Factors affecting left ventricular function after correction of tetralogy of Fallot

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SUMMARY To investigate the possible causes of left ventricular dysfunction after total correction of tetralogy of Fallot, 84 patients, aged 1½ to 16 years, were studied by left ventricular cineangiography both before and a mean of 4.6 months after operation. Left ventricular ejection fraction and mean velocity of circumferential fibre shortening were calculated; using multivariate analysis the results were correlated with age at operation, the degree of hypoxia and polycythaemia before operation, occurrence of hypoxic spells, and the duration of operative procedures (cardiopulmonary bypass and aortic cross clamping). The postoperative left ventricular ejection fraction was decreased slightly or moderately in 46% of patients. The variable most significantly associated with altered left ventricular function was a history of hypoxic spells. Age, the degree of chronic hypoxia, and polycythaemia did not correlate significantly with left ventricular function indices. Although no correlation was found between the duration of cardiopulmonary bypass and left ventricular ejection fraction, bypass times exceeding 120 minutes were associated with decreased ejection fractions; this was statistically significant and independent of the variable “hypoxic spells”.

Thus repeated episodes of acute hypoxia and long operative procedures appear to have a deleterious effect on left ventricular function in tetralogy of Fallot.

Surgical correction of tetralogy of Fallot results in considerable symptomatic and haemodynamic improvement in most patients. Persistence of heart failure or decreased exercise tolerance after surgery is usually due to residual abnormalities—for example, residual ventricular septal defect or right ventricular outflow obstruction. In some cases, however, it may be due to left ventricular dysfunction.

Indeed, several postoperative studies have found left ventricular dysfunction in the absence of other haemodynamic abnormalities.1-5 This is most likely to be due to changes in the myocardium, but its cause is presently unknown; hypoxia, abnormal left ventricular development,6 or the operative procedure are possible factors. It is important to identify risk factors of myocardial damage, since this will allow a strategy to be developed to prevent it.

The purpose of this study was to assess left ventricular function during cardiac catheterisation both before and after complete surgical correction and to determine factors which correlate with left ventricular performance or dysfunction.

Patients and methods

Eighty four patients (59 boys and 25 girls) who had complete correction of tetralogy of Fallot and underwent both preoperative and postoperative catheterisation were studied. Postoperative catheterisation was carried out routinely after correction of tetralogy of Fallot in this hospital whether residual defects are suspected or not. We included in the present study only the 84 patients who had a left ventricular angiogram of good enough quality after operation to allow accurate volume measurement. This was the only criterion for selection. Seventy eight patients had also had a left ventricular angiogram performed preoperatively. The age of the patients at operation ranged from 18 months to 16 years (mean 6-6 years). Only four patients were <2 years old.

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Thirteen patients had undergone previous palliative shunts (Waterston anastomosis in six and Blalock Taussig in seven). Two patients had undergone palliative enlargement of the right ventricular outflow tract before complete correction.

The patients' haematocrit before operation ranged from 35% to 75% (mean 54%). Preoperative arterial oxygen saturation ranged from 45% to 94% (mean 78%). Forty patients had hypoxic spells; these received propranolol (1 to 3 mg/day).

Cardiac catheterisation was performed percutaneously via the femoral vein and artery under light sedation (a mixture of pethidine, promethazine, and chlorpromazine). The preoperative catheterisation was carried out 2–4 weeks before operation. The postoperative study took place generally between two and six months (mean 4.6 months) after it. At postoperative catheterisation, no patient had a residual shunt of haemodynamic importance. Three had a significant residual pulmonary stenosis (gradients of 65, 80, and 90 mm Hg); all the others had gradients <30 mm Hg.

INDICES OF LEFT VENTRICULAR FUNCTION

Left ventricular volumes and ejection fractions were obtained from left ventricular angiograms. Images were recorded either in biplane left and right anterior oblique (52 angiograms in both preoperative and postoperative studies) or single plane right anterior oblique projections (108 angiograms).

Left ventricular volumes were calculated according to the area length method described by Dodge et al. at end diastole and end systole. Care was taken to avoid extrasystoles or postextrasystoles. Either a grid system or a sphere of 6 cm diameter was used to correct for magnification. "True" volumes were obtained from corrected volumes by applying the formula of Graham et al. for the biplane angiograms and the regression equation of Hermann and Bartle for single plane angiograms. Finally, the absolute value for volume was indexed (divided by the body surface area) and expressed in ml/m² (normal values 73(11) ml/m²).

Left ventricular ejection fraction was calculated by the formula: [(EDV-ESV)/EDV]×100% where EDV is the end diastolic volume and ESV the end systolic volume.

Comparison of single plane and biplane measurements—To assess whether patients investigated with single plane cineangiography only could be included in the study, left ventricular volumes and ejection fractions of the 26 patients who had biplane angiograms were calculated twice, first using both planes and then from the right anterior oblique projection only. When both the preoperative and postoperative cineangiograms were included this yielded 52 pairs of values for comparison. For left ventricular volumes the correlation was good (r=0.82), but the single plane method overestimated the volume and there was a large standard error of the estimate (11.2 ml/m²). For ejection fraction, however, the correlation was very good (r=0.89) and the standard error was small (3.9%). When compared by a paired t test, values calculated from the single plane were not different from those obtained using both planes (p=0.33). Within the range of interest (40–70%), ejection fraction calculated from single plane images was very close to values calculated from biplane images. Therefore, we included in the present study the ejection fraction calculated from single plane cineangiograms in cases in which biplane angiograms were not available. Indexed volumes, however, are given only for patients who had biplane angiograms performed.

Mean velocity of circumferential fibre shortening was determined in all patients from the systolic excursion of the left ventricular internal minor equator as described by Karliner et al.; this has been shown to be a good indicator of normal and abnormal left ventricular myocardial function. The normal figure for the mean value in children according to Fisher is 1.55(0.37) circ/s.

CORRELATION OF OTHER VARIABLES WITH LEFT VENTRICULAR FUNCTION

The following factors related to preoperative state were evaluated: age at operation, preoperative haemoglobin concentration and haematocrit, aortic oxygen saturation at preoperative catheterisation, history of hypoxic spells, and preoperative left ventricular end diastolic volume. Hypoxic spells are defined as episodes of acute cyanosis with anxiety and tachypnoea, with or without loss of consciousness, requiring medical attention and usually prompting the administration of beta blocking drugs. One well documented episode was sufficient for inclusion in the group with "spells" if the case history showed that similar episodes had occurred before; most of these children, however, had numerous documented episodes. As for the factors related to the operative procedure the duration of cardiopulmonary bypass and aortic cross clamping was evaluated.

STATISTICAL METHODS

To assess the influence of the above factors on left ventricular ejection fraction and mean velocity of circumferential fibre shortening, multivariate analysis was performed using the SPSS-6000 Package on a CDC Cyber computer. Left ventricular ejection fraction and mean velocity of circumferential fibre shortening were the dependent variables. All interval-scaled independent variables (for example, haemoglobin concentration, haematocrit, etc.) were tested in
conjunction with nominal independent variables (hypoxic spells) in an analysis of covariance. Bypass time and aortic cross clamping were first treated as interval-scaled variables. In a second analysis, they were treated as nominal variables using arbitrary cut off times (bypass time less or more than 120 minutes, aortic cross-clamping time less or more than 70 minutes).

**Results**

**LEFT VENTRICULAR VOLUME**

For comparison of preoperative and postoperative data, biaxial left ventricular angiograms were available both before and after operation in 19 patients of >2 years of age. None of these patients had a shunt or Brock operation before complete correction. Indexed left ventricular end diastolic volume was below normal in the preoperative period (58.8(10) ml/m² (mean (SD))). After correction, it increased significantly to normal values (77.3(11) ml/m² (p<0.01)).

**LEFT VENTRICULAR FUNCTION**

For the determination of left ventricular ejection fraction 78 preoperative values and 84 postoperative values were available. On average, the left ventricular ejection fraction was lower than normal before as well as after operation when compared with normal data. Preoperatively, the left ventricular ejection fraction ranged from 44% to 75% and postoperatively from 43% to 75%. The mean value was 59.6(6.5)% preoperatively and 58.4(6.9)% postoperatively; normal values for children are 63(5)% according to Graham et al.7 and 71(7)% according to Fisher et al.11 Thus the degree of left ventricular dysfunction in this series was moderate. There was no significant difference between preoperative and postoperative mean ejection fractions. Figure 1 shows postoperative left ventricular ejection fraction in relation to body surface area, and the limits of normal according to Graham et al.7: 46% of patients had a left ventricular fraction below normal values for body surface area. If values ≥58% are considered to be normal at all ages12 44% had abnormal left ventricular function.

For mean velocity of circumferential fibre shortening similar results were found, values being low before and after operation (1.24(0.35) circ/s and 1.24(0.34) circ/s) when compared with normal values of Fisher (1.55(0.37) circ/s). Again there was no difference between preoperative and postoperative mean values; 41% had a mean value below normal in the postoperative period.

**POSSIBLE CAUSES OF LEFT VENTRICULAR DYSFUNCTION**

Age at operation did not influence left ventricular function. There was no correlation between age (or body surface area) and ejection fraction (Fig. 1). The mean age of children with abnormal function was not different from that of those with normal function (7.1(3.4) vs 6.6(2.6) years). Very few infants and children <2 years old were, however, included in this study.

**Preoperative left ventricular volume—**To determine whether an underdeveloped left ventricle will function abnormally after operation, preoperative left ventricular volume was correlated with postoperative left ventricular ejection fraction. No significant correlation was found.

**Chronic and acute hypoxia before operation—**To assess whether chronic hypoxia and polycythaemia could be responsible for the deterioration in left ven-

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Fig. 1 *Left ventricular ejection fraction (postoperatively) in relation to body surface area in patients with (●) and without (○) a history of hypoxic spells. The continuous lines denote the mean and the upper and lower limits of normal, according to Graham.*

Fig. 2 *Comparison of (a) left ventricular ejection fraction, and (b) mean velocity of circumferential fibre shortening postoperatively in patients with (●) and without (○) a history of hypoxic spells. Bars represent mean values.*
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Abnormal left ventricular function after total correction of tetralogy of Fallot was first reported by Jarimakani et al. Indeed, these authors found left ventricular ejection fraction to be depressed in many patients and often to a more severe degree than was found in our study. Subsequently, Sunderland et al reported normal left ventricular function in children operated for tetralogy before 2 years of age, stressing the need for early correction. Rocchini et al found abnormal left ventricular function only in patients with residual lesions—that is, residual ventricular septal defect with a significant left to right shunt or severe residual pulmonary stenosis. Thus the subject of left ventricular function in tetralogy remains somewhat controversial, and the causes of dysfunction are open to discussion.

In the present study, we measured left ventricular ejection fraction and mean velocity of circumferential fibre shortening in a large number of children undergoing surgical correction and tried to determine the causes of abnormal left ventricular function. Since very few infants were included in this series, we cannot comment on the effects of operation very early in life. Children with tetralogy followed from birth in our hospital undergo elective corrective surgery between 2 and 3 years of age. Many of the patients included in this study were, however, referred from abroad and not followed by us from birth. This explains the relatively high mean age of 6-6 years and the inclusion of patients as old as 16 years. Some of the children coming from developing countries had had severe hypoxia for months or years.

We found moderately decreased ejection fractions in 46% of the patients; because the vast majority of our patients had a satisfactory repair residual lesions cannot be held responsible. We found no significant difference on average between preoperative and postoperative ejection fractions. It must be emphasised that preoperative and postoperative ejection fraction cannot be directly compared. Firstly, many of the patients received beta blocking drugs at the time of the preoperative study but none at the time of the postoperative catheterisation. Secondly, different loading conditions exist for the left ventricle in
preoperative and postoperative patients—in particular, preload is decreased before surgery; ejection fraction is said to be partly dependent on preload, although there is controversy on this subject. Both propranolol and volume underload would tend to decrease ejection fraction; thus low values in the preoperative study are not totally unexpected. Postoperative left ventricular function is therefore emphasised in the present study. A host of factors could be responsible for left ventricular dysfunction in tetralogy of Fallot. Left ventricular volume is often (though not always) small in tetralogy before operation, as reported by Jarmakani et al. The present study confirms this finding. After operation, the left ventricle increases to normal size; when measured with serial echocardiograms it appears that this process is completed within two to four weeks after operation.

To assess whether this rapid change in size could influence left ventricular function we correlated preoperative left ventricular volume with postoperative left ventricular ejection fraction but found no significant correlation. Thus a small left ventricle preoperatively is not a risk factor for postoperative dysfunction, although it may increase the risk of death in the immediate postoperative period.

The hypothesis that chronic hypoxia may be responsible for left ventricular dysfunction was not confirmed by the present study since there was no correlation between aortic oxygen saturation or haematocrit (preoperatively) and left ventricular function. Episodes of acute hypoxia, however, seem to play a role. Hypoxic spells often occur in tetralogy of Fallot; in the present study, a history of such episodes appears to be a significant predictor of abnormal left ventricular function, which is independent of other factors. The finding that chronic hypoxia is tolerated well but that adverse effects occur in patients with acute episodes is not surprising; it may be explained by what is known about myocardial metabolism in cyanotic congenital heart disease. Indeed, myocardial substrate consumption at rest is not different from normal in tetralogy, even in the presence of appreciably decreased oxygen saturation. When the heart is stressed—for example, by atrial pacing (or by exercise)—oxygen requirements increase, but oxygen saturation in arterial blood will often decrease: indeed, in classical tetralogy with a reactive infundibulum atrial pacing produces a pronounced fall in aortic oxygen saturation. As a result of the imbalance between oxygen supply and demand anaerobic metabolism occurs with a fall in myocardial lactate extraction or even with lactate production and an increase in phosphate in coronary venous blood. The same findings have been reported by Graham et al in the experimental animal made hypoxic by anas-
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