

Early View

Research letter

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Improvement in exercise capacity after a modified Potts shunt in an adult patient with pulmonary arterial hypertension

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The Potts shunt has been proposed as a strategy to alleviate symptoms and to delay lung transplantation in pediatric patients with pulmonary arterial hypertension (PAH) (1). In a way similar to patients with Eisenmenger physiology with a patent ductus arteriosus, the Potts shunt may confer protection to the pressure-overloaded right ventricle (RV) in patients with supra-systemic pulmonary pressures. The results, in selected pediatric patients, have been encouraging in terms of survival, WHO functional classification and need for transplantation (1,2,3,4). Recently, modifications to the classic Potts shunt have been reported by creating a unidirectional central valved conduit to protect the pulmonary circulation from reverse shunting (5,6). We report on a second adult patient who underwent placement of a central unidirectional (valved) Potts shunt for severe suprasystemic PAH. After one-year follow-up, the patient demonstrated overall clinical improvement with a significant increase in exercise tolerance.

A 22-year-old female was diagnosed with idiopathic PAH with supra-systemic pulmonary pressures 18 months prior to surgery. Her treatment consisted of macitentan, sildenafil and intravenous epoprostenol (2250 mcg/24 hrs). Despite medical therapy for 6 months, she remained in WHO functional class III with a SaO₂ of 93%, a NT-proBNP of 434 pg/ml and a six-minute walking distance (6MWD) of 459 m (59% of expected). Baseline exercise testing showed a maximal load of 70 watt (44%), VO₂max 15.8 ml/min/kg (38%), O₂ pulse 4.7 ml/beat (40.4%) and a drop in SaO₂ to 76% at maximal exertion. At right heart catheterization (RHC) a suprasystemic pulmonary artery pressure (PAP), 130/69 mmHg with a mean PAP of 95 mmHg, was measured. Systemic artery pressure (SAP) was 110/78 mmHg with a mean of 87 mmHg. Other parameters of the RHC were mean right atrial pressure (RAP) 9 mmHg, cardiac index (CI) 3.1 L/min/m² and pulmonary vascular resistance (PVR) of 1367 dynes-sec/cm⁵. Given her lack of improvement, she underwent screening for lung transplantation. Two months before surgery her PAP had increased to 138/72 mmHg with a mean PAP of 99 mmHg, a SAP of 113/69 mmHg (mean 83 mmHg), mean RAP 10 mmHg, CI 2.3 L/min/m² and PVR 1921 dynes-sec/cm⁵. NT-proBNP was 422 pg/ml. A month later she was admitted with hemoptysis and desaturations due to a viral respiratory tract infection. Various treatment options

were discussed after recovery. Because of a paucity of donor lungs for the patients' size (50 kg) and her reluctance to undergo transplantation, other options were considered. The anatomy was found to be suitable for a modified Potts shunt. A central valved conduit was preferred because it protects the pulmonary circulation from pressure overload and reverse shunting, it is easier to manage surgically in the event of a lung transplantation, avoids potential bleeding from intercostal aortopulmonary collaterals and because of prior surgical experience (PE).

The operative technique consisted of a midsternal approach and the support of extra-corporeal circulation. Care was taken not to open the pleural cavity. A unidirectional valved conduit was constructed with a 16 mm bovine jugular vein graft (Contegra, Medtronic, Minneapolis, MN) reinforced with a PTFE vascular graft (Gore, Flagstaff, AZ). Upon institution of cardiopulmonary bypass, the aorta distal to the left subclavian artery was clamped and the distal end of the conduit was anastomosed to the aorta. Subsequently, the proximal end of the conduit was attached to the main pulmonary artery (figure 1a). Her immediate postoperative course was complicated by desaturations, pulmonary edema and a respiratory tract infection which required antibiotics, diuretics and venovenous ECMO support for four days. A postoperative chest CT-scan showed large aortopulmonary collateral vessels as a possible source for the pulmonary edema (figure 1b). She was weaned from the ventilator on the 15th day postoperatively. Intravenous epoprostenol was tapered from the eighth postoperative day and substituted for the oral prostacyclin receptor agonist selexipag (1200 mg b.i.d.) one month postoperatively.

One year after surgery, her exercise tolerance was measured (figure 1c). Maximal load was improved to 80 W(53%), VO_2max was 16 ml/min/kg (41%) and O_2 pulse 5.1 ml (45.2%). Her 6MWD had increased to 580 m (75%). She was WHO functional class II, could climb a flight of stairs, swim and had resumed work. NT-proBNP was decreased to 206 pg/ml. Her cardiac MRI one month prior to surgery and one year after surgery showed significant improvement: the right ventricular end-diastolic volume (EDV) was unchanged (138 compared to 137 ml), end-systolic volume (ESV)

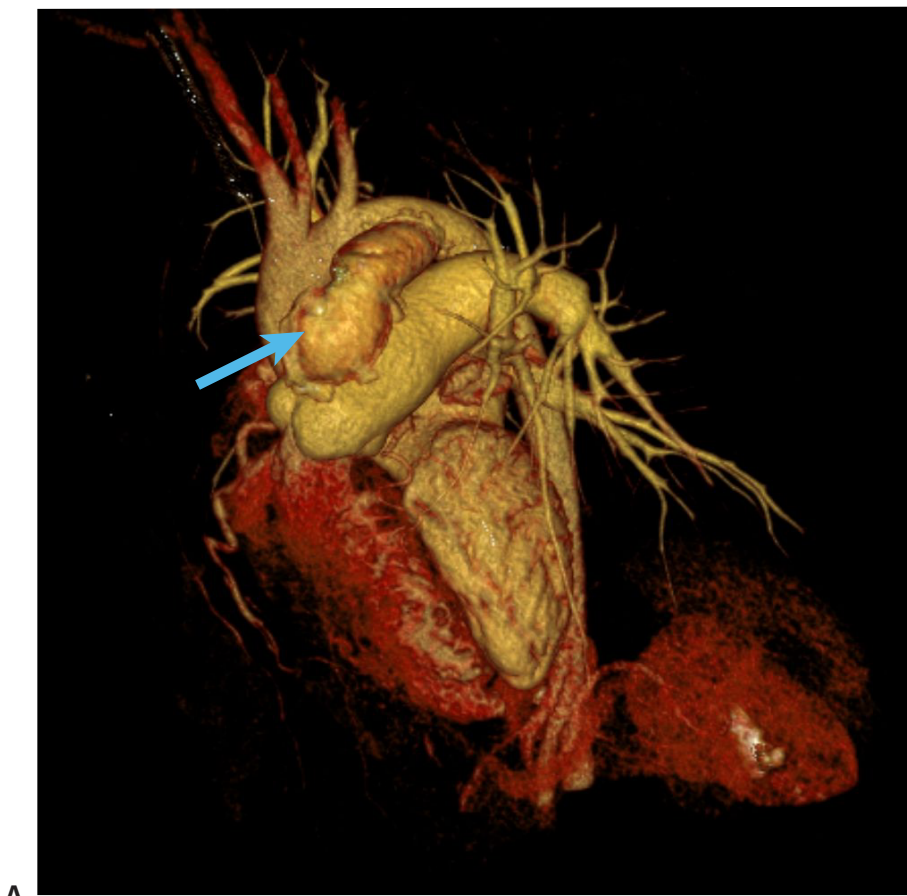
decreased from 86 to 68 ml and ejection fraction improved from 38 to 50%. The left ventricle EDV rose from 92 to a mildly dilated 121 ml, while the ESV rose from 31 to 51 ml. The left ventricular ejection fraction decreased mildly from 66 to 58%.

The improvement of exercise tolerance attests to the fact that a modified unidirectional Potts shunt may provide palliation of symptoms in adult patients with PAH. Walking distance (6MWD) improved most, with a more modest increase in maximal load and VO_2max . Quality of life improved impressively and the patient remains in functional class II despite tapered medication. Several observations may be significant. First, the follow-up with MRI demonstrated a dilatation of the left ventricle and concomitant drop in left ventricular ejection fraction one-year post-shunt. This is a novel observation and may have to be confirmed by other studies. Whether this remodelling improves or not requires further follow-up. Possibly, older patients may adapt more slowly to the abrupt change in physiology caused by the modified Potts shunt. Similarly, the use of postoperative venovenous ECMO support in pediatric patients was rare compared to 80% in a recent series of older patients (5). Another observation particular to this patient was the presence of aortopulmonary collateral vessels. These collaterals can occur in up to 15-30% of patients with idiopathic pulmonary hypertension and are the primary reason for hemoptysis requiring embolization (7). Presently, it is not known how the presence of the Potts shunt physiology interacts with existing collaterals. Historically, however, the development of such collaterals secondary to relative hypoxia was well described in the era of applying Potts shunt for the palliation of so-called blue babies, such as the Tetralogy of Fallot (8). Given the inevitable diversion of pulmonary blood flow, the presence of large systemic collaterals may be a risk factor for postoperative pulmonary edema as seen in this patient. In addition, collaterals may pose a considerable surgical challenge with an approach through a left thoracotomy. Opening the pleural space with collapse of the lung may cause tears of the collaterals emerging from the intercostal vessels with possibly intractable bleeding. A midsternal approach leaves the pleural space intact and avoids bleeding from these friable collaterals.

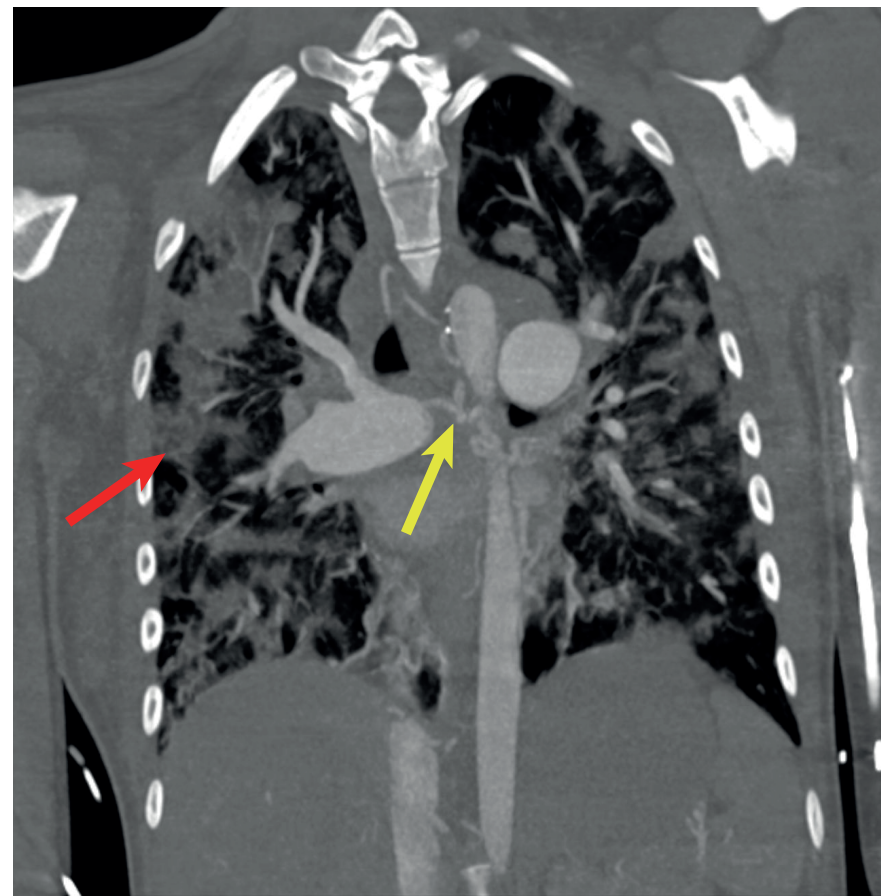
In summary the promising results of the modified Potts shunt need to be confirmed in more adult patients, but the first experience may help to pave the way for a broader use of these shunts in this specific population of patients.

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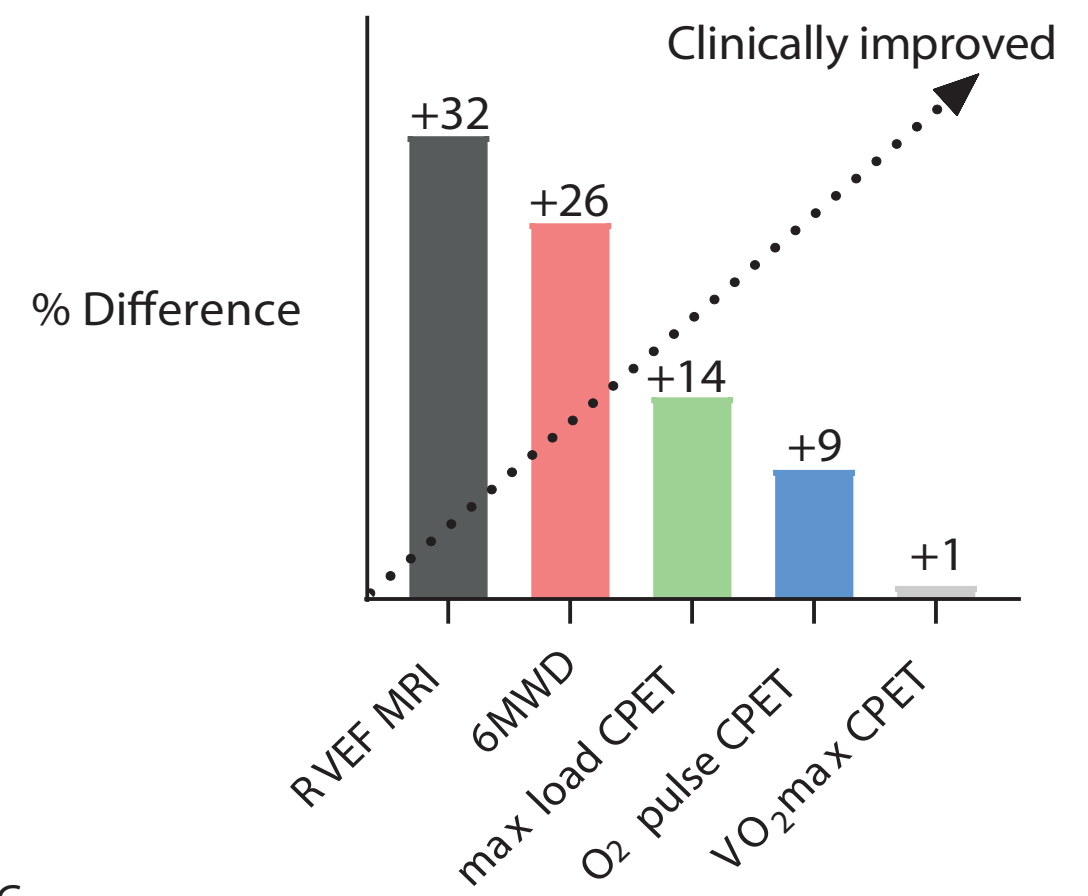
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A



B



C

Figure 1: A) 3D image of the Potts shunt (blue arrow) using Volume Rendering Technique (VRT). The proximal end of the conduit was attached to the main pulmonary artery and the distal end was anastomosed to the aorta. B) Pulmonary edema (red arrow) after Potts shunt procedure originated from large collateral bronchial vessels (yellow arrow). Coronal image of a chest CT-scan with a maximal intensity projection (MIP) of 3mm. C) % Difference in right ventricle ejection fraction (RVEF), six minute walking distance (6MWD), maximal load during cardiopulmonary exercise testing (CPET), O₂ pulse during CPET and maximal oxygen uptake (VO₂max) during CPET. % Difference measured between one month prior to surgery and one year after surgery.