Isolation of the left common carotid or left innominate artery

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SUMMARY Isolation of the left common carotid or left innominate artery from the aortic arch is rare. A six week malformed infant with a right aortic arch had isolation of a left innominate artery and connection to the pulmonary artery by a left ductus arteriosus. A right ductus arteriosus had been ligated. Another infant with a right aortic arch and ostium primum atrial septal defect was shown to have an aberrant left subclavian artery arising from the lower descending aorta. The left common carotid artery filled retrogradely and drained into the pulmonary artery by a left ductus arteriosus. This abnormality has not been reported before.

Many forms of aortic arch abnormalities have been described. Isolation of a left subclavian artery with connection to the pulmonary artery by a ductus arteriosus has been reported, but isolation of the left innominate artery from a right aortic arch and connection to the pulmonary artery by a ductus arteriosus is rare. Isolation of the left common carotid artery from a right aortic arch with an aberrant left subclavian artery has not been described before. We report one case of a right aortic arch with isolation of the left innominate artery and bilateral ductus and another of isolation of the left common carotid artery with an aberrant left subclavian artery.

Case reports

PATIENT 1
The first case was a six week old female infant with the CHARGE association (colobomata, choanal atresia, retarded growth and development, hearing deficit, and micrognathia). She was tachypnoeic with full peripheral pulses and a continuous murmur at the upper sternal edge consistent with a ductus arteriosus. Cross sectional echocardiography demonstrated a right aortic arch with normal intracardiac anatomy and a large ductus. After ligation of a right ductus a continuous murmur persisted at the upper sternal edge. Doppler echocardiography revealed persisting turbulence in the main pulmonary artery. Aortography revealed early filling of three major vessels arising from the right aortic arch: the right common carotid, the right vertebral, and right subclavian arteries. These vessels joined plexuses of vessels in the neck, mediastinum, and right and left scapular areas. The left common carotid artery was noted filling late from above. Dye passed

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from the plexuses into the left subclavian and left vertebral artery, which then joined the left common carotid artery. The left innominate artery then emptied into the left pulmonary artery, presumably via a left ductus. Dye could be seen spilling into both pulmonary arteries. This created a left to right shunt at the pulmonary artery level. There was no vascular ring.

Elective implantation of the left innominate artery to the ascending aorta was planned to remove the left to right shunt and prevent a steal syndrome. The infant died suddenly at home at six months of age. Necropsy confirmed the described abnormality of aortic arch vessels (fig 1) and the normal intracardiac structure. The vessels of the right neck and upper limb were connected to the left innominate artery by the circle of Willis and by collaterals in the neck and both scapular areas. The cause of death remained uncertain. The heart, brain, and other organs were normal.

**Patient 2**

A 10 month old female infant with primordial dwarfism presented with signs suggestive of a ductus arteriosus. Cardiac catheterisation showed an ostium primum atrial septal defect with a right aortic arch and a late filling and a left sided vessel entering the left pulmonary artery from the head and neck vessels. At five years of age follow up angiography demonstrated the right aortic arch from which arose the right common carotid, right subclavian, and vertebral arteries. An aberrant left subclavian artery arose from the right lower descending aorta (fig 2a).

Selective injection of the right common carotid, right vertebral, and left vertebral artery via the aberrant left subclavian artery (fig 2b) showed late retrograde flow into the left common carotid artery, which received blood from the circle of Willis, vertebro-basilar system, and costocervical colaterals. There were no arteriovenous malformations in the cranium. Dye passed from the left common
The Edwards' hypothetical double aortic arch explains aortic arch abnormalities by selective regression of various parts of either arch (fig 3a). Right aortic arch with isolation of a left innominate artery connecting to the left pulmonary artery by a left ductus has been described rarely. Complete separation with regression of the left ductus arteriosus and the late development of a subclavian steal syndrome has also been reported. These abnormalities can be explained by interruption at two sites in the double aortic arch—in the left posterior arch distal to the ductus and in the left anterior arch proximal to the left common carotid artery. The first infant had this abnormality with bilateral ductus arteriosus (fig 3b).

The second abnormality of isolation of the left common carotid artery with an aberrant left subclavian artery has not been described before. An explanation based on the Edwards' model is that distal migration of the left subclavian artery leading to the left ductus that enters the left dorsal aortic root just proximal to the origin of the left subclavian artery produces concurrent isolation of the left common carotid and an aberrant left subclavian artery. Interruption could occur in the left anterior arch proximal to the left common carotid and distal to the left patent ductus but proximal to the left subclavian artery and left dorsal aortic root (fig 3c). The variable proximity of origin of the left subclavian artery and ductal area has been noted in other conditions such as coarctation of the aorta.

Late filling of left neck vessels providing a left to right shunt into the pulmonary artery was recognised fortuitously in both children, who had associated non-cardiac abnormalities. In both patients elective surgery was planned to prevent a later steal syndrome.

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References