False aneurysm following modified Blalock-Taussig shunt

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Abstract
A nine month old infant with life threatening tracheal compression due to a Blalock-Taussig shunt aneurysm is described. Successful surgical management is discussed.


The Blalock-Taussig shunt is now a well recognised procedure for treating cyanotic congenital heart disease in infancy. The original operation consisted of anastomosis of the subclavian artery to the pulmonary artery, but the use of polytetrafluoroethylene grafts to produce a communication between systemic and pulmonary circulation has simplified the procedure.

We report a false aneurysm at the distal end of a Blalock-Taussig shunt in a nine month old infant with tetralogy of Fallot who had undergone a modified Blalock-Taussig shunt in the neonatal period. The aneurysm was successfully repaired with complete relief of the tracheal compression.
was right sided. She was referred abroad for palliative surgery. A left modified Blalock-Taussig shunt using a 5 mm Gore-Tex tube was carried out on the 13th day of life. The postoperative course was uneventful. A repeat two dimensional echocardiogram indicated good left sided shunt function. On return she continued to grow along the third centile and did not show any signs of cyanosis. At nine months of age she developed biphasic stridor not associated with fever or leucocytosis. She rapidly deteriorated to near obstruction requiring urgent intubation. The arterial oxygen saturation increased from 80% to 95% following intubation. She had dilated veins over the upper chest and neck suggestive of superior vena cava obstruction. There was no abnormal pulsation over the left chest but a continuous murmur was heard. The initial chest radiograph revealed a broadened mediostinum, extending over the left upper lobe and compressing and displacing the trachea to the right. A computed tomographic scan of the chest suggested an aneurysm in relation to the left subclavian artery which was confirmed by angiography.

In view of severe tracheal and caval compression, emergency surgery was undertaken. A left lateral thoracotomy was carried out through the fourth interspace and the adherent lung was mobilised off the chest wall and mediastinum, revealing a large pulsatile aneurysm 5 cm in diameter at the thoracic outlet, displacing the trachea and the oesophagus to the right. The subclavian artery arose from a left sided innominate artery. The left carotid and subclavian arteries were completely obscured by the aneurysm.

Proximal control of the subclavian artery was obtained at its origin where the aneurysm was abutting on the carotid artery. Distal control of the subclavian artery was obtained where it exited from the chest beyond the aneurysm. The sac of the aneurysm was opened. The Gore-Tex graft had completely detached itself from the subclavian artery and was lying free in the cavity of the aneurysm. There was no retrograde bleeding from the pulmonary artery. It was obvious that the graft was not patent. There was bleeding from the opening in the subclavian artery through the vertebral artery which had not been controlled. The opening was oversewn and the subclavian artery was proximally and distally ligated. Since the infant maintained arterial saturations above 85% no further shunt surgery was undertaken. The graft was sent for bacteriological culture but was found to be sterile.

The rest of the postoperative course was uneventful and the patient was weaned off the ventilator after five days with oxygen saturation remaining above 85% in air. She started to feed well and had no stridor or respiratory distress. One month after the operation the child was thriving with mild cyanosis. A total correction of the intracardiac defects is planned for the near future.

Discussion

False aneurysms from Blalock-Taussig shunts have been known to produce fatal haemoptysis. However, tracheal and superior vena cava compression due to false aneurysm complicating a modified Blalock-Taussig shunt has not been reported in the literature. The presentation of this patient was dramatic with acute tracheal compression and superior vena cava obstruction necessitating urgent endotracheal intubation. Contrast computed tomographic scan showed the aneurysm in relation to the subclavian artery, but angiography was carried out to better define the anatomy. Surgery relieved the respiratory distress and superior vena cava compression. Preoperative and intraoperative oxygen saturations were satisfactory even with a non-functioning shunt. It was thus not felt necessary to proceed with another shunt. One could only speculate on the need for the shunt procedure in the first instance. The aetiology of this aneurysm remains baffling. The fact that the sutures had completely detached suggests an infective aetiology even though cultures of the original graft were sterile. An alternative possibility was damage to the suture by a side-biting clamp.

1 Blalock A, Taussig HB. The surgical treatment of the malformations of the heart in which there is pulmonary stenosis or pulmonary atresia. JAMA 1945;128:189.
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