Complete correction of transposition of the great arteries with left juxtaposition of the atrial appendages

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Vidne, B. A. and Subramanian, S. (1976). Thorax, 31, 178–180. Complete correction of transposition of the great arteries with left juxtaposition of the atrial appendages. Juxtaposition of the atrial appendages is an uncommon anomaly which is usually associated with transposition of the great arteries. Experience with five patients with transposition of the great arteries in combination with juxtaposition of the atrial appendages in whom Mustard’s operation was performed is reviewed. Technically, the existence of juxtaposition of the atrial appendages in corrective surgery for transposition does not present any additional surgical problems. Emphasis is placed on the advantages of early complete correction, avoiding the need for palliative procedure.

Juxtaposition of the atrial appendages refers to that condition in which both atrial appendages, or one and part of the other, lie beside each other and to one side of the great arteries. The appendage lying to the left of the great arteries is called left-sided juxtaposition and is considerably more common by a ratio of about 6:1 than the situation in which the appendages lie to the right of the great arteries—right-sided juxtaposition. Among left-sided juxtapositions, Charuzi et al. (1973) described a partial juxtaposition state when the right atrial appendage is bifid and only its left unit is juxtaposed.

Juxtaposition of the atrial appendages is nearly always associated with significant congenital heart disease in which transposition of the great arteries is commonly a feature. Tricuspid atresia, double outlet ventricle or double inlet ventricle have also been described (Dixon, 1954; Puech et al., 1966; Melhuish and Van Praagh, 1968; Santoli et al., 1968; Wagner, Alday, and Vlad, 1970; Charuzi et al., 1973).

Between 1971 and 1974, five patients with transposition of the great arteries and juxtaposition of the atrial appendages underwent Mustard’s operation and are the basis of this report.

**Patients**

From a total of 116 Mustard operations for transposition of the great arteries, including transposition with intact ventricular septum and normal pulmonary artery pressure, intact ventricular septal defect (VSD) and pulmonary artery hypertension, complicated transposition with ventricular septal defect and pulmonic and subpulmonic stenosis, five patients had, in addition, juxtaposition of the right atrial appendages. In only one of them was combined juxtaposition of the atrial appendages suspected preoperatively owing to the catheter position. All five patients had left juxtaposition of the atrial appendages.

The ages of these five patients ranged from 3 months to 10 years, being less than 18 months in three of the five (Table I).

All the patients presented with complicated transposition. Complicating lesions consisted of subpulmonic VSD in all patients, subpulmonic stenosis in three patients presenting with a subpulmonary conus (pulmonary-mitral valve discontinuity), pulmonic valvular stenosis in one, patent ductus arteriosus in two patients, and a left superior vena cava draining to the coronary sinus in one patient.

In three of the five patients, a previous palliative operation had been done elsewhere, consisting of pulmonary artery banding in the three and an additional Blalock-Taussig anastomosis in one. Haemodynamic data of the five patients are shown in Table II. Two patients were operated upon with standard cardiopulmonary extracorporeal circulation. Three of the five were operated upon under
Transposition of the great arteries with left juxtaposition of atrial appendages

**Table I**

<table>
<thead>
<tr>
<th>Age</th>
<th>Weight (kg)</th>
<th>CHF</th>
<th>Cyanosis</th>
<th>Tachypnoea</th>
<th>Hepatomegaly</th>
<th>ECG</th>
<th>Cardiomegaly</th>
<th>Hb (g/dl)</th>
<th>Previous Palliative Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 m</td>
<td>7-6</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>LVH</td>
<td>+</td>
<td>17-3</td>
<td>Pulmonary artery banding</td>
</tr>
<tr>
<td>18 m</td>
<td>9-3</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>RVH</td>
<td>+</td>
<td>16-4</td>
<td>Rashkind septostomy, pulmonary artery banding</td>
</tr>
<tr>
<td>4½ yr</td>
<td>±</td>
<td>±</td>
<td>±</td>
<td>±</td>
<td>±</td>
<td>LVH</td>
<td>±</td>
<td>13-7</td>
<td></td>
</tr>
<tr>
<td>3 m</td>
<td>4-7</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>-</td>
<td>RV</td>
<td>±</td>
<td>14-0</td>
<td>Rashkind septostomy</td>
</tr>
<tr>
<td>10 yr</td>
<td>19-1</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>RVH</td>
<td>+</td>
<td>15-4</td>
<td>Pulmonary artery banding</td>
</tr>
</tbody>
</table>

*Goldenhar’s syndrome (Goldenhar, 1952).*

**Table II**

<table>
<thead>
<tr>
<th>Pressure (mmHg)</th>
<th>Oxygen Saturation %</th>
<th>RA LA RV PA LV Ao</th>
<th>SVC</th>
<th>ICV</th>
<th>RA RV PA PV LA LV Ao</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>90/10</td>
<td>113/15</td>
<td>115/10</td>
<td>90/45</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>62/5</td>
<td>35/20</td>
<td>70/7</td>
<td>90/7</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>95/5</td>
<td>40/25</td>
<td>100/6</td>
<td>95/60</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>70/5</td>
<td>16/10</td>
<td>78/6</td>
<td>70/40</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>100/12</td>
<td>16/12</td>
<td>105/10</td>
<td>100/50</td>
<td></td>
</tr>
</tbody>
</table>

**Table III**

<table>
<thead>
<tr>
<th>Deep Hypothermia</th>
<th>Baffle Patch</th>
<th>VSD PS PDA</th>
<th>Debanding</th>
<th>Closure Shunt</th>
<th>PA Reconstruction</th>
<th>Coronary Sinus</th>
<th>Pulmonary Mitral Continuity</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>+</td>
<td>Pericardium</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>Cut</td>
<td>+</td>
<td></td>
<td>Good</td>
</tr>
<tr>
<td>+</td>
<td>Pericardium</td>
<td>+</td>
<td>-</td>
<td>+</td>
<td>Cut</td>
<td>+</td>
<td></td>
<td>A-V Block</td>
</tr>
<tr>
<td>+</td>
<td>Pericardium</td>
<td>+</td>
<td>-</td>
<td>+</td>
<td></td>
<td>+</td>
<td>+</td>
<td>Good</td>
</tr>
<tr>
<td>+</td>
<td>Pericardium</td>
<td>+</td>
<td>-</td>
<td>+</td>
<td></td>
<td>+</td>
<td>+</td>
<td>Died</td>
</tr>
<tr>
<td>+</td>
<td>Pericardium</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td></td>
<td>+</td>
<td>+</td>
<td>Died</td>
</tr>
<tr>
<td>-</td>
<td>Pericardium</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td></td>
<td>+</td>
<td>+</td>
<td>Good</td>
</tr>
</tbody>
</table>
RESULTS

Two of the five patients died immediately after surgery. One, 3 months old, died because of low cardiac output four hours after surgery. No obvious cause for the low output state was found. The second death was in a 4½-year-old child who died immediately after surgery due to low cardiac output. At necropsy moderate to severe pulmonary vascular disease was found.

In all three surviving patients, tracheostomy was performed. One developed a complete A-V block and a permanent pacemaker was implanted.

The follow-up period is from six months to four years. There were no late deaths and no evidence of pulmonary venous obstruction.

Technically, correction of transposition of the great arteries in patients with additional juxtaposition of the atrial appendages does not present any great problem, especially with the use of deep hypothermia and circulatory arrest.

DISCUSSION

From a functional point of view, juxtaposition of the atrial appendages appears to be of no significance although it may give rise to a confusing situation in diagnostic studies. In patients with transposition of the great arteries and juxtaposition of the atrial appendage, the abnormally placed atrial appendage could be particularly relevant in some palliative procedures. In performing balloon septostomy, the catheter may appear to conform to the criteria of a left atrial position and still be in the right atrial appendages in left-sided juxtaposition (Tyrrell and Moes, 1971; Rosenquist, Stark, and Taylor, 1974).

A Blalock-Hanlon atrial septectomy could be more difficult to perform since the part of the right atrium between the interatrial groove and the atrioventricular groove is smaller. In this case, the inflow occlusion technique would be more appropriate. Technically, the presence of juxtaposition of the atrial appendage in the correction of transposition of the great arteries does not present any additional surgical problem. All the patients presented had left juxtaposition of the right atrial appendage which appeared combined with ‘correctable complicated transposition of the great arteries’ in contrast to the right juxtaposition which appears to be combined with ‘non-correctable lesions’.

As a result of our surgical experience and the potential difficulties in performing classical palliative procedures, in this particular group of patients with these combined anomalies early correction is strongly recommended.

REFERENCES


Requests for reprints to: Professor S. Subramanian, FRCS, Department of Cardiovascular Surgery, Children’s Hospital, 219 Bryant Street, Buffalo, New York State, USA.
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Thorax 1976 31: 178-180
doi: 10.1136/thx.31.2.178

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