operación ingresó de urgencia con cianosis, disnea, dolor torácico y síncope. Se diagnosticó un tromboembolismo pulmonar, en la arteria pulmonar izquierda, y se procedió a la lisis mecánica del trombo y fibrinólisis local con tPA sin éxito, falleciendo 3 h más tarde.

Palabras clave: Procedimiento de Fontan. Trombo. Fibrinólisis.
administered for 1 week with 5 mg/kg/day aspirin added later. Postoperatively, moderate right cardiac insufficiency with pleural hemorrhage, ascitis, and hepatomegaly were treated conservatively with a low-fat diet, diuretics, and vasodilators. One month after surgery the patient was admitted to the emergency room with sudden cyanosis, intense dyspnea, thoracic back pain, and presyncope. Helicoidal computerized axial tomography (CAT) showed a repletion defect in the left pulmonary artery that continued through the inferior lobar arteries and singularly from the thrombus (Figure 1). Cardiac catheterization was performed; on angiography complete obstruction of the left pulmonary artery was observed without a fenestration short circuit (Figure 2). We then performed mechanical lysis of the thrombus and local fibrinolysis with tPA (0.6 mg/kg/h, for 6 hours); despite which the patient died 3 hours later of cardiac shock. At autopsy complete obstruction of fenestration by a thrombus around the Gore-Tex® tube was observed, as were obstruction of the left pulmonary artery and a thrombus of the inferior vena cava and renal vein outlets.

DISCUSSION

Although the incidence of intracardiac thrombosis in the proximal veins of the heart following Fontan surgery is high (up to 33% in asymptomatic patients) PTE, a serious complication with a mortality rate of approximately 50%, has rarely been described. Transesophageal echocardiography is very sensitive for the detection of intracardiac thrombus but its usefulness in diagnosing PTE has not been defined. In this patient, obstruction of the Gore-Tex® tube in
fenestration would probably have been detected, but possibly not the pulmonary artery thrombus. Helicoidal CAT rapidly confirmed the clinical diagnosis and precisely located the thrombus. There are many risk factors for thrombosis after Fontan surgery: a) anastomosis and non-biological prosthetic implants in a low pressure circulatory system, especially in this hemodynamically high-risk case, and b) The existence of a procoagulate post-operative state. In this patient, another associated factor may have been the early occlusion of fenestration and its deleterious affect on cardiac output, with major slowing of venous circulation. The point at which thromboembolic complications present varies: 50% of patients in the first 3 months and later on in the remainder (mean, 6.1 years). Effective prophylactic therapy, therefore, should be administered for more than 3 months, although recommendations vary greatly and there is no consensus regarding the type and duration of therapy.

As far as treatment of serious PTE is concerned, tPA has been successfully used after mechanical thrombosis with a modified pigtail catheter. In this patient, this option was used in the place of surgery which, although useful in some cases, was ruled out because of hemodynamic instability.

In conclusion: a) there is a high risk level of PTE following Fontan surgery; b) helicoidal CAT is useful for its immediate diagnosis, and c) prospective multicenter studies are needed to define the correct prophylaxis for this procedure.

BIBLIOGRAFÍA