Prevalence of haemoptysis in adults with pulmonary atresia and ventricular septal defect, and the role of mammary artery collateral vessels

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Recurrent or massive haemoptysis is a potentially lethal complication occurring in patients with congenital heart disease (CHD). In particular, it is most frequently described in patients with pulmonary vascular obstructive disease such as tetralogy of Fallot and pulmonary atresia with ventricular septal defect (PA-VSD). Although widely believed to be a rare complication of PA-VSD, the true prevalence of this complication and anatomic vessels involved are unknown. Most of the patients who survive to adolescence or adulthood have had palliative or corrective surgery, and have developed an alternative blood supply to the lungs through systemic-to-pulmonary collateral vessels. These collateral vessels are prone to rupture and may result in serious and even fatal haemoptysis. Selective embolisation of these systemic vessels is a widely accepted and successful technique used in the control of recurrent or massive haemoptysis, but identification of the culprit collateral(s) can be difficult.

We sought to determine the prevalence of haemoptysis in a cohort of adult patients with PA-VSD and report the collateral vessels involved.

METHODS
The records of all patients with PA-VSD regularly attending the adult CHD clinic at our tertiary referral centre (established in 1991) were examined to determine the number of patients who were recorded to have had a past history of haemoptysis. Twenty six patients, of whom eight were male, were identified with PA-VSD, mean age (at the time of writing) 29 years (range 18–54 years).

RESULTS
Three (12%) out of 26 patients had haemoptyses requiring hospital admission.

Case 1
A 23 year old woman presented with recurrent haemoptyses. She was known to have congenitally corrected transposition of the great arteries with PA-VSD, but had subsequently undergone shunt ligation, VSD closure, and conduit reconstruction of the pulmonary outflow tract. On admission, bronchoscopy demonstrated blood in the left lower lobe bronchus. Thoracic aortography showed collateralisation of the pulmonary artery vessels arising via the intercostal arteries. Arteriography of the left internal mammary artery (IMA) revealed an abnormal area of dilated vessels arising from a branch vessel which collateralised the left lower lobe and appeared to be the source of bleeding. Left bronchial arteriography showed a second abnormal collection of vessels. Successful embolisation was performed of both the left IMA and left bronchial artery using polyvinyl alcohol particles. No further haemoptysis has since occurred.

Case 2
A 22 year old man presented with massive haemoptysis. He was born with a double outlet right ventricle, transposed great arteries, PA-VSD, and override of the right atrioventricular valve. Previously he had had left and right Blalock-Taussig shunts, and a modified Fontan procedure. Admission chest x ray suggested bleeding in the right lower lung field, subsequently confirmed on bronchoscopy. A right IMA demonstrated an enlarged arterial side branch forming a prominent group of abnormal vessels (fig 1, left panel) supplying the right lower lobe. Two fibred platinum coils were inserted with successful cessation of flow in the culprit branch vessel only (fig 1, right panel). Similarly, an abnormal area of dilated vessels was found arising from the right bronchial artery (a branch of the left superior intercostal artery). This vessel was also occluded successfully with preservation of the left superior intercostal artery, and haemoptysis ceased.

Case 3
A man, born with a double outlet right ventricle with pulmonary atresia, multiple ventricular septal defects, and a straddling tricuspid valve in the setting of dextrocardia, presented with recurrent haemoptysis. His past medical

Abbreviations: CHD, congenital heart disease; IMA, internal mammary artery; NBC, non-bronchial systemic collaterals; PA-VSD, pulmonary atresia with ventricular septal defect
history included systemic-to-pulmonary artery shunts and
total cavopulmonary connection using an intracardiac con-
duct. On admission, bronchoscopy demonstrated prominent
vessels over the whole bronchial tree and several pinpoint
areas of bleeding in both right and left main bronchi.
Conservative management was initially undertaken but
haemoptysis continued. Selective angiography was offered but
the procedure was declined by the patient.

DISCUSSION

Haemoptysis is an important and sometimes fatal complicat-
ion in patients with PA-VSD, occurring as a result of extensive
systemic-to-pulmonary collateralisation that has developed as a
compensatory mechanism to provide pulmonary blood flow.1,2
Although haemoptysis is widely believed to be a rare complica-
tion of PA-VSD, there are no reports to date that have
investigated the prevalence of this complication.3 This study
investigated retrospectively a group of patients with PA-VSD and
found that haemoptysis is a relatively frequent complication in
adult survivors, occurring in approximately 12% of patients—a
rate much higher than previously suspected.4 Furthermore, IMA
collaterals were responsible in at least two out of these three
cases, a previously unreported finding in this condition.

The treatment for recurrent or massive haemoptysis can be
either medical, surgical or embolotherapy. Embolotherapy is
indicated for those patients who continue to have recurrent
haemoptysis in spite of conservative therapy, and is widely
accepted as a successful treatment of massive haemoptysis.
Surgical intervention can also be effective but is associated
with significant risks and is widely accepted as a successful treatment of massive haemoptysis.

Surgical intervention has been shown to produce immediate control of bleeding in
up to 90% of patients,1 but carries risks such as spinal cord
ischaemia caused by anterior spinal artery occlusion; benefit
may be transient as 20% of patients will rebleed within six
months, with approximately 50% experiencing further signifi-
cant haemoptyses on longer term follow up.5 In order to
achieve successful control of haemoptysis, it is paramount
that the operator has a thorough understanding of bronchial
anatomy and recognises that other non-bronchial arteries
may be involved. These non-bronchial systemic collaterals
(NBC) originate from the phrenic, intercostal, internal mam-
mary, thyrocervical, and other branches of the subclavian and
axillary arteries.1 Our study found that the arteries responsible
in at least 2 of 3 cases were non-bronchial and is the first to
demonstrate the IMA as a cause of haemoptysis in PA-VSD.
Furthermore, although the majority of non-cardiac related
haemoptysis originates from the bronchial arteries, the source
of bleeding is just as likely to originate from NBC in the con-
text of CHD. Indeed, on reviewing all cases of CHD
complicated by haemoptysis receiving embolotherapy (written
in English), bronchial and NBC arteries appear to be cul-
prit vessels in approximately equal proportions.

Haemoptysis is a common complication in patients with
repaired/palliated PA-VSD. Embolotherapy can be a life saving
treatment in this condition, provided the operator is aware
that NBC arteries are often culprit vessels and, in particular,
the internal mammary artery.

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