MEASUREMENT

Evaluation of aortic coarctation after surgical repair: role of magnetic resonance imaging and Doppler ultrasound

Eberhard G Mühlér, Jörg M Neuerburg, Andreas Rüben, Ralf G Grabitz, Rolf W Günther, Bruno J Messmer, Götz von Bernuth

Abstract

Objective—To compare the usefulness of magnetic resonance imaging (MRI) and Doppler ultrasound with that of cross sectional echocardiography and oscillometric blood pressure measurement for the evaluation of aortic coarctation after surgical repair.

Design—Prospective study. Aortic diameters measured by cross sectional echocardiography, MRI, and angiography (selected cases) and functional data determined by physical examination, oscillometric blood pressure measurement, and continuous wave Doppler.

Patients—40 patients aged 2–28 years (mean 10·6 years) who had had surgical correction of aortic coarctation (mean follow up 5·7 years).

Results—In all patients MRI gave diameter measurements of the aortic arch and the thoracic aorta whereas in half of them cross sectional echocardiographic measurement of the isthmic region failed. The correlation coefficient for aortic diameters measured by MRI and angiography was 0·97 and that between MRI and echocardiography was 0·89. Peak velocities in the descending aorta correlated better with residual narrowing of the aortic isthmus or distal aortic arch or both than systolic blood pressure gradients between the upper and lower limbs. A peak velocity of <2 m/s in the descending aorta during systole excluded important restenosis. Prolongation of antegrade blood flow during diastole always indicated a morphological abnormality—either important restenosis or aneurysmal dilatation.

Conclusions—MRI was better than cross sectional echocardiography for imaging the aortic arch after coarctation repair and measuring its diameter. Peak velocity in the descending aorta correlated better with residual stenosis than did the systolic blood pressure gradient between the upper and lower limbs and this index could be used to indicate a need for MRI.

Several types of operation have been developed but despite this long experience there is still controversy about which method is appropriate in an individual patient. Obviously the choice requires detailed information on the morphological and functional state after surgical repair of aortic coarctation. Until now, retrograde aortic catheterisation with measurement of the intra-aortic pressure drop and angiography have been the standard methods of assessing the functional and morphological condition after coarctation repair. But this investigation is invasive and requires the use of X rays.

Cross sectional echocardiography from a suprasternal approach usually allows visualisation of the aortic arch and its branches and detects aortic coarctation. Image quality is often poor, however, (particularly in older patients) after coarctation repair because of the small acoustic window and the long distance between the transducer position and the isthmic region. Furthermore, assessment by ultrasound is disappointing because the acoustic window is inadequate when a prosthetic vascular conduit is used for surgical correction of coarctation. Recent studies cast doubt on the reliability of measurements of luminal diameter by cross sectional echocardiography without additional colour Doppler flow mapping, which enhances the contrast between the vessel lumen and its wall.

Several groups have reported on the usefulness of MRI in detecting morphological anomalies of the great vessels, especially in aortic coarctation. Diminished pulses in the lower limbs after coarctation repair suggests restenosis or persisting stenosis. Gradients can be measured from blood pressures in the upper and lower limbs. Flow velocities in the descending aorta distal and proximal to the isthmic region can be measured throughout the cardiac cycle by Doppler ultrasound and it has become clear that not only Doppler determined velocities in the descending aorta but also the flow profile are important in the assessment of the functional state after coarctation repair.

We have evaluated whether the morphological situation after surgical repair of aortic coarctation can be properly demonstrated and measured by MRI and cross sectional echocardiography. We compared morphometrical data with the functional data obtained by oscillometric measurement of blood pressure and Doppler ultrasound measurements.
Patients and methods

Patients
Forty patients (28 male and 12 female; aged 2-28 years, mean 10·6 (5-0) were examined 5-7 (3-2) years (range 3 weeks-17 years) after surgical repair of aortic coarctation. Cineangiograms obtained before operation in all but one patient showed distinct hypoplasia of the distal aortic arch in 13 patients as well as localised coarctation of the isthmus. The following associated anomalies were present: patent ductus arteriosus (n = 15), bicuspid aortic valve (n = 25), aortic stenosis (n = 10), ventricular septal defect (n = 7), and mitral valve anomalies (n = 14). Twenty five patients underwent resection and end-to-end anastomosis of the coarctation, five patients had a subclavian flap angioplasty, and 10 had a graft patch angioplasty. At the time of investigation three patients with coarctation repair in the first year of life (end-to-end-anastomosis in two, patch graft angioplasty in one) had already undergone reoperation because of recoarctation (patch graft aortoplasty in all).

In two of the 40 patients and in four additional patients with uncorrected coarctation, cineangiograms and magnetic resonance images were available for comparative measurements.

Methods
Investigations included a physical examination, magnetic resonance imaging, cross-sectional echocardiography of the aortic arch and the descending aorta, oscillometric blood pressure measurements of the upper and lower limbs, and recording the velocity flow profile in the descending aorta by Doppler ultrasound.

The magnetic resonance examinations were performed on an outpatient basis without sedation, except in the youngest patient who had a suspected aneurysmal dilatation. We used a superconducting magnetic resonance unit (Siemens, Magnetom) operating at 1·5 T to examine all the patients. T1-weighted images were obtained in a body coil except for the youngest patient. We used an ECG-gated single echo multislice spin echo technique. The repetition time ranged from 450 ms to 1100 ms depending on the heart rate. Magnetic resonance images were obtained in 3-6 mm contiguous transverse (n = 40), sagittal (n = 35), and rotated sagittal (n = 36) slices with echo times of 15 ms-28 ms. The total imaging time was 45 min-60 min. We used a 256 × 256 matrix with a field of view of 500 × 500 mm and a zoom factor of 1·4-1·8 (pixel size 1·1-1·8 mm). In each patient, the diameter of the aortic lumen was measured in all available planes distal to the innominate, left carotid, and left subclavian arteries in the isthmic region and at the diaphragmatic level. In six patients end diastolic diameters were also measured at corresponding levels on left anterior oblique or lateral angiograms and compared by linear regression analysis with the measurements derived from MRI. In 36 patients the aortic arch was examined by cross sectional echocardiography from the suprasternal position with a mechanical sector scanner and a 5 MHz or 3-5 MHz transducer and simultaneous recording of the electrocardiogram. We measured the end diastolic luminal diameter of the aorta whenever possible distal to the innominate, left carotid, and left subclavian arteries and in the isthmic region (inner edge method). We used linear regression analysis to compare these data with those obtained by MRI. MRI and echocardiographic measurements were performed without knowledge of the dimensions obtained by the other method.

Systolic arm-to-leg blood pressure gradients were determined by the oscillometric method with cuffs of adequate size (Dinamap). In all but one patient with an aberrant right subclavian artery we used the right arm; leg pressure was measured on the side not used for previous in one patient (end-to-end-coarctation, with the catheterisation. The systolic blood pressure difference was determined as the mean of three measurements for each limb. Systemic hypertension was diagnosed according to the guidelines of the second Task Force study.17

We used a 2-25 MHz continuous wave Doppler transducer in the suprasternal position to measure (without angle correction) the velocity flow profile in the descending aorta. The systolic peak velocity of blood flow was measured. The velocity profiles were also carefully examined for evidence of prolonged anterograde flow during diastole. To evaluate the surgical result we defined residual narrowing as a percentage reduction in the diameter of the aortic isthmus (Ao isth) compared with the diameter of the descending aorta (Ao desc) at diaphragmatic level ((Ao desc - Ao isth) × 100/Ao desc) measured by MRI.

Statistical analysis
To compare the morphological data obtained by MRI, cineangiography, and echocardiography we used linear regression analysis (Pearson correlation coefficient) and non-parametric test (Kruskal-Wallis) to compare MRI data with functional data obtained by Doppler ultrasound and oscillometric blood pressure measurements.

Results
MRI imaged the aortic arch and identified its major branches in all cases. Because we used different slice orientations (that is, transverse, sagittal, and parasagittal), partial volume effects could be minimised and we were able to measure the diameters of the isthmus, descending aorta, and aortic arch in all patients. Though the parasagittal planes proved to be the most valuable for assessing the morphology of the aortic arch and isthmus, we were able to image the complete aortic arch region in a single slice in only 13 patients because the aorta was curved in more than one plane.

Figure 1 shows the excellent correlation between the values of luminal diameter.
Evaluation of aortic coarctation after surgical repair: role of magnetic resonance imaging and Doppler ultrasound

Figure 1  Linear regression of aortic diameters determined by angiography (end diastolic) and MRI in six patients with aortic coarctation (95% confidence interval is shown).

Figure 2  Linear regression of aortic diameters determined by MRI and cross sectional echocardiography (end diastolic) in 35 patients after coarctation repair (95% confidence interval shown).

Table 1  Morphological result determined by MRI

<table>
<thead>
<tr>
<th>Aortic isthmus</th>
<th>Narrowing</th>
<th>&lt;10%</th>
<th>10–25%</th>
<th>&gt;25%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aortic arch</td>
<td>&lt;10%</td>
<td>17</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>10–25%</td>
<td>4</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>&gt;25%</td>
<td>1</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>n = 38</td>
<td>22</td>
<td>12</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

Group 1: Narrowing of the aortic arch and/or isthmus <10% (n = 17).
Group 2: Narrowing of the aortic arch and/or isthmus 10–25% (n = 16).
Group 3: Narrowing of the aortic arch and/or isthmus >25% (n = 5).

obtained by MRI and angiography. In contrast to MRI, cross sectional echocardiography gave high resolution images of the aortic isthmus in only 18/36 patients whereas satisfactory images of the arch segments between the innominate and left subclavian artery were obtained in all but two patients. Figure 2 shows the linear correlation (r = 0.89) between measurements obtained by cross sectional echocardiography and the corresponding values obtained by MRI. The echocardiographic values were slightly lower than the MRI values in most cases, probably because of calibre differences related to the cardiac cycle. Most of the magnetic resonance images were obtained during mid-systole to early diastole, whereas all echocardiographic measurements were obtained at end diastole (onset of the R wave).

The surgical results were classified into three groups according to residual isthmic narrowing as measured by MRI and defined above: less than 10% diameter reduction (n = 22), 10–25% diameter reduction (n = 12), >25% diameter reduction (n = 4). These limits correspond to a reduction in cross sectional area of less than 20%, 20–45%, and more than 45%. Two patients had aneurysmal dilatation of the isthmus region: they are described separately.

As well as narrowing of the operated isthmic region, diameter reduction of the distal aortic arch seems to play an important part: the diameter of the distal aortic arch between the left carotid and the left subclavian artery was smaller than the diameter of the descending aorta in 21 patients and smaller than the isthmus diameter in 14 of them. In 10 of our 13 patients who had a hypoplastic aortic arch before operation, distal aortic arch values remained lower than those of the descending aorta (six end-to-end anastomoses, two patch grafts, and two subclavian flap aortoplasties).

To compare the morphological result with the functional state in operated coarctation we classified narrowing according to the smallest diameter, whether in the isthmus or in the distal aortic arch, in relation to the descending aorta. Table 1 shows the resulting groups. In five patients a small preaortic arch segment leading to a change of classification—that is, from group 1 to 2 (n = 4) and from group 1 to 3 (n = 1). This classification of the morphological result was compared with the Doppler and blood pressure measurements and the result of the physical examination: Restenosis was suspected by physical examination in only two patients, both in group 3. Arterial hypertension of the upper limbs was present in 4/17, 5/16, and 3/5 patients of group 1, 2, and 3 respectively. Peak velocities in the descending aorta were significantly different in the three groups whereas blood pressure gradients did not show a significant difference between group 1 and 2 (table 2). Correlation between the morphological data (that is, percentage narrowing) and the functional data was better for Doppler measurements (r = 0.65; p = 0.001) than for oscillometric arm-to-leg gradients.
Table 2  A comparison between the morphological result and oscilometric blood pressure gradients and systolic peak flow velocities (mean (SD)) in the descending aorta

<table>
<thead>
<tr>
<th>Narrowing (%)</th>
<th>Blood pressure gradient (mm Hg)</th>
<th>Peak velocity (m/s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;10 (n = 17)</td>
<td>-0.8 (12.5)</td>
<td>1.98 (0.32)</td>
</tr>
<tr>
<td>10-25 (n = 16)</td>
<td>1.7 (0.1)</td>
<td>p &lt; 0.04</td>
</tr>
<tr>
<td></td>
<td>p &lt; 0.05</td>
<td>2.38 (0.37)</td>
</tr>
<tr>
<td>&gt;25 (n = 5)</td>
<td>1.6 (15.6)</td>
<td>p &lt; 0.001</td>
</tr>
</tbody>
</table>

(r = 0.48; p = 0.002). There was considerable overlap between systolic blood pressure differences in each of the three groups. Only two patients, both in group 3 and with clinical signs of restenosis, had systolic arm-to-leg blood pressure differences of more than 20 mm Hg. Whereas there were differences in blood pressure as low as -6 mm Hg in group 3 and as high as +18 mm Hg in group 1.

Doppler ultrasound investigations showed that the systolic peak flow velocity in the descending aorta exceeded 1.4 m/s in all patients. Peak flow velocities were less than 2 m/s in 11 patients in group 1 with an excellent morphological result (fig 3) and in two further patients in group 2.

On the other hand, increased peak flow velocity alone did not always separate patients with significant narrowing from those without. Peak velocities of more than 2 m/s (maximum 2.6 m/s) were found in six patients who had an excellent morphological result (group 1). Peak velocity exceeded 2 m/s in all but two patients in group 2 (maximum 3.0 m/s). Systolic peak velocity exceeded 2.6 m/s in all five patients in group 3.

In all patients in groups 1 and 2 the velocity flow profiles were strictly limited to systole. In contrast, two patients in group 3 and in addition the two patients with aneurysmal dilatation showed prolongation of antegrade blood flow during diastole (fig 4).

Discussion

Cross sectional echocardiography, which is the best method of recognising intracardiac structural anomalies, certainly has limitations in patients with aortic coarctation. Though high resolution images of the aortic arch can be obtained that correlate well with angiographic measurements, the aortic isthmus, the region of interest in surgically corrected coarctation, cannot be measured or even qualitatively examined in many, especially older, patients. In our study the imaging quality was acceptable for luminal diameter measurements in only half of the patients. This accords with earlier studies.7,8,18

MRI gives an excellent natural contrast between flowing blood and the vessel wall. In contrast to ultrasound, MRI allows imaging of the thoracic aorta independently of an acoustic window and there is no limitation of imaging planes. Many have reported on the
usefulness of MRI investigation of the aorta in untreated coarctation,\textsuperscript{12,16} operated coarctation,\textsuperscript{17,20,21} or angioplasty treated coarctation,\textsuperscript{11,12} but only a few studies compared MRI measurements of luminal diameter with angiographic measurements.\textsuperscript{7,13} We found an excellent correlation between MRI and angiographically determined aortic diameters, as have others.\textsuperscript{7} In our experience, correct measurement of aortic luminal diameters that avoids partial volume effects requires at least two imaging planes (axial and parasagittal or sagittal) with adequate slice thickness. The unexpected high discordance between angiographic and MRI measurements reported in a previous study\textsuperscript{8} is probably due to inadequate slice thickness and partial volume effects.

Doppler ultrasound has been widely used to assess native and operated aortic coarctation. Continuous wave Doppler examination from the suprasternal position allows a simple measurement of the maximal blood flow velocity in the descending aorta. Variation of the angle between the ultrasound beam and the direction of the jet flow leads to underestimation of the true velocity. Up to an angle of 25\% the error is less than 10\%,\textsuperscript{24} but the true velocity is overestimated if mathematical correction for the apparent cosine is applied.\textsuperscript{25} There are several reports of considerable overestimation of Doppler gradients in surgically corrected coarctation, when the simplified Bernoulli equation (4v\textsuperscript{2}) was used.\textsuperscript{14,26,27} Aldousany et al pointed out, that prestenotic velocity is usually increased in patients with treated coarctation and therefore cannot be neglected in calculations of pressure drops.\textsuperscript{28} Though we measured prestenotic velocities in the distal aortic arch in only a few patients, we believe that the morphological result correlates simply with the maximal velocity measured in the descending aorta. Firstly, MRI showed that narrowing of the aortic arch was a common and important factor. In 21/40 patients the diameter of the distal aortic arch was smaller than that of the descending aorta and in 14 it was smaller than the diameter of the isthmus. In these patients increased prestenotic velocity (v\textsubscript{i}) had a morphological basis. Consequently, incorporation of this "prestenotic" velocity in the Bernoulli equation leads to underestimation of gradients (fig 5). Secondly, sharper angulation of the aortic arch after resection and end to end-anastomosis without narrowing may cause flow acceleration and a pressure drop.\textsuperscript{28} Thirdly, magnetic resonance velocity mapping in the aorta showed skewed cross sectional flow profiles which makes interpretation of a single point flow measurement in a vessel at a given level with a pulsed Doppler system liable to error.\textsuperscript{29} The severity of vessel stenosis influences not only the peak systolic velocity but also the flow profile during the cardiac cycle. Experimental studies showed that antegrade flow during diastole was prolonged by
increasing stenosis. Recent studies reported a 90–100% specificity for severe coarctation when important flow was maintained during diastole.14,16

Though prolonged diastolic flow always indicated a morphological abnormality in our study, this index was not specific for relevant restenosis: two patients with severe aneurysmal dilatation both presented with prolonged antegrade flow during diastole (fig 4).

MRI allowed excellent visualisation of the aortic arch and the thoracic aorta with reliable measurement of luminal diameter whereas cross sectional echocardiography failed in half the study patients. A comparison of the morphometric data obtained by MRI with the Doppler ultrasound measurements indicated a morphological abnormality. It was found in patients with important restenosis and aneurysmal dilatation. Therefore we recommend MRI in the patient with treated coarctation if the peak velocity exceeds 2-6 m/s and in all patients with prolonged antegrade flow during diastole.