MRI evaluation of the systemic-pulmonary arterial shunts in patients with pulmonary artery stenosis or complex pulmonary artery atresia.

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Authors: D. L. Radu¹, R. Lesanu¹, R. A. Capsa¹, I. G. Lupescu², S. A. Georgescu³; ¹Bucharest/RO, ²BUCHAREST/RO, ³Sector 2/RO
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Purpose

- Our main purpose was to evaluate the role of MRI in the study of the PA and the system of aorto-pulmonary collateral vessels and secondary to depict the particular anatomy in patients that reached adulthood, but did not require surgical treatment.
- Since echocardiography examination is often technically limited and arterial catheterization is an invasive procedure, this study evaluates the efficiency of magnetic resonance imaging (MRI) as a noninvasive tool in diagnosis of pulmonary artery anatomy (PA) and aorto-pulmonary shunts, informations which are crucial in determining surgical management and followup of the patients with complex congenital heart disease, involving stenosis or pulmonary atresia.

Methods and Materials

Study methodology: retrospective study covering the period 1 January 2001 - June 1, 2010.

Inclusion criteria: We have studied the clinical and imaging data of 32 patients (diagnosed with tetralogy of Fallot or different forms of pulmonary stenosis), sent for MRI examination in the Department of Radiology and Medical Imaging of Fundeni Clinical Institute.

The goal of the MRI examination was to depict the anatomy of the pulmonary vascular system and to image the aortopulmonary collaterals. We have excluded patients with advanced renal disfunction (GFR< 15 mL/min/1.73 m2).

Imaging protocol: Patients followed a protocol that also included transthoracic echocardiography (TTE) or transoesophageal echocardiography (TEE) and angiocardiology/selective pulmonary artery catheterization; imaging data was compared with intraoperative results in all cases that required surgery.

All the MRI studies were performed on a GE Signa Horizon 1,5 T machine, using a TORSO phased array coil and respiratory and cardiac gating (MRI safe carbon electrodes). In all studies we used administration of a paramagnetic contrast agent. For the morphological assesment of the heart we used SE sequences in at least 2 planes (perpendicular and parallel to the interventricular septum) with slice thickness of 10mm and spacing of 2mm. For the angiographic evaluation we used gadolinium enhanced (Gd
iv 0.2 mL/kg, flow 3 ml/s) 3DMRA sequences with bolus detection (SMARTPREP-GE); after the acquisition of the source images, multiplanar reconstructions and MIP/VR were performed. For the evaluation of the RV mass, volume and ejection fraction cine MRI sequences were performed.

**Results**

**RESULTS**

We included 32 patients, with a mean age of 24 years and a male/female ratio of 1:3 (fig 1 on page 4.).

After the MRI exam was performed, we split the initial group in several categories, corresponding to the MRI features observed:

- tetralogy of Fallot with pulmonary atresia (n=11),
- tetralogy of Fallot with pulmonary stenosis (n=9),
- trilogy of Fallot (n=4),
- pentalogy of Fallot (n=3) (fig 2 on page 5).

Five patients had undergone previous shunt surgery (3 with palliative Blalock-Taussig shunt- fig 4 on page 7, fig 5 on page 8 and 2 with definitive surgical correction). The rest of the patients had spontaneous pulmonary vascularisation, with systemic-pulmonary collaterals.

The aortopulmonary shunts were well demonstrated, with clear delineation of the spatial relationship of the shunts to both adjacent vascular and non vascular structures. In all cases, MRA confirmed the presence or absence of central pulmonary arteries (24 (72%) of 32 patients had central pulmonary arteries).

The shunts were classified either as individual vessels (2.5mm diameter) or as multiple smaller vessels that tended to arise in a cluster (each vessel typically 2.5mm diameter)- fig 3 on page 6. The majority of shunt vessels arose from the descending aorta (63.6% of single aortopulmonary shunts and 66.7%of multiple smaller vessels). In most cases, it was possible to tell whether they supplied a single lobe or entire lung (30% drained into the right upper lobe, and 18.1% supplied the right pulmonary artery).

The most common origin of the systemic-pulmonary shunt was at the level of the descending aorta (63% in patients with tetralogy of Fallot)- fig 6 on page 9.
DISCUSSION

This study assessed the value of MRI both with and without Gd administration in the morphologic assessment of the aortopulmonary shunts in a predominantly adult population. Early detection and treatment are associated with a better outcome but require accurate demonstration of the anatomic distribution of the anomalous vessels, which is also important for serial evaluation(1).

Both the initial diagnosis and the management during follow-up of congenital heart disease depend on an accurate depiction of cardiac anatomy and function(1,2). It is often difficult to obtain sufficient information with transthoracic echocardiography in adolescents and adults because they have larger chests and hearts and because of the natural reduction of the ultrasound (US) window. Special problems occur in patients who have undergone midline thoracotomy and have acquired precordial fibrotic tissue(1,3).

Several groups have reported their findings in detecting cardiovascular anomalies using MRA, but in contrast to the present study, these were either in predominantly pediatric populations or were retrospective studies(4,5,6). Geva et al (4) demonstrated the accuracy of MRA in the delineation of all sources of pulmonary blood supply in patients with complex pulmonary stenosis and atresia compared with diagnostic catheterization with x-ray angiography. Although some adult patients were included in their series, the median age range was 4.7 years, unlike the present study. In a prospective study, Sanjay et al. (5) showed that contrast-enhanced 3D MRA is a safe, rapid, noninvasive and robust method to detect vascular anomalies in adult patients with CHD with aortopulmonary collateral vessels. In this particular study the mean age was closer to our own study group (31 years) and it depicted the origin and distribution of aortopulmonary collateral vessels, compared with classical angiography.

Images for this section:
<table>
<thead>
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<th>Sex, male/female</th>
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<tbody>
<tr>
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<td>Tetralogy of Fallot with pulmonary atresia</td>
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<tr>
<td>Tetralogy of Fallot with pulmonary stenosis</td>
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<td>Trilogy of Fallot</td>
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<td>Status post palliative Blalock Taussig shunt</td>
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<td>Status post definitive surgical correction</td>
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**Fig. 1:** Demographic and cardiac diagnostic date in the study group.
**Fig. 2:** Origing of the systemic-pulmonary shunts according to the level of the aorta and associated anomalies.
Fig. 3: 3D MRA. MIP reconstruction oblique coronal view in a 25 year old patient with Tetralogy of Fallot, showing spontaneous pulmonary revascularisation with multiple systemic-pulmonary collateral vessels at a parietal thoracic level. PA- pulmonary artery, Ao-Aorta, arrow- collateral vessels
**Fig. 4:** Oblique coronal SE sequences and MIP oblique sagittal reformat (fig 5). 19 year old patient with tetralogy of Fallot and palliative correction with Blalock Taussig shunt which is partially occluded and with an aneurysmal aspect (arrow). LA- left atrium, LV- left ventricle.
Fig. 5: MIP oblique sagital reformat- same patient as figure 4.
Fig. 6: MIP reconstruction. 21 year old patient with Tetralogy of Fallot and pulmonary stenosis. Spontaneous pulmonary revascularisation through multiple aorto-pulmonary collateral arteries at the parietal thoracic level (arrow).
Fig. 7: Axial SE sequences and 3D FSPGR post Gd iv. The absence of the pulmonary trunk at the supravalvular level. There is a small vestigial pulmonary artery trunk which is connected to the ascending aorta and then it divides into two hypoplastic branches that provide the vascularisation of both lungs. In the oblic coronal reformat, aorto-pulmonary colateralls vessels between the descending aorta and inferior lobar branches (Ao- aorta, PV- pulmonary veins, arrow- right pulmonary artery).
Conclusion

- MRI can provide accurate information in assessing systemic-pulmonary shunts in patients with complex pulmonary artery stenosis or atresia and it is a very necessary tool in the preoperative management and subsequent followup.
- Although MRI is an indispensable tool, careful correlation with the ultrasonophic and angiographic data must be performed in each case.

References

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Personal Information

SPITALUL CLINIC FUNDENI BUCURESTI

ROMANIA, Bucharest, Sos. Fundeni nr.258, sector 2

radu.dumitru@gmail.com