Long-term haemodynamic evaluation of aortic pericardial xenograft

ANAND P. TANDON, DONALD R. SMITH, WILLIAM WHITAKER, AND MARIAN I. IONESCU

From the Departments of Cardiology and Cardiothoracic Surgery, The General Infirmary, Leeds

SUMMARY Haemodynamic studies were performed in 30 patients at a mean interval of 43.4 (range 27 to 59) months after aortic valve replacements with pericardial xenografts. Five valve sizes—19, 21, 23, 25, and 27 mm annulus diameter—were used. Of these 30 patients, 16 had preoperative haemodynamic investigations. Comparison of the pre- and postoperative data showed a marginal but significant increase in cardiac output (P < 0.05). There was a significant reduction in the pulmonary wedge and left ventricular end-diastolic pressures at rest and on exercise (P < 0.05 and P < 0.01).

At the postoperative study the mean peak systolic gradient was 8.3 mmHg at rest and 12.3 mmHg on exercise in patients with the smallest xenograft inserted (19 mm) and decreased with each corresponding increase in graft size, so that across the 27 mm graft it was hardly measurable. The calculated xenograft surface area ranged from 1.1 to 2.1 cm² at rest and 1.3 to 2.4 cm² during exercise. Aortic root angiography showed competent valves in all 30 patients, but a grade 1 to 2 perivalvular leak was shown in 8 patients.

This long-term study has indicated significant circulatory improvement and very small transvalvular gradients in patients with aortic pericardial xenografts.

Clinical results of heart valve replacement with glutaraldehyde stabilised pericardial xenografts have already shown a very good survival record, low thrombogenicity without anticoagulants, and maintenance of structural integrity of the grafts over a period in excess of 5½ years (Ionescu et al., 1977). Haemodynamic confirmation of the functional performance of the valve was necessary. This report presents the results of a late haemodynamic assessment of 30 patients who had aortic valve replacement with the Ionescu-Shiley pericardial xenograft.¹

Clinical background

Since March 1971, 176 patients have had single aortic valve replacements with pericardial xenografts. The hospital and late mortalities were 6.2 and 5.1 per cent, respectively. Actuarial analysis of the expected survival rate and individual event-free curves for reoperation, bacterial endocarditis, and thromboembolism have been carried out by the method of Anderson et al. (1974) and the results are shown in Fig. 1. Of the total 176 patients, 17 had early diastolic murmurs. Perivalvular leaks were confirmed in 14 patients either at angiography (12 patients) or at reoperation (2 patients). Clinically 96 per cent of patients are in grade 1 (NYHA) at the latest evaluation.

Subjects and methods

Haemodynamic investigations were performed in 30 patients at a mean interval of 43.4 (range 27 to 59) months, postoperatively. The criteria for selection were an interval of at least 2 years from valve replacement and the informed consent of the patient. An effort was made to include patients with early diastolic murmurs in order to investigate them angiographically. In our belief, these 30 patients were in no other way different from the remaining uninvestigated patients with aortic pericardial xenografts. The clinical details of the 30 patients studied are outlined in Table 1. Additional mitral annuloplasty and implantation of permanent epicardial pacing systems were undertaken in 2 patients each at the time of the original operation. Of the 30 patients reported herein, 16 had preoperative cardiac catheterisations. The number of patients with different xenograft sizes is shown in Table 2.

All patients were admitted to hospital 24 hours

¹Shiley Laboratories, Irvine, California.

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Haemodynamics of aortic pericardial xenograft

![Graph showing aortic replacement with data points and a 95.1% survival rate.](image)

**Fig. 1** Actuarial analysis of results after aortic pericardial xenograft valve replacement. The data are expressed as percentage of expected survival rate and individual event-free curves. The numbers in parentheses along the horizontal axis denote the number of patients at the beginning of each year.

### Table 1 Preoperative clinical details of 30 patients

<table>
<thead>
<tr>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td>10</td>
<td>30</td>
</tr>
<tr>
<td>Mean Age (years)</td>
<td>49.7 (±2.4)</td>
<td>24-69</td>
</tr>
<tr>
<td>Range</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Table 2**: Postoperative haemodynamic data as related to xenograft size (mean values ± SEM)

<table>
<thead>
<tr>
<th>Xenograft size (annulus diameter in mm)</th>
<th>In vitro surface area (cm²)</th>
<th>No. of patients</th>
<th>AVF (ml/s)</th>
<th>PWP (mmHg)</th>
<th>LVEDP (mmHg)</th>
<th>PSV (mmHg)</th>
<th>EPG (mmHg)</th>
<th>XSA (cm²)</th>
</tr>
</thead>
<tbody>
<tr>
<td>19</td>
<td>1-86</td>
<td>3</td>
<td>192</td>
<td>249</td>
<td>10-6</td>
<td>24-5</td>
<td>11-3</td>
<td>25</td>
</tr>
<tr>
<td>21</td>
<td>2-38</td>
<td>6</td>
<td>194</td>
<td>282</td>
<td>9-6</td>
<td>19-3</td>
<td>10-6</td>
<td>20-3</td>
</tr>
<tr>
<td>23</td>
<td>2-96</td>
<td>12</td>
<td>204</td>
<td>324</td>
<td>8-9</td>
<td>19-8</td>
<td>9-2</td>
<td>18-1</td>
</tr>
<tr>
<td>25</td>
<td>3-60</td>
<td>8</td>
<td>260</td>
<td>367</td>
<td>9-5</td>
<td>18-1</td>
<td>9-2</td>
<td>13-0</td>
</tr>
<tr>
<td>27</td>
<td>4-30</td>
<td>1</td>
<td>196</td>
<td>302</td>
<td>12-12</td>
<td>0-0</td>
<td>10-10</td>
<td>0-0</td>
</tr>
<tr>
<td>All patients</td>
<td>30</td>
<td>322</td>
<td>9-4</td>
<td>20-3</td>
<td>9-9</td>
<td>18-3</td>
<td>6-4</td>
<td>9-6</td>
</tr>
</tbody>
</table>

*Had additional mitral annuloplasty at the time of aortic valve replacement.*

**Abbreviations:** R, rest; E, exercise; AVF, aortic valve flow; PWP, pulmonary wedge pressure; LVEDP, left ventricular end-diastolic pressure; PSV, peak systolic gradient; EPG, ejection systolic gradient; XSA, calculated xenograft surface area.

before the haemodynamic study. On admission, a detailed clinical history, estimation of functional capability, physical examination, haematological assessment, a chest radiograph, a 12-lead electrocardiogram, and a phonocardiogram were obtained in all patients. Left ventricular voltage was measured by the sum of SV₁ and RV₅ from the electrocardiograms performed preoperatively and at the time of haemodynamic study. Right, retrograde left, and transseptal catheterisations were performed in the post-absorptive state without any previous sedation. Pulmonary and systemic pressures were transduced by strain-gauge manometers (SEM 486), integrated electronically, and recorded on a multichannel ultraviolet light recorder (SEM 3012) with the zero level set 5 cm below the sternal angle. Cardiac output was measured by the direct Fick method. Haemodynamic data were obtained during a 4-minute period of rest and between the 4th and 6th minute of a 6-minute period of supine leg exercise on a bicycle ergometer at a predetermined maximal...
load. Aortic root angiography was performed in all patients at the end of the study.

Pulmonary and systemic vascular resistances were calculated using standard formulae. The ejection systolic gradient across the aortic pericardial xenograft was measured by planimetric integration of at least five simultaneously recorded phasic left ventricular and aortic root tracings. The pericardial xenograft surface area was calculated according to the hydraulic formula of Gorlin and Gorlin (1951) using the ejection systolic gradient.

Table 3 Pre- and postoperative haemodynamic data (mean values ± SEM and statistical significance)

<table>
<thead>
<tr>
<th></th>
<th>Preoperative (16 patients)</th>
<th>Postoperative (30 patients)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>R</td>
<td>E</td>
<td>R</td>
</tr>
<tr>
<td>O₂ uptake (ml/min per m²)</td>
<td>166.2</td>
<td>507.8</td>
<td>2.9</td>
</tr>
<tr>
<td>Cardiac index (l/min per m²)</td>
<td>±12.5</td>
<td>±23.1</td>
<td>±0.2</td>
</tr>
<tr>
<td>Stroke index (ml/beat)</td>
<td>±2.7</td>
<td>±7.9</td>
<td>±0.1</td>
</tr>
<tr>
<td>PWP (mmHg)</td>
<td>&lt;0.01</td>
<td>&lt;0.01</td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>LVEDP (mmHg)</td>
<td>&lt;0.01</td>
<td>&lt;0.01</td>
<td>&lt;0.05</td>
</tr>
</tbody>
</table>

SEM, standard error of the mean; PWP, pulmonary wedge pressure; LVEDP, left ventricular end-diastolic pressure; PSG, peak systolic gradient R, rest; E, exercise.

Results

The details of the haemodynamic data are given in Tables 2 and 3 and Fig. 2 and 3.

Fig. 2 In vitro flow and gradient across pericardial xenografts measured in a continuous flow rig. The curves represent mean values obtained from measurements made with at least two valves of each size.

Fig. 3 Linear regression curve of ejection systolic gradient related to calculated xenograft surface area.

Electrocardiographic and Radiological Changes

A highly significant reduction, from a preoperative mean value of 53.2 (±1.3) per cent to 47.7 (±0.9) per cent was noted in the cardiothoracic ratio at the postoperative study (P < 0.001).

The mean left ventricular voltage before operation was 50.3 (±2.3) mm and showed a significant reduction to 34.3 (±2.1) mm at the postoperative investigation (P < 0.001).

Cardiac Output and Oxygen Uptake

The cardiac index showed a marginal but significant increase (Table 3) at the postoperative study both at rest and during exercise (P < 0.05). Cardiac output response to exercise was normal. The oxygen uptake showed significant reduction both at rest and on exercise (P < 0.01).

The stroke volume at rest increased from the mean preoperative value of 29.2 ml/m² to 40.4 ml/m² at the postoperative study. A similar increase was noted during exercise. The increase in stroke
Haemodynamics of aortic pericardial xenograft

<table>
<thead>
<tr>
<th>SG (mmHg)</th>
<th>Vascular resistance (dyne cm⁻¹ m⁻¹)</th>
<th>Pulmonary</th>
<th>Systemic</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>E</td>
<td>R</td>
<td>E</td>
</tr>
<tr>
<td>83-3</td>
<td>231·9</td>
<td>216·6</td>
<td>2677·2</td>
</tr>
<tr>
<td>±10·0</td>
<td>±34·7</td>
<td>±23·7</td>
<td>±381·6</td>
</tr>
<tr>
<td>6·4</td>
<td>239·1</td>
<td>171·2</td>
<td>3024·4</td>
</tr>
<tr>
<td>±1·0</td>
<td>±15·9</td>
<td>±19·1</td>
<td>±140·3</td>
</tr>
<tr>
<td>&lt;0·001</td>
<td>Not significant</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

A significant increase in mean diastolic pressures was noted with increasing xenograft size (r=0·996 at rest and r=0·951 during exercise). As shown in Table 2 the calculated areas in vitro are smaller than the in vivo surface area but a significant correlation was noted between the two values (r=0·995 at rest and r=0·934 on exercise).

Regression analysis showed a linear relation between the calculated xenograft surface area and the ejection systolic gradient as shown in Fig. 3.

AORTIC VALVE FLOW

The mean flows through the pericardial xenograft at rest and during exercise were 225±11 and 322±13·7 ml/s, respectively, at the postoperative study. The flows across various sizes of pericardial xenograft are given in Table 2. A significant correlation was noted between aortic valve flow and the annulus diameter of the xenograft implanted (r=0·861 at rest and r=0·998 during exercise).

Discussion

This long-term haemodynamic investigation has shown significant circulatory improvement after aortic valve replacement and maintenance of the function of the pericardial xenograft in the aortic position up to 59 months postoperatively.

The cardiac output showed a marginal but statistically significant increase and its response to exercise was normal. Oxygen utilisation improved after valve replacement. Similar findings have been reported by Olin (1970), Björk et al. (1971, 1974), Bristow and Kremkau (1975), Ionescu et al. (1974), and Dubiel and Cullhed (1975).

Pulmonary wedge and left ventricular end-diastolic pressures showed significant reduction both at rest and during exercise. The abnormal rise of these pressures during exercise appears to be related to the size of the xenograft inserted. How-
ever, the number of patients in each subgroup is too small for this trend to be subjected to statistical analysis.

Published data regarding systolic gradient and calculated valve surface area with other currently used aortic valve substitutes are given in Table 4. Pericardial xenografts, when compared with these valves, offer the least resistance to forward flow.

In the present investigation the systolic gradient was inversely related to the annulus diameter of the xenograft inserted. As expected, augmentation of the calculated xenograft surface area was noted with increasing annulus diameter of the valve.

Several authors (Cohn et al., 1976; Hannah and Reis, 1976; Jones, 1976; Morris et al., 1976) have commented on the high systolic gradients associated with the smaller sizes of Hancock porcine xenografts, and there is general agreement that for clinical use valves larger than 23 mm annulus diameter should be preferred for aortic valve replacement. High gradients have also been reported with the small sizes of Lillehei-Kaster prostheses. Nicoloff (1976) found a mean peak systolic gradient of 46 mmHg (range 28 to 70) in 10 patients with No. 14 Lillehei-Kaster valve (21 mm annulus diameter). Sigwart et al. (1976) propose that Lillehei-Kaster valves of at least 18 mm internal diameter (25 mm annulus diameter) should be used in the aortic position in adults in order to minimise prosthesis-induced stenosis.

Because of the high gradients produced by such valves, elaborate surgical manoeuvres have been advocated and used to enlarge the aortic annulus in order to accommodate a larger valve (Najafi et al., 1969; Nicks et al., 1970; Konno et al., 1975; Blank et al., 1976). The present study has established that the gradient across pericardial xenografts, even those of small size, is insignificant and therefore the insertion of this valve does not require additional surgical techniques for annulus enlargement. Consequently the use of the pericardial valve should be advantageous in patients with a small aortic annulus.

A separate series of sequential haemodynamic studies, performed at mean intervals of 9.9 and 42.2 months after aortic valve replacement, showed that the postoperative circulatory improvement was maintained and the transvalvular gradient did not change with the passage of time (Tandon et al., 1977).

This study has shown significant haemodynamic improvement as a result of aortic valve replacement with the Ionescu-Shiley pericardial xenograft and has substantiated the results of the clinical assessment. The transvalvular gradients are insignificant and predictable. Repeat circulatory studies are contemplated at longer intervals in order to assess continually the durability and functional performance of this valve.

### References


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**Table 4** Postoperative haemodynamic data in patients with aortic valve substitute according to annulus diameter

<table>
<thead>
<tr>
<th>Authors</th>
<th>Valve substitute</th>
<th>Peak systolic gradient</th>
<th>Calculated surface area</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>19 21 23 25 27†</td>
<td>19 21 23 25 27†</td>
</tr>
<tr>
<td>Björk et al. (1971)</td>
<td>Björk-Shiley valve</td>
<td>— 22 13.8 9.3 10.7 1.3 1.7 2.2 2.4 1.83</td>
<td>— (30) (32) (7) (21) (14) (13) (1) (27) (21)</td>
</tr>
<tr>
<td>Sigwart et al. (1976)</td>
<td>Lillehei-Kaster valve</td>
<td>— 30* 32* 21* 14* 13* 27* 1* 0.94 1.21 1.56 1.89 1.6</td>
<td></td>
</tr>
<tr>
<td>Cohn et al. (1976)</td>
<td>Hancock porcine xenograft</td>
<td>21 20 10 16 0.95 1.05 1.15 1.8 1.4</td>
<td>— (37) (37) (37)</td>
</tr>
<tr>
<td>Morris et al. (1976)</td>
<td>Hancock porcine xenograft</td>
<td>23 16 1.05 1.29 1.42 1.25</td>
<td>— (70) (70) (70)</td>
</tr>
<tr>
<td>Hannah and Reis (1976)</td>
<td>Hancock porcine xenograft</td>
<td>26 14 1.0 1.29 1.42 1.25</td>
<td>— (70) (70) (70)</td>
</tr>
<tr>
<td>Present series</td>
<td>Ionescu-Shiley pericardial xenograft</td>
<td>8 3 7 9 1.1 1.4 1.6 1.8 2.1 1.6</td>
<td>— (12-3) (13-3) (13-3) (10) (5-7) (5-7) (1) (9-6) (9-6)</td>
</tr>
</tbody>
</table>

The figures in parentheses are systolic gradients during exercise.

*Mean ejection systolic gradient.

Annulus diameter (mm) of the valve substitute.
Haemodynamics of aortic pericardial xenograft


Addendum

Since the preparation of this manuscript, in November 1976, the number of patients who received aortic pericardial xenograft valves has increased to 216 and 6 more patients had haemodynamic investigations. The clinical results of the entire series, at 7 years follow-up, are essentially similar to those described in this paper.

Requests for reprints to M. I. Ionescu, Esq., F.A.C.S., Department of Cardiothoracic Surgery, The General Infirmary, Leeds LS1 3EX.
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A P Tandon, D R Smith, W Whitaker and M I Ionescu

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