Orthotopic Heart Transplantation in Patients With Transposition of the Great Arteries

Christian Muñoz-Guijosa, Antonino Ginel, José Montiel, Vicens Brofa, Sonia Mirabet, Antonio Bayés-Genis, and José M. Padró

Servicio de Cirugía Cardíaca, Unidad de Miocardiopatías, Insuficiencia Cardiaca y Trasplante Cardiaco, Hospital de la Santa Creu y Sant Pau, Barcelona, Spain

INTRODUCTION

Progress in cardiac surgery and cardiology has resulted in pediatric patients with congenital heart disease (CHD) who previously would have died now reaching adulthood. In fact, in some countries, the percentage of the adult population with CHD repaired in infancy is already higher than the pediatric population. In patients with transposition of the great arteries (TGA), physiological or intra-atrial repair techniques (Mustard and Senning) have been used for more than 20 years. Both techniques were described in the late 1960s. Given that the Senning technique can be performed without having to use prosthetic material for redirection of blood flow, this was the most frequently used technique, considering its growth potential. Anatomical correction (Jatene procedure or arterial switch) enables avoiding use of the left ventricle as a systemic ventricle, but, as it was developed later on (in the 1970s), there are still many patients who reach adulthood with some variation of intra-atrial repair technique. The majority of these patients are clinically well throughout their adult life, but as a consequence of the potential for right ventricular (systemic) failure, some may develop cardiac insufficiency. The poor results obtained with other surgical techniques, such as the late arterial switch,
This results in the free wall of the RA being, in reality, the free wall of the systemic atrium. The venous cannulation must be carried out keeping this in mind. The superior vena cava (SVC) can be cannulated directly. Drainage of the inferior vena cava (IVC) can be performed by directly accessing it near the diaphragm or through the femoral vein. On initiating the cardiectomy, the first cavity accessed is the systemic atrium. After opening the systemic atrium, the neoseptum is extracted, in order to access the venous atrium.

After explanting the septum, both vena cavae are mobilized and sectioned. Finally, the remaining LA is sectioned circumferentially.

In these 3 cases, the cardiac transplant was carried out using the bicaval technique. In one of these patients there was no innominate vein and the left SVC persisted. During surgery recannulation of the left SVC to the right SVC with a prosthetic conduit was performed (Figure 1).

In the Patient with D-TGA and dextrocardia, the Mustard-type correction allowed venous blood to flow from the left side toward the right side. The cardiectomy was performed maintaining intra-atrial technique.

### METHODS

We carried out a descriptive study of 4 patients (3 women, 1 man) with TGA and physiological correction, with end-stage cardiac insufficiency, who underwent heart transplantation between 1992 and 2004. Data collection was by review of the clinical charts (Table); 3 patients had D-TGA and 1 had D-TGA, dextrocardia and visceralatrial situs inversus; 3 patients underwent a Senning-type correction and 1 a Mustard-type correction. None of the patients had pulmonary hypertension. The age range at the time of transplantation was 13-25 years. In 3 cases the implant was performed using the bicaval technique and in 1 case, the classical biatrial technique.

### RESULTS

In the patients with Senning repair, redirection of blood flow is achieved through surgical alteration of the interatrial septum and connection of the left atrium (LA), open at the outlet of the right pulmonary veins, with the lateral wall of the right atrium (RA). This results in the free wall of the RA being, in reality, the free wall of the systemic atrium. The venous cannulation must be carried out keeping this in mind. The superior vena cava (SVC) can be cannulated directly. Drainage of the inferior vena cava (IVC) can be performed by directly accessing it near the diaphragm or through the femoral vein. On initiating the cardiectomy, the first cavity accessed is the systemic atrium. After opening the systemic atrium, the neoseptum is extracted, in order to access the venous atrium. After explanting the septum, both vena cavae are mobilized and sectioned. Finally, the remaining LA is sectioned circumferentially.

In these 3 cases, the cardiac transplant was carried out using the bicaval technique. In one of these patients there was no innominate vein and the left SVC persisted. During surgery recannulation of the left SVC to the right SVC with a prosthetic conduit was performed (Figure 1).

In the Mustard procedure, venous redirection is achieved by extracting the interatrial septum and creating a tunnel in the interior of the atrium connecting both vena cavae to the mitral valve. Thus, the pulmonary veins drain into the tricuspid valve. During the procedure, venous drainage is achieved through direct cannulation of both vena cavae.

In the patient with D-TGA and dextrocardia, the Mustard-type correction allowed venous blood to flow from the left side toward the right side. The cardiectomy was performed maintaining intra-atrial...
Another option would be late conversion to a 2-stage arterial switch: banding of the pulmonary artery and later takedown of the intra-atrial repair and arterial switch.\textsuperscript{6} At first this technique presented encouraging results. Later studies, with longer follow-up periods,
confirmed that the success rate was lower than 20% in patients older than 12 years of age. The main cause of failure was the inability of the LV to adapt to systemic pressure. Given that the majority of patients who develop ventricular failure are in their 20s or 30s, this technique is not considered a true alternative. Faced with this situation, for patients who progress toward cardiac insufficiency, heart transplantation is an interesting therapeutic option, although its use still cannot be generalized due to limited experience in this group of patients.

Heart transplantation in adult patients with CHD presents its own series of problems: previous surgery, the presence of prosthetic material, and anatomic anomalies are the principal complications. Performing a heart transplant in these situations is facilitated by a series of anatomical constants. The LA is a structure situated in the midline and which receives drainage from the pulmonary veins. The pulmonary artery is a structure situated in the middle mediastinum. The aorta, at its exit from the pericardium, is located anterior and to the right of the pulmonary artery. These anatomic constants enable us to perform a heart transplant in practically any type of CHD. Preparation of venous return is the fundamental element in these situations. Special attention must be paid to patients in whom the Senning technique was employed, as the structure most anterior to the mediastinum is the systemic atrium. Both vena cavae remain in its interior, in a deeper position.

In the case of the patient with situs inversus and dextrocardia, cardiac transplantation of a normal heart is a great challenge. The repositioning of venous drainage is the key to the intervention. Several authors have proposed the possibility of transferring blood from the left to the right via prosthetic conduits. In our case, due to the presence of a Mustard-type rechanneling, venous redirection had already been achieved. Cardietomy was performed preserving this venous redirection, which enabled a cardiac transplant with no great alterations.

Cardiac transplantation in patients with complex CHD may be performed with results similar to those obtained in the normal population. It is essential to be aware of any previous surgery, the resulting anatomy, and the variations specific to each patient, in order to plan each intervention.

REFERENCES


