



Two hundred and twenty-nine cases of bidirectional cavopulmonary anastomosis with and without antegrade pulmonary blood flow, a single-center experience

Original Article

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Abstract

Bidirectional cavopulmonary anastomosis is palliative surgical procedure for stepwise adaptation of the ventricle by time-phased relief of blood volume from the single functional ventricle. There still exists a controversial question regarding maintaining additional antegrade pulmonary blood flow. We retrospectively reviewed the surgical cases of 261 patients who underwent bidirectional cavopulmonary anastomosis in our institution from 2012 to 2022 with special regard to antegrade pulmonary blood flow as our preferred strategy. The mean age at the time of surgery was 33.1 months (range 2.9–192 months), and the mean weight was – 7.6 kg (range 3.9–38 kg). Furthermore, we divided all the patients into two groups: in group 1 ($n = 182$) – patients who underwent bidirectional cavopulmonary anastomosis with antegrade pulmonary blood flow, and in group 2 ($n = 47$) – patients without antegrade pulmonary blood flow. The mean follow-up time was 56 months (range 24–120 months). Mortality rate was 4.8 % ($n = 11$) in the past 10 years. Statistical difference between groups was in the following positions: group 2 had less ICU stay ($p < 0.000125$) and hospital stay ($p < 0.017110$); group 1 had a longer duration of pleural effusion ($p < 0.000003$) and amount of drainage output ($p < 0.007$), also demonstrated higher oxygen saturation ($p < 0.000264$) and Glenn shunt pressure ($p < 0.002$) after the surgery; but there was no difference in oxygen saturation after 6, 12, and 24 months; mortality in both groups has no statistic difference. Considering our experience, we take a stand on the controlled to antegrade pulmonary blood flow strategy during bidirectional cavopulmonary anastomosis.

Introduction

In patients with functional single ventricle physiology, bidirectional cavopulmonary anastomosis is a palliative staged surgical procedure before total cavopulmonary connection. It allows stepwise adaptation for the ventricle by time-phased relief of blood volume from the single functional ventricle and prevents complications that can occur.^{1–4}

There still exists a controversial question regarding maintaining additional antegrade pulmonary blood flow. Some research centres^{5,6} claim that persistent antegrade pulmonary blood flow enhances the growth of pulmonary veins (PAs) (because of pulsatile blood flow), prevents pulmonary arteriovenous malformations, and improves arterial oxygen saturation. Other research centres⁷ insist that antegrade pulmonary blood flow potentially raises central venous pressure exposing the venous system to ventricular pressure, resulting in a higher prevalence of superior caval vein syndrome and persistent pleural effusions or late development of chylothorax.

Materials and methods

Patients

We retrospectively reviewed the surgical cases of 261 patients who underwent bidirectional cavopulmonary anastomosis in our institution from 2012 to 2022. The 32 patients were excluded from the study, due to a lack of information needed for statistical analysis. As a result, we analyzed 229 patients: the mean age at the time of surgery was 53.1 months (range 2.9–192 months), and the mean weight was – 7.6 kg (range 3.9–38 kg). The variety of congenital heart anomalies in this cohort is shown in Table 1, most of the patients had an association of heart defects. Furthermore, we divided all the patients into two groups: in group 1 ($n = 182$) – patients who underwent bidirectional cavopulmonary anastomosis with antegrade pulmonary blood flow, and in group 2 ($n = 47$) – patients who underwent bidirectional cavopulmonary

Table 1. Patients characteristics

Variables		All patients <i>n</i> = 229	Group 1 (<i>n</i> = 182)	Group 2 (<i>n</i> = 47)
Age at BCPA (m) mean (Range)		33.1 (2.9–192)	36.7 (2.9–176)	25.4 (2.9–204)
Weight (kg) mean (Range)		7.6 (3.8–38)	13.3 (3.8–40)	11 (3.9–36)
Diagnosis	Tricuspid atresia, %	48 (20.9%)	35 (15.2%)	13 (5.6%)
	Mitral atresia, %	8 (3.4%)	6 (2.6%)	2 (0.8%)
Hypoplastic left heart syndrome, %		2 (0.8%)	1 (0.4%)	1 (0.4%)
CAVSD, %		26 (11.3%)	14 (6.1%)	12 (5.2%)
TAPVC, %		4 (1.7%)	1 (0.4%)	3 (1.3%)
Double-outlet right ventricle, %		47 (20.5%)	35 (15.2%)	13 (5.6%)
Ebstein anomaly, %		7 (3.0%)	7 (3%)	0 (0%)
Pulmonary atresia, %		44 (19.2%)	25 (10.9%)	19 (8.2%)
TGA, %		32 (13.9%)	9 (3.9%)	23 (10%)
ccTGA, %		22 (9.6%)	6 (2.6%)	16 (6.9%)
LVOTO, %		5 (2.1%)	1 (0.4%)	4 (1.7%)
ASD, %		24 (10.4%)	15 (6.5%)	9 (3.9%)
VSD, %		154 (67.2%)	104 (45.4%)	50 (21.8%)
RV-CorA fistula, %		5 (2.1%)	2 (0.8%)	3 (1.3%)
Pulmonary stenosis	Valvar pulmonary stenosis	12	11 (4.8%)	1 (0.4%)
	Supravalvar pulmonary stenosis	3	3 (1.3%)	0 (0%)
	Subvalvar (infundibular) pulmonary stenosis	12	12 (5.2%)	0 (0%)
	Mixt	49	46 (20%)	3 (1.3%)
	Pulmonary artery banded	74	66 (28.8%)	8 (3.4%)
Ventricular dominance	Left, %	99 (43.2%)	84 (36.6%)	15 (6.5%)
	Right, %	21 (9.1%)	19 (8.2%)	2 (0.8%)

BDCPA = bidirectional cavopulmonary anastomosis; CAVSD = complete atrioventricular septal defect; TAPVC = total anomalous pulmonary venous connection; TGA = transposition of the great arteries; ccTGA = congenitally corrected transposition of the great arteries; LVOTO = left ventricular outflow tract obstruction; ASD = atrial septal defect; VSD = ventricular septal defect; RV-CorA fistula = right ventricle - coronary artery fistula.

anastomosis without antegrade pulmonary blood flow. The cohort in both groups was statistically homogeneous. The mean follow-up time was 56 months (range 24–120 months) after bidirectional cavopulmonary anastomosis, (11) 4.8 % were lost to follow-up. The final result was determined as either bidirectional cavopulmonary anastomosis as a definitive procedure, Fontan completion, or death. Information in the patient's database was obtained after follow-up visits where the following examinations were performed: systemic arterial oxygen saturation on room air gained by pulse oximetry and echocardiographic study, cardiac catheterization, if needed.

Each patient undergoes cardiac catheterisation before bidirectional cavopulmonary anastomosis or bidirectional cavopulmonary anastomosis. Another indication for cardiac catheterisation included: evidence of excessive aortopulmonary or intrapulmonary collaterals and worsening cyanosis.

Surgical technique

All procedures were performed through a median sternotomy using aortic and bicaval cannulation with moderate hypothermic cardiopulmonary bypass. Previously created systemic-to-pulmonary shunts were removed. Albeit there is no need for aortic

cross-clamping for bidirectional cavopulmonary anastomosis alone, in some patients aortic cross-clamping with cardiac arrest, or artificial fibrillation was induced for intracardiac repair or revision. Cavopulmonary connection was performed by anastomosing the superior caval vein to the right pulmonary artery in an end-to-side fashion with some technical modification to prevent anastomotic stenosis. In cases with additional left superior vena cava (LSVC), bilateral bidirectional cavopulmonary anastomosis was performed in all cases. Azygos vein was ligated, except for patients with azygos continuation of interrupted inferior caval vein.

Bidirectional cavopulmonary anastomosis with antegrade pulmonary blood flow is our preferred institutional strategy. If antegrade pulmonary blood flow was present, PA (pulmonary artery) banding is established, and the circumference of the band is determined by saturation (75–85% on FiO₂ 21%) and central venous pressure (15 mm Hg).

Statistical analysis

Retrospective records of pre- and post-operation patients who underwent bidirectional cavopulmonary anastomosis (BDCPA) in our institution from 2012 to 2022 were analysed. The SPSS

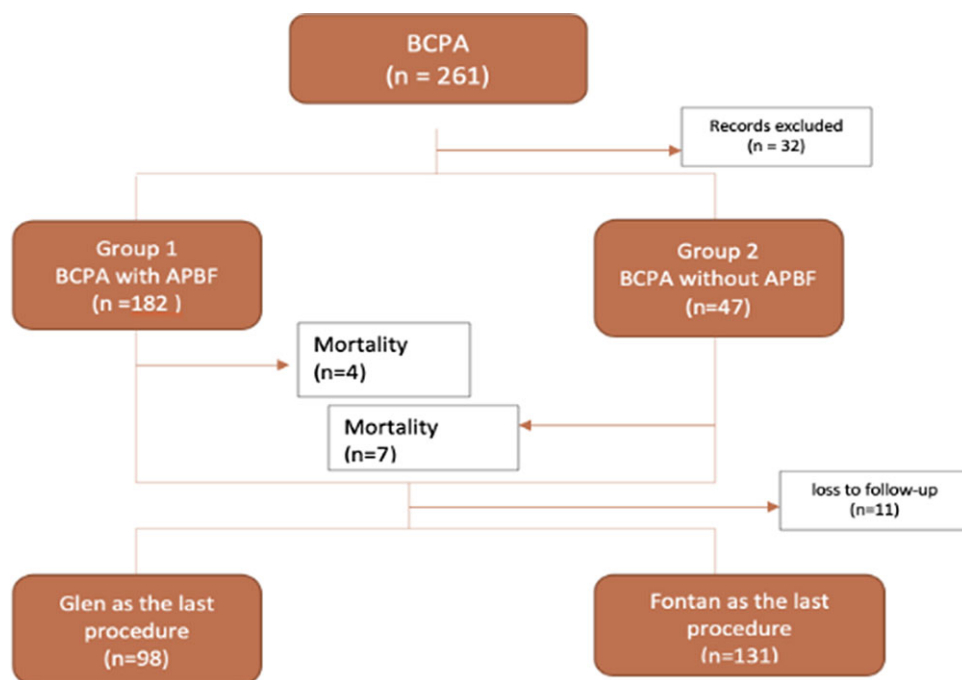


Figure 1. Overview of the study cohort.

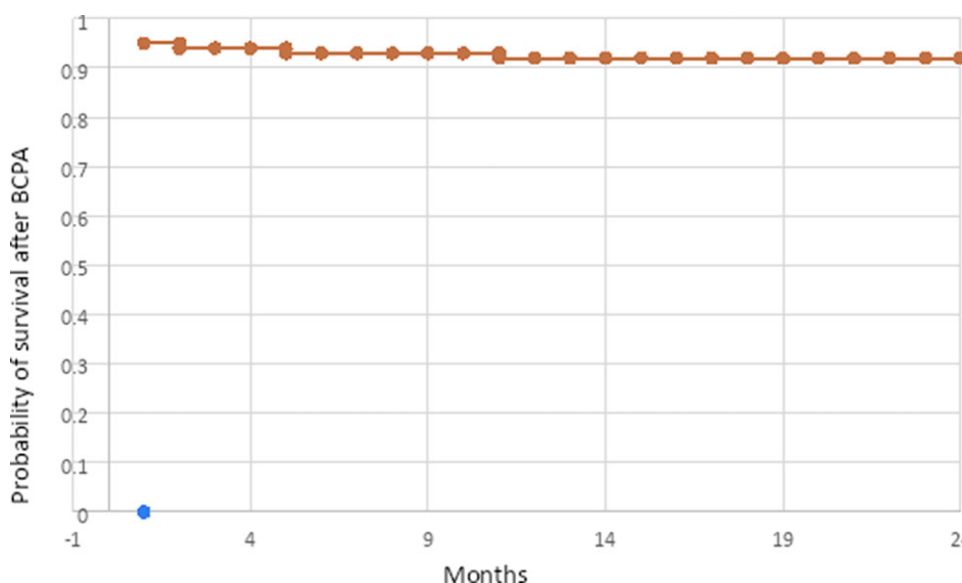


Figure 2. Kaplan–Meier survival (includes hospital mortality).

statistical program for Windows version 10 (SPSS Inc., Chicago, Ill) was used for data analysis. The results of this study are presented as median with the range. For group comparison, we used a Mann–Whitney test. A Kaplan–Meier test was used for survival analysis. A *p*-value of less than 0.05 was considered statistically significant.

Results

In our centre, BDCPA is routinely performed at age 33.1 months (range 2.9–192) with an average weight of 7.6 kg (range 3.9–38) in patients with single ventricle anatomy. The final result was determined as either BDCPA as a definitive procedure, Fontan completion, or death (Figure 1). Each patient undergoes catheterization before the surgical procedure.

Mortality rate was 4.8 % (*n* = 11) in the last 10 years. A Kaplan–Meier curve demonstrates the probability of survival at 24 months after BDCPA - 0.92 (Figure 2).

In Table 2 we demonstrate postoperatively results in patients who underwent BDCPA and in Table 3 we compared two groups of study: group 1 (*n* = 182) - patients who underwent BDCPA with antegrade pulmonary blood flow and group 2 (*n* = 47) - patients who underwent BDCPA without antegrade pulmonary blood flow. Our research has shown that the statistical difference between the two groups was in the following positions: group 2 had less ICU stay (*p* < 0.000125) and hospital stay (*p* < 0.004910) than group 1; group 1 had a longer duration of pleural effusion (*p* < 0.000003) and amount of drainage output (*p* < 0.007) in comparison with the group 2; group 1 demonstrated higher oxygen saturation (*p* < 0.000264) and Glenn shunt pressure (*p* < 0.002) after the

Table 2. Postoperative results

Variables	All patients <i>n</i> = 229	Group 1 (<i>n</i> = 182)	Group 2 (<i>n</i> = 47)	<i>p</i> -value
Hospital stays (days), mean	17.3	17	12.9	0.004910
Intensive care stay (days), mean (Range)	5.8 (0–78)	7.02	5.1	0.000125
Post-operative drainage (days), mean (Range)	3 (3.1–25)	5.1	3.4	0.000003
Pleural effusion ml/kg, mean (Range)	25.6 (2.7–285.4)	28.9	13.1	0.007640
Glenn shunt pressure during the surgery (mmHg), mean (Range)	14.3 (4–23)	16.8	14.2	0.000013
Glenn shunt pressure after extubation (mmHg), mean (Range)	13.3 (8–27.2)	13	11.8	0.002235
Systemic infection	25	20	5	0.478820
Mean oxygen saturation at ICU, %	84.1 (60–95)	86.3	79	0.000264
Mean oxygen saturation (at the time of discharge from hospital), %	85.1 (71–96)	85.5	82	0.000815
Mean oxygen saturation after 6 months, %	85.3 (66–96)	85.9	83.5	0.167970
Mean oxygen saturation after 12 months, %	85.3 (72–96)	85.9	83.9	0.103233
Mean oxygen saturation after 24 months, %	86.8 (67–96)	85	85.2	0.100020
Mortality, (%)	11 (4,8)	4 (1,7)	7 (3)	0,070103

Group 1 – Bidirectional cavopulmonary anastomosis with antegrade pulmonary blood flow; Groupe 2 – Bidirectional cavopulmonary anastomosis without antegrade pulmonary blood flow.

surgery; but there was no difference between the groups in oxygen saturation after 6, 12, 24 months; mortality in both groups has no statistic difference.

Discussion

Patients with functional single ventricle physiology must undergo BDCPA as an intermediate step before the Fontan procedure, which allows stepwise adaptation for the ventricle by time-phased relief of blood volume from the single functional ventricle.^{1–4}

In our center, BDCPA is routinely performed from 3 to 6 months in patients with single ventricle anatomy. However, the exact time is still controversial because early BDCPA is a high risk of postoperative complications. Still, on the other hand – it's positively induced on the body growth and long-term outcomes in the next stage – Fontane procedure.^{8,9} Each patient undergoes catheterization before the surgical procedure. Other palliative interventions, depending on how well pulmonary and systemic blood flow is balanced, may be needed in the neonatal period.

The literature review demonstrates that in most institutions mortality rate is between 1 to 13% in cohorts with different anatomic conditions and ages.^{10–12} Our center achieved a mortality rate of 4.8 % (*n* = 11) in the last 10 years, which demonstrates good technique and postoperative patient care in the ICU.

Risk factors for mortality and morbidity included: age less than 3 months, high transpulmonary gradient, low weight, pulmonary branch stenoses, and severe preoperative cyanosis, which were also shown by other institutional studies.^{13,14}

Furthermore, in this study, we analyzed our center strategy concerning antegrade pulmonary blood flow in patients who underwent BCPA, as it is still a controversial question in most institutions. Antegrade pulmonary blood flow is provided through the native pulmonary artery that can be banded if needed and determined by saturation (75–85% on FiO₂ 21%) and central venous pressure (15 mmHg).

Our study has shown that there is no difference between the two groups of study (group 1 - patients who underwent BDCPA with antegrade pulmonary blood flow and group 2 - patients who

underwent BDCPA with no APBF) in aspects of survival, but the patients with antegrade pulmonary blood flow have higher saturation in the first 6 months that positive induced on body growth and long-term outcomes on the next stage – Fontane procedure, prevents pulmonary arteriovenous malformations and enhances the growth of PAs. But on the other hand, antegrade pulmonary blood flow is a trigger for a longer duration of pleural effusion which as a consequence leads to longer ICU and hospital stays.

In summary, considering our experience and foreign institutions' experience, we recommended the controlled antegrade pulmonary blood flow strategy during the BCPA. However, we have been analyzing the further condition of patients with antegrade pulmonary blood flow to improve their long-term outlook.

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Competing interests. None.

Ethical standards. This manuscript does not involve human or animal experimentation.

References

- Baffa JM, Rychik J, Gullquist SD et al. Outcome following bidirectional cavopulmonary anastomosis prior to modified Fontan procedure. *J Am Coll Cardiol* 1991; 17: A33.
- Hopkins RA, Armstrong BE, Serwer GA, Peterson RJ, HN Oldham Jr. Physiologic rationale for a bidirectional cavopulmonary shunt: a versatile complement to the Fontan principle. *J Thorac Cardiovasc Surg* 1985; 90: 391–398.
- Mazzera E, Corno A, Picardo S et al. Bidirectional cavopulmonary shunts: clinical applications as staged or definite palliation. *Ann Thorac Surg* 1989; 47: 415–420.

4. Bridges ND, Jonas RA, Mayer JE, Flanagan MF, Keane JF, Castaneda AR. Bidirectional cavopulmonary anastomosis as interim palliation for high-risk Fontan candidates: early results. *Circulation* 1990; 82: 170–176.
5. Henaine R, Vergnat M, Mercier O et al. Hemodynamics and arteriovenous malformations in cavopulmonary anastomosis: the case for residual antegrade pulsatile flow. *J Thorac Cardiovasc Surg* 2013; 146: 1359–1365.
6. Srivastava D, Preminger T, Lock JE et al. Hepatic venous blood and the development of pulmonary arteriovenous malformations in congenital heart disease. *Circulation* 1995; 92: 1217–1222.
7. Kogon BE, Plattner C, Leong T, Simsic J, Kirshbom PM, Kanter KR. The bidirectional Glenn operation: a risk factor analysis for morbidity and mortality. *J Thorac Cardiovasc Surg* 2008; 136: 1237–1242.
8. Norwood WI, Jacobs ML. Fontan's procedure in two stages. *Am J Surg* 1993; 166: 548–551.
9. Jonas RA. Indications and timing for the bidirectional Glenn shunt versus the fenestrated Fontan circulation. *J Thorac Cardiovasc Surg* 1994; 108: 522–524.
10. Karl TR. The bidirectional cavopulmonary shunt for hypoplastic left heart syndrome. *Semin Thorac Cardiovasc Surg Pediatr Card Surg Annu* 2001; 4: 58–70.
11. Bove EL. Current status of staged reconstruction for hypoplastic left heart syndrome. *Pediatr Cardiol* 1998; 19: 308–315.
12. Alejos JC, Williams RG, Jarmakani JM et al. Factors influencing survival in patients undergoing the bidirectional Glenn anastomosis. *Am J Cardiol* 1995; 75: 1048–1050.
13. Friedman KG, Salvin JW, Wypij D et al. Risk factors for failed staged palliation after bidirectional Glenn in infants who have undergone stage one palliation. *Eur J Cardiothorac Surg* 2011; 40: 1000–1006.
14. Douglas WI, Goldberg CS, Mosca RS, Law IH, Bove EL. Hemi-Fontan procedure for hypoplastic left heart syndrome: outcome and suitability for Fontan. *Ann Thorac Surg* 1999; 68: 1361–1368.