Guided Transcatheter Valvulotomy in Pulmonary Atresia With Intact Ventricular Septum

Juan Alcibar, Alberto Cabrera, Natividad Peña, Christian Baraldi, Josune Arriola, and José Aramendi

Transcatheter valvulotomy in pulmonary atresia with an intact ventricular septum can be used as a first step to create biventricular circulation and to stimulate further development of the hypoplastic right ventricle. We describe our experience in a case of a neonate with this congenital cardiac defect who underwent successful transcatheter perforation of the atretic pulmonary valve. This report highlights the utility of a special technique based on the use of a gooseneck snare positioned just above the atretic valve to guide the advance of a coronary guidewire. Other therapeutic alternatives are considered.

Key words: Pulmonary atresia. Valvulotomy. Intact ventricular septum.

INTRODUCTION

Pulmonary atresia with an intact ventricular septum (PAIVS) is a serious heart condition that accounts for 0.7% to 3.1% of all cases of congenital heart disease. Except in patients with severe right ventricular hypoplasia or right ventricle-dependent coronary circulation, establishing right ventricle-pulmonary artery continuity may be the first step to achieving biventricular circulation, as indicated in the guidelines for clinical practice and invasive techniques in pediatric cardiology. To this aim, several techniques have been described for perforation of the atretic membrane. Early efforts were mechanical, using a conventional guidewire. Later techniques involved laser and radiofrequency, followed by conventional balloon valvuloplasty.

To limit the possibility of cardiac perforation, which has been reported with all of these techniques, we performed transcatheter perforation in a newborn with this severe heart defect, using a special coronary guidewire guided by an open gooseneck snare positioned just above the atretic valve, followed by valvuloplasty.

CLINICAL CASE

A term neonate born to a primiparous mother was admitted to our hospital for cyanosis 18 hours after birth. The examination disclosed a weight of 3580 g, generalized cyanosis and 50% saturation at 100% FiO2, normal pulses, blood pressure 60/37 mm Hg, and heart rate 130 bpm. On auscultation, a mild functional murmur was detected at the left sternal border, with a single second sound. The ECG disclosed sinus rhythm with QRS axis +100º and right atrial growth. Heart disease was diagnosed by Doppler ultrasound, which showed reduced tricuspid mobility, an 8.5 mm annulus (Z=–3.5), anterograde flow and severe regurgitation, with a gradient of 130 mm Hg. The atretic pulmonary valve presented a favorable membranous morphology.
and a diameter of 8 mm; the pulmonary trunk and branches were well developed. The ventricular septum was intact, although the atrial septum showed a small, 4 mm right-to-left defect. Following the diagnosis of PAIVS, the patient was stabilized with prostaglandin E1 at a dose of 0.5 $\mu$g/kg/min and dopamine at 8 $\mu$g/kg/min, achieving 94% saturation.

On the third day of life, catheterization was performed by right femoral arterial/venous puncture and (with the systemic saturation levels indicated above) manometry data were as follows: right atrium: a, 14 mm Hg; mean, 10 mm Hg; right ventricle, 110/0-15 mm Hg; left atrium: mean, 9 mm Hg; left ventricle: 64/0-9 mm Hg. Left anteroposterior ventriculography disclosed a morphologically normal ventricle and a left aortic arch, clearly visible anterograde opacification of the coronary arteries and, by the ductus, well-developed pulmonary atresia. Right ventriculography demonstrated a markedly underdeveloped tripartite right ventricle with valvular dimensions indicated above, pulmonary atresia and severe tricuspid regurgitation (Figure 1A). The sinuses were not visualized and the coronary arteries showed no contrast enhancement by dependent circulation. Valvotomy was decided on the basis of these findings. Using the femoral artery approach, the catheter was advanced to the arch by retrograde direction and a 4 Fr Judkins right catheter was placed in the ductus. A 5 mm (microvein) Amplatz Goose Neck snare loop was then advanced through the catheter, the open loop was placed over the atretic valve and the coronary catheter was withdrawn to the descending aorta. Another 5 Fr Judkins right catheter was then introduced through the femoral vein, but it could not be properly positioned in the infundibulum. It was exchanged for a 5 Fr balloon wedge pressure catheter (Arrow International), which was coaxially placed in the infundibulum with its distal
orifice close to the valve. Then, guided by the open snare loop as a «target» and with rotating movements over the valve, a 0.014 inch PT Graphix Standard coronary guidewire (Boston-Scimed) was advanced; once past the barrier, it was inserted inside the loop until it reached the descending aorta through the ductus (Figure 1B). In order to gain support and stability, the guidewire was caught and withdrawn in the femoral artery, and with this thrust the valve was dilated with a 3×20 Maverick balloon catheter (Boston-Scimed) to 8 atmospheres, and subsequently with a Balt 8×20 (Montmorency) to 6 atmospheres, observing significant indentation with both maneuvers. After opening the valve, right ventricular systolic and diastolic blood pressure decreased (50/0-7 mm Hg) and the pulmonary valve gradient was 10 mm Hg. Right ventriculography confirmed free passage of contrast to the pulmonary artery and an important reduction in tricuspid regurgitation (Figure 1C).

Mechanical ventilation was maintained during the following days. Prostaglandins were reduced, and there was an expected decrease in saturation. Twenty days after the valvotomy, a trunk-to-trunk systemic/pulmonary shunt and ligation of the ductus were performed. The infant remained stable with saturation levels of 90% and was discharged six days later. Doppler ultrasound prior to discharge disclosed good pulmonary flow, with a gradient of 32 mm Hg, slight pulmonary regurgitation, absence of tricuspid regurgitation and good functioning of the shunt.

DISCUSSION

Transcatheter valvotomy in PAIVS requires favorable anatomical conditions: a tripartite right ventricle with a moderate degree of hypoplasia allowing subsequent development, a patent infundibulum, and a membranous-type valvular atresia with anatomical continuity. As in our patient, experience has shown that transcatheter valvotomy is a definitive treatment in only 50% of cases; systemic-pulmonary shunt and/or infundibulum resection is required.4-6 In this regard, we were aware of the significantly underdeveloped ventricle in our patient, and valvular perforation was attempted as a palliative measure before creating a shunt. Based on the extensive experience of Jou-kou Wang et al.,5 transcatheter valvotomy was the definitive treatment in PAIVS, with a tricuspid valve Z value ≥ -0.1, pulmonary valve Z value ≥4.1 and right-to-left ventricular area ratio ≥0.65. All patients with tricuspid valve Z value ≤-0.8 and pulmonary valve Z value ≤-4.2 with a right-to-left ventricular area ratio ≤0.54 required shunting and/or enlargement of the ventricular outflow tract. Another fundamental anatomical condition is the exclusion of right-ventricle dependent coronary circulation.4-10 The presence of anatomical coronary obstructions and supplementary sinusoid circulation would trigger catastrophic ischemia with valve opening and decompression of the right ventricle. For this reason, the coronary arteries should be studied carefully by aortography or left ventriculography.

Since the pioneer work by Latson3 in the early 1990s, pulmonary valvotomy has been performed mechanically,3-6 with laser7 or radiofrequency methods,5,6,8,10,11 using a conventional catheter or a special 2 Fr Coe catheter9 and through anterograde8 or transducat retrogrades approaches.11

Although the success rate with the mechanical technique is lower,5 we believe outcome can be improved by using a special guidewire for treating obstructive coronary conditions and directing the perforation with a gooseneck snare. We also consider this technique to be simpler than the use of repeated contrast in the infundibulum or echocardiographic monitoring.5,6 In our setting, we are accustomed to treating chronic obstructive coronary disease. Here, we have attempted to adapt the material for use in PAIVS and in other severe obstructive heart diseases. The standard PT Graphix guidewire is used in patients with complex anatomy requiring maximum thrust to cross over the lesion, as in cases of total occlusion and coronary revascularization. The guidewire is slightly rigid at its distal end, and when rotated in a clockwise direction, perforates the valve. Its special ICE hydrophilic coating buffers vascular friction and allows it to glide easily through the ductus to the descending aorta. It can then be retrieved and withdrawn, as has been previously shown.5,6,8,11

Based on the experience described, and contemplating the application of this technique in less complex patients, we suggest that mechanical valvotomy using a special guidewire for obstructive coronary conditions and targeted by a transductal gooseneck snare may be an effective procedure to establish right ventricle-pulmonary artery continuity in anatomically indicated cases of PAIVS.

IN MEMORIAM

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