Comparison of bronchopulmonary collaterals and collateral blood flow in patients with chronic thromboembolic and primary pulmonary hypertension

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Abstract

Objective—To compare the visualisation of bronchopulmonary collaterals and bronchopulmonary collateral blood flow in patients with chronic thromboembolic pulmonary hypertension and primary pulmonary hypertension.

Setting—Referral centre for cardiology at an academic hospital.

Patients—Nine patients with chronic thromboembolic pulmonary hypertension and 17 with primary pulmonary hypertension.

Interventions—Bronchopulmonary collaterals were visualised by selective bronchial arteriography or thoracic aortography. Bronchopulmonary collateral blood flow was estimated by injecting indocyanine green into the ascending aorta and sampling below the mitral valve from the left ventricle.

Results—The degree of pulmonary hypertension was comparable in the two groups. Large bronchopulmonary collaterals were visualised in all the patients with thromboembolic pulmonary hypertension who had bronchial arteriography or aortography or both. None of the primary pulmonary hypertension group studied by aortography had bronchopulmonary collaterals (P << 0·001). All the patients with chronic thromboembolic pulmonary hypertension had significant bronchopulmonary collateral blood flow, which was (mean (SD)) 29·8 (18·6)% of the systemic blood flow. There was no recordable collateral blood flow in 11 of 15 patients with primary pulmonary hypertension. In the remaining four patients the mean value was 1·1 (1·8)% of the systemic blood flow (P << 0·001).

Conclusions—Visualisation of bronchopulmonary collaterals by thoracic aortography or by bronchial arteriography, or the demonstration of an increased bronchopulmonary collateral flow, helps to distinguish patients with chronic thromboembolic pulmonary hypertension from those with primary pulmonary hypertension.

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Methods

Patient groups

We studied nine patients with severe thromboembolic pulmonary hypertension and 17 with primary pulmonary hypertension. Haemodynamic criteria for inclusion in the
thromboembolic group were pulmonary arterial systolic pressure of > 70 mm Hg; pulmonary arterial mean pressure of > 45 mm Hg; and pulmonary vascular resistance index of > 10 units. After a full clinical assessment, the diagnosis was based on the results of perfusion-ventilation lung scans and pulmonary angiography using previously described criteria.10-12-24 None of the patients in the thromboembolic group had thromboendarterectomy.

CARDIAC CATHETERISATION AND PULMONARY ANGIOGRAPHY

Right and left heart catheterisation was performed percutaneously from the groin using standard techniques. Pressures were recorded from the right atrium, right ventricle, pulmonary artery, pulmonary wedge, left ventricle, and aorta, and transeptally from the left atrium. Cardiac output was calculated by dye dilution techniques. Congenital heart disease, such as patent arterial duct, and other acquired cardiac diseases were excluded. Pulmonary angiography was performed selectively in the right and left pulmonary artery, except in the first few patients.

BRONCHOPULMONARY COLLATERALS

Bronchopulmonary collaterals were assessed by two methods: (1) measurement of bronchopulmonary collateral blood flow using the dye dilution technique; and (2) angiographically by aortography or selective bronchial arteriography or both.

MEASUREMENT OF BRONCHOPULMONARY COLLATERAL FLOW

Bronchopulmonary collateral flow was measured by a method based on the principle developed by Cudkowicz,16 and used by Nakamura.25 We modified this method by using a cuvette densitometer to avoid errors from ear densitometry. Sampling for bronchopulmonary collateral flow was from the left ventricle below the mitral valve, to ensure proper mixing of flow from the right and left pulmonary veins in the left atrium.

Dye curves were recorded using BD5 or BD9 recorders (Kipp and Zonen, Delft, The Netherlands) using a D-402A densitometer (Waters Instruments, Rochester, Minnesota, USA) with the measuring cuvette directly connected to the catheter to reduce the sampling volume. All dye dilution curves were recorded at least twice. A constant rate of blood withdrawal through the cuvette was achieved using a Harvard pump at 40 ml/min speed (Harvard Apparatus, Southnatick, Massachusetts, USA). Blood was infused back to the patient after each recording. Early on, the curve areas were measured by planimetry,26 and in later studies using the Hewlett-Packard catheterisation computer adapted by one of us (JE) for on line measurement of shunts. An example of the dye curves recorded is shown in fig 1. The first dye curve (B) measured the pulmonary blood flow by injection of indocyanine green (usually 5 mg) into the pulmonary artery, with sampling from the aorta. The second curve (C) was recorded by injection of double or quadruple amount of dye into the ascending aorta and sampling just below the mitral valve through a transeptal or retrograde catheter, to detect any aorto-pulmonary shunt. In the presence of bronchopulmonary collateral flow, the early recirculation had an appearance time of about three seconds, while the normal recirculation usually started after 10 seconds. The bronchopulmonary collateral flow was calculated as the ratio of the shunt curve area (C) divided by the pulmonary blood flow area (B). This value multiplied by the pulmonary blood flow gives the bronchopulmonary collateral flow in litres per minute. The systemic blood flow (SBF) was derived by subtracting the bronchopulmonary collateral flow (BPCF) from the pulmonary blood flow.

Then, \[
\text{BPCF} = \text{SBF} \times 100 = \% \text{ of SBF}
\]

Figure 1. Series of dye dilution curves in patient with chronic thromboembolic pulmonary hypertension (CTEPH) and high bronchopulmonary collateral blood flow (BPCF). Sequence of curves was arranged for graphic reasons. Curve B measured pulmonary blood flow (PBF) by injection of dye into the pulmonary artery (PA) with sampling from the aorta (AO). Curve C quantified the left to right shunt by injection of double the amount of dye into the ascending aorta with double recorder sensitivity and sampling from the left ventricle close to the mitral valve (MV). Ratio of the C curve area divided by B curve area multiplied by pulmonary blood flow (in l/min) gives the BPCF in l/min. Curve B recorded by injection into the ascending aorta (AO) and sampling from main pulmonary artery (PA) excludes patent arterial duct as the cause of the left to right shunt demonstrated by curve C. In the absence of BPCF, the curve C would have a pattern similar to curve A with long appearance time (AT). CG, Cardiogram; F\text{AMP} \times mg CG \times 100 = \% SBF
Patient groups and haemodynamic results. Values are mean (SD)

<table>
<thead>
<tr>
<th></th>
<th>CTEPH</th>
<th>PPH</th>
</tr>
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<tbody>
<tr>
<td>Men (n)</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Women (n)</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>Age (mean (SD)) years</td>
<td>45.6 (8.3)</td>
<td>31.2 (12.8)</td>
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<tr>
<td>Aortic pressure (mm Hg)</td>
<td></td>
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<tr>
<td>Systolic</td>
<td>120.9 (14.5)</td>
<td>117.6 (18.1)</td>
</tr>
<tr>
<td>Diastolic</td>
<td>79.3 (6.8)</td>
<td>80.6 (13.6)</td>
</tr>
<tr>
<td>Mean</td>
<td>94.4 (8.9)</td>
<td>96.6 (15.3)</td>
</tr>
<tr>
<td>PA pressure (mm Hg)</td>
<td></td>
<td></td>
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<tr>
<td>Systolic</td>
<td>97.3 (5.0)</td>
<td>91.5 (21.9)</td>
</tr>
<tr>
<td>Diastolic</td>
<td>33.8 (6.4)</td>
<td>40.6 (11.4)</td>
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<tr>
<td>Mean</td>
<td>57.7 (8.2)</td>
<td>59.4 (13.7)</td>
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<td>LA pressure (mm Hg)</td>
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<tr>
<td>Mean</td>
<td>8.0 (6.4)</td>
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<td>RA pressure (mm Hg)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>7.6 (2.8)</td>
<td>7.8 (6.2)</td>
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<tr>
<td>Cardiac index (l/min/m²)</td>
<td>2.02 (0.6)</td>
<td>2.10 (0.7)</td>
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<tr>
<td>PVRI (units/m²)</td>
<td>21.7 (5.2)</td>
<td>25.0 (11.9)</td>
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<tr>
<td>BPCF (l/min)</td>
<td>0.93 (0.49)</td>
<td>0.027 (0.045)</td>
</tr>
<tr>
<td>BPCF (% of SBF)</td>
<td>29.8 (18.6)</td>
<td>1.1 (1.8)</td>
</tr>
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</table>

BPCF, bronchopulmonary collateral flow; CTEPH, chronic thromboembolic pulmonary hypertension; LA, left atrium; PA, pulmonary artery; PPH, primary pulmonary hypertension; PVRI, pulmonary vascular resistance index; RA, right atrium; SBF, systemic blood flow.

Results

The age and sex distribution and basic haemodynamic data are shown in the table. Patients with thromboembolic pulmonary hypertension were on the average about 15 years older than the group with primary pulmonary hypertension. All patients with thromboembolic pulmonary hypertension had segmental or larger perfusion defects that were normally ventilated, while those with primary pulmonary hypertension had normal or subsegmental inhomogeneity in perfusion. Pulmonary angiography in patients with thromboembolic pulmonary hypertension showed varying combinations of filling defects, abrupt narrowing or cut off of arteries, webs, bands, or lumenal irregularities, as in other reports. In primary pulmonary hypertension there was symmetrical dilatation of proximal and hilar pulmonary arteries with relatively rapid taper and marked peripheral arterial pruning. The pulmonary artery systolic and mean pressures and pulmonary vascular resistance index were raised and similar in patients with primary pulmonary hypertension and thromboembolic pulmonary hypertension (NS). One patient in the primary pulmonary hypertension group did not have pulmonary angiography. This patient had the lowest cardiac index in this report (1.02 l/min/m²) and the highest right atrial (mean 28 mm Hg), pulmonary artery systolic (145 mm Hg), and mean pulmonary artery pressure (95 mm Hg). The pulmonary angiogram of a patient with thromboembolic pulmonary hypertension is shown in fig 2.

BRONCHOPULMONARY COLLATERAL FLOW

The bronchopulmonary collateral flow was estimated in eight of the nine patients with thromboembolic pulmonary hypertension and in 15 of the 17 patients with primary pulmonary hypertension. In the remaining three, indocyanine green was not available at the time of cardiac catheterisation. The bronchopulmonary collateral flow, expressed in l/min and as a percentage of systemic blood flow, is shown in fig 3. Bronchopulmonary collateral flow was detected in all eight of the patients with thromboembolic pulmonary hypertension in whom the estimation was made. The mean flow was 0.93 (SD 0.49) l/min, or 29.8 (18.6)% of systemic blood flow. There was no detectable bronchopulmonary collateral flow in 11 of the 15 patients with primary pulmonary hypertension in whom the estimation was made. In the remaining four patients, the mean value was 0.027 (0.045) l/min, which was 1.1 (1.8)% of systemic blood flow. Thus there was a highly significant difference in bronchopulmonary collateral flow between patients with chronic thromboembolic pulmonary hypertension and patients with primary pulmonary hypertension (P < 0.001).
boembolic pulmonary hypertension and all showed bronchopulmonary collaterals. Aortography was performed in three patients with thromboembolic pulmonary hypertension and this also showed bronchopulmonary collaterals (fig 5). Aortography (fig 6) was done in five patients with primary pulmonary hypertension and bronchopulmonary collaterals were not seen.

**Discussion**

Thromboembolic pulmonary vascular disease embraces many syndromes, depending on the segments of the pulmonary arterial tree that are primarily affected.\(^{27,28}\) Occlusion of the small muscular arteries and arterioles, which was in the past referred to as microthromboembolism, is now attributed to organised thrombi rather than emboli.\(^{29}\) In chronic thromboembolic pulmonary hypertension the obstruction is in the larger proximal and intermediate pulmonary arteries. "This type of thromboembolic obstruction can be treated by pulmonary thromboendarterectomy."\(^1\)

Generally by the time the diagnosis is made the clots become organised into the vessel wall, and interpretation of the pulmonary angiogram can be difficult.\(^{17}\) The medial hypertrophy of pulmonary arteries in thromboembolic pulmonary hypertension is often mild or absent, suggesting that vasoconstriction does not play an important role.\(^{27}\) In proximal thromboembolic pulmonary hypertension the smaller pulmonary arteries and arterioles are generally unaffected, allowing a pressure gradient between the potential bronchopulmonary anastomoses. There is also an initial injury to the lung parenchyma from pulmonary infarction. On the other hand, in primary pulmonary hypertension the predominant vascular lesions are in the small muscular arteries and arterioles.\(^{29}\) The changes are bilateral, widespread, uniform, and not confined to a particular segment of the lung.\(^{29,30}\)

At necropsy in primary pulmonary hypertension there is no embolic source and in one study thromboembolic lesions were present in less than 3% of small pulmonary arteries.\(^{30}\) Fibrinoid necrosis and plexiform lesions, believed to be related to intense vasoconstriction, are regularly observed in advanced stages.\(^2\)

The bronchial arteries, usually two major arteries to each lung arise from the thoracic aorta or an intercostal artery. The right bronchial arteries usually arise from the intercostal arteries, generally the first intercostal. The left bronchial arteries commonly arise directly from the aorta. Rarely the bronchial arteries originate from the internal mammary or coronary arteries and can therefore be missed on aortography.\(^{14}\) At the level of the respiratory bronchioles, the bronchial arteries give rise to capillaries which communicate with pulmonary capillaries.\(^{29}\) The bronchial veins from the extrapulmonary airway finally drain into the right heart. The bronchial veins from the intrapulmonary airways and lung parenchyma drain through the "bronchopulmonary arterioles and arterioles.\(^{30}\)

**Figure 4** Selective bronchial arteriogram in a patient with thromboembolic pulmonary hypertension (CTEPH). The dilated bronchial artery is clearly seen as well as mesh of small bronchial vessels connected to the pulmonary arterial branches downstream to the embolic occlusion. \(\nabla\), bronchial artery; \(\rightarrow\), branches of pulmonary artery distal to the occlusion.

**Figure 5** Aortogram in the same patient as in fig 4. Intercostal arteries and a dilated bronchial artery that feeds mesh-like collaterals which faintly opacify the pulmonary artery branches downstream of the embolic occlusion are seen. \(\nabla\), bronchial artery.

**Figure 6** Aortogram in a patient with primary pulmonary hypertension. In spite of well opacified intercostal arteries, no dilated bronchial arteries are seen.

**VISUALISATION OF BRONCHOPULMONARY COLLATERALS**

Selective bronchial arteriography (fig 4) was done in seven of the nine patients with thromboembolic pulmonary hypertension and all showed bronchopulmonary collaterals. Aortography was performed in three patients with thromboembolic pulmonary hypertension and this also showed bronchopulmonary collaterals (fig 5). Aortography (fig 6) was done in five patients with primary pulmonary hypertension and bronchopulmonary collaterals were not seen.
Bronchopulmonary collaterals in chronic thromboembolic pulmonary hypertension

Thus sampling from the left ventricle below the mitral valve would detect bronchopulmonary collateral flow. The bronchial arterial blood flow in the human lung is of the order of 1–2% of the cardiac output. Many chronic and acute lung diseases are associated with an increase in bronchial blood flow. This has been shown for bronchiectasis and granulomas, pulmonary interstitial fibrosis, bronchogenic carcinoma, pleural disease, asthma, bronchitis, emphysema, and acute conditions like pneumonia and adult respiratory disease syndrome.

Ligation of a pulmonary artery in the dog results in the development of bronchopulmonary collaterals to the affected side, and the collateral blood flow could be as much as one third of the output of the right ventricle. Malik and Tracy used beads to embolise the pulmonary circulation to a degree sufficient to increase the pulmonary artery pressure and pulmonary vascular resistance to about three times the normal value. They observed that the bronchial blood flow did not change at five minutes, decreased at six minutes, and was greatly increased to around 300% at two weeks postembolisation. Orell and Hultgren carried out postmortem bronchial arteriography in 28 cases with pulmonary thromboemboli of varying ages. In 18 of the 23 cases with emboli more than two weeks old, there was filling of the pulmonary artery distal to the occlusions through bronchopulmonary collaterals. In this study, bronchopulmonary arterial anastomoses at the level of 1–2 mm thick peripheral bronchi were the most common. Matsuda performed bronchial arteriography in 23 patients with documented pulmonary embolism. All 17 patients in the chronic stage with no radiological infiltrates had bronchial to pulmonary arterial collaterals with antegrade filling of the distal pulmonary arteries. By contrast only one out of six had such collateral vessels when studied at a time when radiological infiltrates were still present. Injection of indocyanine green in the ascending aorta and sampling below the mitral valve will detect an aortopulmonary shunt. None of our patients had a patent arterial duct. Significant bronchopulmonary collateral flow was present in all eight of our patients with thromboembolic pulmonary hypertension in whom the assessment was made. On the other hand there was no detectable bronchopulmonary collateral flow in 11 of 15 patients with primary pulmonary hypertension. In the remaining four patients the flow was small. The difference in bronchopulmonary collateral flow between thromboembolic pulmonary hypertension and primary pulmonary hypertension patients was highly significant (fig 3). The cardiac and pulmonary vascular indices were comparable in the thromboembolic and primary pulmonary hypertension patients. Normal bronchial arteries may be visualised on routine cineangiography when contrast material is injected into the descending thoracic aorta, but bronchopulmonary communi-

CONCLUSIONS

Large bronchopulmonary collaterals and an increase in collateral flow were found in patients with thromboembolic pulmonary hypertension and not in primary pulmonary hypertension. These bronchopulmonary collaterals can be demonstrated on thoracic arteriography without resorting to selective bronchial arteriography or an estimation of collateral blood flow. This study helps in our understanding of some of the pathophysiological differences between thromboembolic pulmonary hypertension and primary pulmonary hypertension. The use to which this observation is put could depend upon the clinical situation. In the context of thromboembolic and primary pulmonary hypertension, the demonstration of bronchopulmonary collaterals establishes the presence of proximal pulmonary thromboembolism. At present, pulmonary angiography may be considered essential while planning pulmonary thromboendarterectomy. The
demonstration of bronchopulmonary collaterals by thoracic aortography could be one way of selecting critically ill patients with severe pulmonary hypertension and suspected thromboembolism for pulmonary angiography. The demonstration of bronchopulmonary collaterals is also likely to help in the differentiation of patients with thromboembolic pulmonary hypertension from those with primary pulmonary hypertension and in situ thrombosis. Bronchopulmonary collaterals would not be expected to develop in patients with pre-existing primary pulmonary hypertension. However, we did not have any patients in this clinical subset.

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