Applied Physiology to the Contemporary Management of the Neonate with Hypoplastic Left Heart Syndrome

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The surgical treatment of hypoplastic left heart syndrome is still a challenge. Few selected large volume centers that adopted protocols focused on understanding of post-Norwood pathophysiology have reduced their mortality rates to around 15%. The inherent inefficacy of the parallel circulation in Norwood operation lends itself to problems related to postoperative management of these patients crucially revolving around keeping a balance between systemic blood flow (Qs) and pulmonary blood flow (Qp). This paper describes the physiology of the Norwood principle, the importance of an adequate hemodynamic assessment, to guide the different postoperative management options.

INTRODUCTION

Hypoplastic left heart syndrome (HLHS) constitutes a spectrum of cardiac anomalies that result in underdevelopment of left-sided heart structures. It is characterized by aortic atresia or severe stenosis with hypoplasia or absence of the left ventricle. Coarctation of the aorta is usually the most frequent associated anomaly and it may impede retrograde blood flow to a diminutive ascending aorta. Postnatal survival is dependent on the ductus arteriosus patency and shunting at atrial level. The natural history is almost universally lethal in the first month of life.

The past decade experienced enormous improvements in the surgical treatment of HLHS. Several current available surgical alternatives have been extensively explored (Table 1). Although multi-institutional studies using intention to treat based analyses have demonstrated higher intermediate term survival for patients entered into heart transplantation, the latter has become less or equally important than the staged palliative surgical approach. Reasons include shortage of available donors, post-transplant morbidity and limited long-term survival. Most importantly, there have been significant improvements in the surgical palliation, originally described by Norwood in 1983. The progressive decline in the surgical mortality is a result of multidisciplinary protocols incorporated to the practice of pediatric cardiac surgery. Despite the initial prohibitive mortality rates, mastering of surgical and anesthetic techniques and the development of safer cardiopulmonary bypass with adequate myocardial and cerebral protection have made feasible the application of the Norwood principle to HLHS.

Nevertheless, most pediatric heart centers still face poor results in the treatment of this complex malformation. Few selected large volume centers that adopted protocols focused on understanding of post-Norwood physiology have reduced their mortality rates to around 10 to 15%. Greater emphasis is being demanded to achieve the task of further reduction in this figure that, most would agree, can be obtained by addressing the directives listed on Table 2.

This review article describes the physiologic principles that guide the modern surgical treatment of the neonate with HLHS.

KEY WORDS
Congenital left heart lesions, Congenital heart disease, cyanotic, Univentricular heart, Neonate, Postoperative care
SUCCESSFUL POSTOPERATIVE MANAGEMENT only to coronary related reasons. Clinical experience and flow as the second most common cause of death next pointed out mismatched pulmonary to systemic blood flow towards the path of least resistance. This poses problems in the post-operative management of Norwood patients because a high resistance in the systemic bed leads to pulmonary over-circulation, having the so-called “steal phenomenon” in the systemic side. Conversely, if there is higher resistance in the pulmonary vascular bed, there will be adequate systemic perfusion but with poorly oxygenated blood. In either case, there will be a situation of circulatory shock due to tissue anaerobism. The inherent inefficacy of the parallel circulation in Norwood operation lends itself to problems related to postoperative management of these patients crucially revolving around keeping a balance between systemic blood flow (Qs) and pulmonary blood flow (Qp).

Bartram et al11 studied 122 patients who underwent Norwood operation between 1980 and 1995 and pointed out mismatched pulmonary to systemic blood flow as the second most common cause of death next only to coronary related reasons. Clinical experience and simulated models support the idea of balancing (Qp) and (Qs) to sustain aerobic milieu that is best possible with adequate systemic oxygen delivery (DO2). Barnea et al12 correlated the DO2 and the Qp/Qs ratio in a mathematical model of the Norwood physiology. They concluded that the DO2 increases proportionately to the Qp/Qs up to a certain point (between 0.7 and 1)13, when starts to decline.

Unfortunately, the deleterious effects of excessive diastolic run off are not limited to coronary malperfusion. Importantly cerebral, renal and splanchic circulations face the risk of hypoperfusion. Although roughly the adaptive mechanisms usually do not differ between adults and children, some peculiarities should be examined in the latter, which may have relevant implications over the post-operative recovery. Firstly, the oxygen consumption of the child at rest is higher when compared to the adult14. Profound hypothermia and total circulatory arrest, which has been employed in the majority of centers in the first stage of Norwood operation, have effects in the relationship between oxygen delivery and consumption. Moreover, the metabolic response to stress is more pronounced in children15. Oxygen consumption is independent of oxygen delivery in a wide range of situations. For example, during periods of low cardiac output, aerobic metabolism is maintained initially because of higher oxygen extraction rate. However, this later mechanism has a limit, which matches an oxygen extraction rate around 50 to 60%, when lactic acidosis develops16,17. Although not least important, cardiopulmonary bypass may play an aggravating role in this scenario, due to situations of inadequate oxygen delivery, excessive loss of vasomotor tone and altered microcirculation. In addition, regional metabolic requirements may be elevated, closely related to non-homogeneous cooling and re-warming or as a result of failing to provide an adequate oxygen delivery to the tissues. Systemic inflammatory response to cardiopulmonary bypass can be implicated into this issue18. During pediatric cardiopulmonary bypass, the blood supply to different organs and systems are significantly altered due to redistribution of flow, in hypothermia or normothermia and low-flow or high-flow perfusion19. Mesenteric hypoperfusion usually is a consequence of these impaired regional blood flow distributions20. The immediate consequences are altered intestinal permeability, bacterial translocation, and passage of endotoxins to the systemic circulation21. The activation of cytokines leads to systemic inflammatory response, one of the trigger mechanisms implicated in the development of multiple organ failure.

Important determinants of Qp and Qs are the pulmonary (PVR) and systemic (SVR) vascular resistances, both of which are frequently susceptible to individual variations in response to cardiopulmonary bypass and deep hypothermic circulatory arrest. This makes a fixed and non-individualized management approach to fit the post-operative needs of all Norwood patients an idealist’s

<table>
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<td>[ R = \frac{\Delta P}{Q} = \frac{8 \eta l}{\pi r^4} ]</td>
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| \( R \) = Hydraulic resistance; \( \Delta P = P_i - P_o \) = Inflow to outflow pressure differential; \( Q \) = Volume flow; \( \eta \) = Viscosity of the fluid; \( r \) = Radius of the tube.
Modified Norwood: Why the change?

The “classic” Norwood procedure consists of atrial septectomy, reconstruction of ascending aorta and aortic arch, creation of unrestricted pulmonary venous return through a large atrial communication and placement of a systemic to pulmonary shunt (Figure 1). The 15-year experience at the Children’s Hospital in Philadelphia with 840 patients having the stage I Norwood have identified as independent predictors of hospital mortality low birth weight (<2.5 kg), operation performed after 2 weeks of age, associated cardiac anomalies, total support time and ECMO support. Concern over left pulmonary artery and left bronchial compression by the no-patch technique has been raised, but the problem has not been recognized clinically as occurring with an increased frequency compared with patch repair techniques.

Until recently, most of the arch reconstructions required an obligatory period of deep hypothermic circulatory arrest. Several studies evaluating the effects of prolonged circulatory arrest clearly demonstrated long-term neurologic sequelae, and acute deleterious effects on kidneys, liver and intestines due to extended periods of cold global ischemia. More importantly, deep hypothermic circulatory arrest has been reported to cause an increase in pulmonary vascular resistance postoperatively. In addition, Tweddell and coworkers found that systemic vascular resistance was also elevated after the Norwood procedure using deep hypothermic circulatory arrest. Moreover, Tokunaga and coworkers demonstrated that sympathetic nerve activity and systemic vascular resistance significantly increased immediately after deep hypothermic circulatory arrest in an animal model.

Imoto and colleagues firstly described the technique of selective regional perfusion through cannulation of the shunt in order to provide antegrade cerebral perfusion, completely avoiding deep hypothermic circulatory arrest. The procedure can be performed with deep hypothermic low-flow or moderate hypothermia, high-flow and low-resistance perfusion. Pigula and colleagues added cannulation of the descending aorta to maintain lower-body perfusion. Although no randomized studies supporting the benefits of regional perfusion are available, clinical observations suggest earlier return of renal function and less hemodynamic instability in regionally perfused patients. Although some studies have provided objective evidence of improved cerebral metabolic activity, there has not been any favorable impact on survival with the use of selective regional perfusion, and experience is still too early to evaluate long-term neurologic outcome.

Although the aforementioned modifications were important contributions, many other technical changes have been introduced to achieve a balance circulation during the early postoperative period, since it is a major determinant in the immediate and the inter-procedural survival. Those modifications have focused on limiting pulmonary blood flow (smaller, longer shunts or shunt...
banding) and improving systemic blood flow. The systemic to pulmonary artery shunt size is a very important factor that affects distribution of flow between two parallel circulations, compromising the coronary blood flow during the diastole. Positron emission tomographic studies of coronary blood flow quantification in infants after repair of their congenital cardiac defects demonstrated less coronary reserve as compared to adults. Specifically after the Norwood procedure, there is higher resting coronary flow but a lower indexed coronary blood flow to the systemic ventricle than those after a biventricular repair. This is related to the increased energy requirements of the systemic ventricle demanded to pump through both systemic and pulmonary beds. Qualitative analysis of coronary blood flow using trans-esophageal echocardiography and Doppler flowmetry described coronary blood abnormalities after Norwood operation, when the predominant flow occurs during the systole. Recent attempts to further eliminate the deleterious effects of systemic arterial source of pulmonary blood, by use of a non-valved right ventricle to pulmonary artery conduit is an addition to the surgical armamentarium. The latter will be addressed as a different section, since it represents an important contribution that changed the postoperative hemodynamics and its management protocols.

Prior to discussing various management themes, it is mandatory to be in contact with advances in techniques employed to guide therapy in these neonates.

**Hemodynamic Assessment in HLHS**

Clinical parameters, widely used on a routine basis, were demonstrated to be non-predictive of major adverse events after pediatric cardiac surgery, especially in neonates. The definition of a reliable marker of tissue hypoperfusion has been extremely difficult to be accomplished. Reasons for that rely on limitations of invasive monitoring imposed by patient weight, and certain anatomic features, such as atrial septal defects that can interfere in the accurate measurement of cardiac output, mixed venous oxygen saturation and oxygen delivery and consumption. In addition, few studies evaluated or included indicators of systemic oxygen delivery in the postoperative management of patients following the Norwood procedure.

Individually, none of the parameters obtained in blood gas analysis are considered important in terms of estimating hemodynamic status. On the other hand, combined parameters can estimate indirectly the oxygen delivery and tissue perfusion. Oxygen arterial saturation greater than 80% was proposed to be indicative of pulmonary overcirculation and consequently of systemic hypoperfusion, but did not show reliability in some clinical studies.

The mixed venous oxygen saturation (SvO₂) is generally accepted as an indicator of adequacy of cardiac output and has a strong association with lactic acidosis in intensive care patients. Considering a stable arterial content of oxygen and an adequate cellular metabolism, SvO₂ higher than 60% means adequate cardiac output. The main advantages of its determination are the capacity in determining both the oxygen delivery and consumption. However, several factors interfere with its values other than the cardiac output, such as the hemoglobin value, arterial oxygen saturation, and the metabolic rate. Since SvO₂ represents the mixture of all venous return blood from the organism, the best sampling site should be the pulmonary artery. Nevertheless, that is not an ideal site in congenital heart malformations with septal defects, since every left to right shunt may lead to inaccuracy. Others have validated the SvO₂ determination in the superior vena cava, close to the right atrium junction. Recently, small oxymetric catheters that are suitable for use in neonates have been developed and safely used. The acquisition of this technology proved to be beneficial in the determination of systemic oxygen delivery after the Norwood procedure, with a favorable impact on morbidity and mortality. The therapeutic management is guided by the oxymetric data and aimed at achieving adequate systemic oxygen delivery defined as a SvO₂ greater than 50%, with a pulmonary to systemic flow ratio nearing unity.

The arteriovenous oxygen content difference (AVDO₂) is another parameter that can be used as a marker of tissue perfusion, and it has been considered as indicative of a balanced circulation when its values were less than or equal to 5 ml/dl.

Although the identification of lactic acidosis has been suggested as a clinically useful indicator of decreased oxygen delivery, it predictably lags the period of inadequate tissue oxygen delivery. Several studies examined the prognostic value of blood lactate after congenital heart operations and they have found conflicting results, but agreed in the power of its serial determination. Rossi and coworkers postulate that elevated lactate levels might represent previous hemodynamic compromise, during or before operation, sometimes associated with liver dysfunction. Uncomplicated survivors of Norwood procedure have an elevated lactic acid level in the early postoperative period. Furthermore, abrupt life-threatening decreases in the systemic oxygen delivery can occur and lead to death before lactic acid becomes elevated.

The use of intracardiac lines inserted before weaning from cardiopulmonary bypass has an importance in estimating circulating blood volume, ventricular function and may serve as a guide to the diagnosis of residual problems in the postoperative period. Moreover, the benefit of its real time determination may encourage further assessment with bidimensional echocardiography or cardiac catheterization. Besides the diagnosis of residual defects responsible for deteriorated postoperative recovery, echocardiography has a fundamental role on the quantitative and qualitative evaluation of global and regional ventricular function and the presence
of pericardial effusions. Analyzing specifically the postoperative period of Norwood procedure, some clinical situations and anatomic features deserve special attention during the echocardiographic evaluation. Presence of new onset or worsening of tricuspid regurgitation might be early indicators of ventricular dysfunction. The persistence of poor oxygenation should lead to the suspicion of small pulmonary arteries or signs of obstruction or stenosis in the systemic to pulmonary artery shunt. A restrictive atrial septal defect may cause low cardiac output, with persistently elevated left atrial pressures. The presence of residual arch obstruction is another factor that may compromise the cardiac output, and lead to systemic hypoperfusion. Obstruction of left pulmonary artery or left main stem bronchus may be associated with some types of aortic arch reconstruction procedures.

**Postoperative Management Option**

Currently there are two schools of thought to achieve this precise balance after the Norwood procedure. It is important to understand that those schools are not static and usually intertwined, in different protocols, according to the institution. The first, primarily uses maneuvers to either manipulate Qp by reduction of minute ventilation and inhalation of hypoxic and/or hypercarbic gas mixtures. The second manipulates Qs by infusions of systemic vasodilators.

**Qp manipulation**

**PVR** - The effect of acidosis, hypoxia and hypercarbia on pulmonary vasculature has been well understood. Inducing permissive respiratory acidosis to effectively control Qp and its positive effects on the outcome of hypoplastic left heart patients has been recognized since 1986. Methods have evolved since then. In the initial period, the aim was to reduce alveolar minute ventilation and increase dead space, leading to carbon dioxide retention. This could be done by reducing respiratory rate, tidal volume or both with high positive end-expiratory pressures and room air inspired oxygen fraction. The almost instantaneous reduction of pulmonary blood flow was an advantage that was utilized by centers striving to improve results in postoperative Norwood cases. On the other hand, some drawbacks of this management have been identified. These hypoventilatory methods led to decreased functional residual capacity, micro-atelectasis and intrapulmonary shunting in the neonate resulting in ventilation-perfusion mismatch, pulmonary venous desaturation and hypoxia. Obviously, deprivation of oxygen is undesirable in the normal course of recovery after cardiopulmonary bypass and circulatory arrest.

Therefore, other ways to induce respiratory acidosis were explored. Increasing the fraction of carbon dioxide (CO2) in the inspired gas was suggested as the alternative method when the mechanical variables of ventilation (respiratory rate, tidal volume and positive end expiratory pressure) are set free from control of PCO2. The advantage of this technique was to achieve elevated PVR without adversely effecting DO2. Addition of higher amounts of CO2 (delivered level of 1-2% or 8-30 mmHg) in the inspired gas is aimed to maintain the paCO2 in the range of 45-50 mmHg. Although attractive, this strategy was used in combination with increased minute ventilation. Theoretically, the increase in minute ventilation would lead to an additional increase in PVR because of a raised mean airway pressure. The simultaneous downside of CO2 washout and resultant hypocapnic alkalosis, by higher minute ventilation could be countered by inspired CO2. Bradley et al concluded that the inspired CO2 could improve DO2 effectively, only if the minute ventilation is kept constant. Hypercarbia poses yet another advantage towards reduction of Qp:Qs ratio in that its systemic vasodilatory effect may increase and redistribute total cardiac output favorably.

However, experimental studies showed that the concentrations of CO2 required in the inspired gas to achieve statistically significant elevation of PVR was extremely high (80-95 mmHg). It was also demonstrated that there is a significant PVR elevation, when the inspired O2 concentration is reduced. Hence, the logical next step using this principle was to reduce the oxygen content in the breathing gas mixture to less than 21%. This was achieved by addition of nitrogen in the inspired gas. The hypoxic or sub ambient gas therapy was successfully used, keeping the inspired oxygen fraction in the 14 to 20% range.

This protocol should be especially beneficial in some clinical instances such as low birth weight neonates with unusually high PVR, unresponsive to hypoxic gas mixture. Adversely, these effects were more prominent in pre-bypass settings in reducing Qp as compared to post-bypass scenario after Norwood repair.

On the other hand, recent studies have shown that high levels of fraction of inspired oxygen can in fact improve mixed venous oxygen saturation and systemic oxygen delivery. Bradley et al postulate that protocols aimed at minimizing the FiO2 and carefully controlling ventilation may not be warranted.

**Hematocrit** - Increasing viscosity of blood creates inherent resistance to flow according to Poiseuille's law. This effect is exponentially pronounced with hematocrit values higher than 45% and more evident in high-flow than in low-flow conditions. Some authors have included this strategy routinely in the post-operative management of SVR that is also subject to abrupt fluctuations, regardless of cardiopulmonary bypass strategy employed. The minute-to-minute control of systemic vascular resistance improves results in postoperative Norwood cases.

**Qs manipulation**

It has been demonstrated that neonates after the Norwood procedure maintain a higher baseline level of SVR than in low-flow conditions. Some authors have included this strategy routinely in the post-operative management of SVR that is also subject to abrupt fluctuations, regardless of cardiopulmonary bypass strategy employed. The minute-to-minute control of systemic vascular resistance improves results in postoperative Norwood cases.
is an amalgam of the influences of the autonomic nervous system by changing the total cross-sectional area of the systemic vascular bed and the local metabolic factors. From the aortic to the venous side, greatest resistance is exerted at the arteriolar level (60%), followed by capillaries & small veins (15% each) and large and mid-sized arteries (10%)78.

The rationale of the use of vasodilators is justified initially by common consequences of cardiopulmonary bypass, such as pulmonary endothelial swelling, interstitial lung edema and microatelectasis, which already keeps the PVR high and further elevations would be unnecessary. In addition, unrecognized pulmonary venous desaturation occurs early after Norwood operation76,79. Moreover, it is thought that further reduction in alveolar oxygen availability only impairs even more the pulmonary venous saturation, thus hampering DO2.

Reduction in SVR has been achieved by an arteriolar dilator (sodium nitroprusside), an alpha-receptor antagonist (phenoxybenzamine) or chlorpromazine or an inodilator (milrinone). Nitroprusside is a mixed, arterial and venous, vasodilator with nitric oxide related mechanism of action. It has a short half-life and it is easily reversible. The disadvantage of sodium nitroprusside is that it does not tackle the frequent and abrupt changes in SVR.

Phenoxybenzamine blocks irreversibly and non-competitively alpha-adrenergic receptors, leading to more prolonged vasodilatation. Phenoxybenzamine has been advocated by most centers performing neonatal surgery at the onset of CPB. Usually, it can be titrated with the mean arterial pressures, although some groups have advocated continuous infusion of the same in the post-operative period80,81. Use of phenoxybenzamine after the Norwood procedure improves DO2, and induces fixed and balanced Qp:Qs ratio. In this setting any increase in mean arterial pressure with afterload reduction promoted by phenoxybenzamine, reflects in better SvO2. Therefore, no steps need to be taken to reduce FiO2 or manipulate mechanical ventilation. Problems related to excessive vasodilation with the use of phenoxybenzamine have been reported82, which can be countered with judicious use of vasoconstrictors like nor-epinephrine and vasopressin.

Chlorpromazine83, a phenothiazine neuroleptic drug with significant alpha blocking capabilities has also been successfully used. Choice of inotropic agents has drifted from those having vasoconstrictive properties towards those with vasodilatory properties. In order to reduce the range for pulmonary vascular resistance to fluctuate, pulmonary vasculature can be dilated maximally at weaning from cardiopulmonary bypass with inhaled nitric oxide and high concentration of inspired oxygen as potent pulmonary vasodilators84. Under this condition, pulmonary blood flow is dependent on systemic to pulmonary shunt adjustments. This completely distinct approach was proposed by Nakano et al81, which simply taper inhaled nitrous oxide and inspired oxygen fraction as arterial oxygen saturation improved, with continuous infusion of chlorpromazine to keep SVR low. Frequent ventilator manipulation is rarely required.

**RIGHT VENTRICLE TO PULMONARY ARTERY CONDUIT: THE DEFINITIVE SOLUTION?**

The right ventricle to pulmonary artery (RV-PA) conduit to reestablish pulmonary blood supply in stage I palliation for HLHS was firstly introduced by Norwood in 198185. At that time, shunts were excessively large and all patients died either from pulmonary overcirculation or from right ventricular failure. Kishimoto et al86 revived the initial concept using a xenopericardial valved conduit, which was replaced later by Sano et al87 that used a 4 or 5 mm nonvalved PTFE (Figure 2) conduit. Their initial experience with 19 consecutive patients achieved an excellent 89% hospital survival. More importantly, placing the pulmonary and systemic circulations in parallel resulted in a more predictable postoperative recovery. The pulmonary bed was neither anymore subjected to nor dependent on diastolic flow, and there should be less change in pulmonary blood flow with pulmonary hypertensive crisis or during resuscitation in the presence of low cardiac output or after a cardiac arrest. No particular Qp and/or Qs manipulation were required postoperatively, maintaining adequate blood oxygenation and higher diastolic pressures88,89. Excellent hemodynamics provided by this technique was particularly beneficial for low birth weight infants, a subset known to be of higher hospital mortality, usually due to pulmonary overcirculation even with the smallest 3 mm Blalock-Taussig shunt.

The RV-PA conduit became worldwide popular and its results were considered reproducible88-91, consistently

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**Fig. 2 – Modified Norwood operation without patch arch reconstruction.**

**Neoaorta is formed by the remnant hypoplastic ascending aorta with coronary ostia, the pulmonary trunk and descending aorta distal to arterial duct. A non valved right ventricle to pulmonary artery conduit is the only source of pulmonary blood flow.**
improving the mortality rates after the first stage palliation in many centers. However, highly experienced centers on the modified Norwood have not shown a favorable impact on hospital survival.

Several nonrandomized studies have compared the RV-PA conduit and the modified Blalock-Taussig shunt as the source of pulmonary blood flow. Hemodynamic evidences of those studies are summarized in Table 4. In spite of more predictable hemodynamics in the RV-PA conduit group, there were no significant differences in length of intensive care stay, duration of ventilatory support, inotropic use and systemic oxygen delivery.

The RV-PA conduit has potential limitations that need to be further investigated. The effects of a right ventriculotomy are of a great concern, in terms of ventricular failure and trigger of arrhythmias. Current ventriculotomy are of a great concern, in terms of need to be further investigated. The effects of a right ventricular overload with the RV-PA conduit group, there were no significant differences in length of intensive care stay, duration of ventilatory support, inotropic use and systemic oxygen delivery.

Another potential problem is related to the degree of flow reversal in the nonvalved conduit. Nonetheless, free pulmonary regurgitation seems to be well tolerated over the short term. Likewise every other prosthetic tube in pediatric cardiac surgery, it becomes obstructed with time, particularly within 3 months after surgery. That obligates an earlier second stage, which may be favorable in terms of reducing the interprocedural attrition. At this stage, pulmonary resistance is higher. On the contrary, pulmonary artery growth has been controversially shown to be as good as with the BT shunt, despite a lower Qp:Qs. Usually, the RV-PA conduit was left open in order to provide an extra source of pulmonary blood flow. Outcomes after the second stage performed earlier support the idea that the pulmonary blood flow is lower, but enough to provide good oxygenation without important ventricular loading. That concept is supported by similar outcomes in patients submitted to early (3 months) second stage after the modified Norwood procedure, but expected more prolonged postoperative recovery. However, Malec et al haven't found any need for earlier second stage with the RV-PA conduit, since the lower Qp:Qs ratio ensured good condition for the development of the pulmonary vasculature (more centrally located shunt and pulsatility of forward flow from the pumping ventricle).

**STENTING OF THE ARTERIAL DUCT AND BANDING OF THE PULMONARY ARTERIES**

Stenting the arterial duct in combination with pulmonary artery banding and, if necessary, atrial septotomy offers a different approach to palliation of HLHS. Neoaoctic reconstruction and establishment of a bi-directional cavopulmonary connection can then be performed during a single operation. Moreover, in selected hypoplastic left ventricles, in which left ventricular growth can be observed foremost during the postnatal follow-up, the surgical decision made immediately after birth would result in a single ventricle palliation, although in the same patient biventricular repair may have been provided a few months later. In this context, despite multiple left heart obstructive lesions, a biventricular repair is thought to be preferable when possible.

Michel-Beihne et al adopted this strategy in 20 patients. Based on their initial experience, they advocate that a newborn with HLHS admitted with prostaglandin E1 infusion with a wide open duct, no ductal narrowing and unrestricted atrial septal defect would be considered for bilateral banding within the first 3 to 5 postnatal days. If a pulmonary run off in consequence of a decrease in pulmonary vascular resistance is observed, this procedure should be performed earlier. Ductal stenting, as well as re-evaluation of the effectiveness of the pulmonary banding would be performed 2 to 3 days before hospital discharge. Then, the prostaglandin infusion is discontinued about 2 hours before catheterization to achieve a smaller and more prolonged postoperative recovery.

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**Table 4 – Advantages and disadvantages of the modified Blalock-Taussig (BT) shunt in comparison with the right ventricle to pulmonary artery (RV-PA) conduit during the modified Norwood procedure**

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<tr>
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<th>BT shunt</th>
<th>RV-PA conduit</th>
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<tr>
<td><strong>Advantages</strong></td>
<td>Better pulmonary artery growth*</td>
<td>Higher diastolic blood pressure</td>
</tr>
<tr>
<td></td>
<td>Better midterm oxygenation</td>
<td>Lower pulse pressure <strong>94</strong></td>
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<tr>
<td></td>
<td></td>
<td>Better coronary perfusion <strong>94</strong></td>
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<tr>
<td><strong>Disadvantages</strong></td>
<td>Diastolic runoff <strong>91,92,98</strong></td>
<td>Lower pulmonary blood flow <strong>90</strong></td>
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<td></td>
<td>Higher Qp:Qs</td>
<td>Early or progressive hypoxemia</td>
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<tr>
<td></td>
<td></td>
<td>Ventricular dysfunction <strong>97,94</strong></td>
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<tr>
<td></td>
<td></td>
<td>Ventricular arrhythmias <strong>97,94</strong></td>
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* controversial **97,90,91,94,97,98; ** potential.
narrower duct, facilitating stent placement and preventing stent dislocation. A newborn with a restrictive foramen ovale would be catheterized before bilateral banding is provided. In case of any narrowing within the duct, a stent would be placed before the atrial septectomy. Arch reconstruction and bi-directional cavopulmonary connection were performed 3.5 to 6 months later. Bigger structures often allow avoidance of deep hypothermic circulatory arrest by means of cerebral perfusion through the innominate artery. Bidirectional cavopulmonary connection enables unloading the single right ventricle at earlier stage, establishing serial instead of parallel pulmonary and systemic circulations. The postoperative recovery was usually managed with arterial and venous vasoconstrictors and low dose phosphodiesterase inhibitor. The early success rate of this approach was 90%. Additionally, it provided extended waiting periods for heart transplantation in selected 10% of these patients, in which Norwood pathway was not the preferred choice. This minimizes the development of severe pulmonary hypertension before the transplant, extends safely the waiting time of listed patients and improves the ease of subsequent transplant management.

However, this technique deserves further investigation with longer follow-up. Potential issues include interprocedural deaths due to heart failure or pulmonary hypertension. Close follow-up is necessary to detect restrictive atrial septal defect, narrowing of the duct, or compromised pulmonary blood flow. In addition, the development of significant aortic coarctation may compromise retrograde flow blood and coronary perfusion.

**CONCLUSIONS**

The surgical treatment of hypoplastic left heart syndrome is still a challenge. Heart transplantation is a viable alternative to this problem, and it is influenced by institutional preferences and donor availability. Continued impairment of right ventricular function, severe tricuspid regurgitation or coronary fistulae leaves heart transplantation as the treatment of choice. Progressive improvements have been achieved in the surgical palliation, mainly based on the refined application of physiology principles. The balance between systemic and pulmonary circulations is the keystone in the successful postoperative management of the modified Norwood procedure. The current literature strongly supports this concept, electing mixed venous oxygen saturation as the best guide of adequate tissue perfusion. The management options vary among several institutions. Both PVR as well SVR manipulations are welcomed, and sometimes should be used in combination. Although dealing with the complex interaction of two circulations in parallel is manageable in most of the cases, sometimes requires excessive teamwork and experience. New technical modifications, such as the right ventricle to pulmonary artery conduit, have been incorporated to surgery in order to lessen the postoperative complications, supporting the idea of a more “physiologic” pathway. The impact of the ventriculotomy on ventricular systolic, diastolic, and electrical function as well as atrioventricular valve function remains to be determined. Current data was not enough to determine any long-term survival benefit. Only the future will tell us the best way to treat hypoplastic left heart syndrome.

**Potential Conflict of Interest**

No potential conflict of interest relevant to this article was reported.

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