Total Circulatory Arrest for the Replacement of the Descending and Thoracoabdominal Aorta

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Hypothesis: Hypothermic total circulatory arrest (TCA) in the resection and replacement of the thoracoabdominal and descending thoracic aorta is safe, will significantly decrease the incidence of postoperative renal failure, and should be preferentially performed over left heart bypass (LHB).

Design: Retrospective review case series.

Setting: Large, private, urban teaching hospital.

Patients: All adult patients with aortic disease that involved the distal aortic arch, the descending thoracic aorta, or the thoracoabdominal aorta who underwent resection and graft replacement of the diseased segment via LHB or TCA at our institution from 1989 to 2001 are included in this study. A total of 59 patients were evaluated: 10 had descending thoracic aneurysms, 20 had thoracoabdominal aneurysms, 22 had chronic type B dissections, 4 had acute type B dissections, and 3 had adult coarctations.

Interventions: In 1989 to 1994, LHB was primarily used; in 1994 to 2001, TCA was primarily used.

Main Outcome Measures: Renal failure, 30-day operative mortality, paraplegia, and any other morbidities.

Results: A significant decrease occurred in the incidence of postoperative renal failure from 15% (3/20) in patients who underwent LHB to 0% (0/39) in patients who underwent TCA (P = .04). Furthermore, a significant decrease occurred in the 30-day operative mortality, which decreased from 20% (4/20) in patients who underwent LHB to 5% (2/39) in patients who underwent TCA (P = .04). Postoperative paraplegia decreased from 5% (1/20) in patients who underwent LHB to 2.6% (1/39) in patients who underwent TCA (P > .99).

Conclusions: Our use of TCA in the resection and replacement of the diseased thoracoabdominal and descending thoracic aorta has produced excellent results. Our patients have experienced no postoperative renal failure and a low 30-day operative mortality. The use of TCA in this patient population is a viable option for surgeons comfortable with the technique.

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Many studies1-13 have reported the use of profound hypothermic total circulatory arrest (TCA) in the treatment of type A and B aortic dissections and thoracoabdominal aortic aneurysms. The safety and efficacy of hypothermic TCA for the resection of the descending and thoracoabdominal aorta have been well established in recent years.1,6,9,12,14 Atherosclerosis is a major factor in deciding whether the aorta is amenable to cross-clamping, thus influencing the decision to use profound hypothermic TCA. According to Kouchoukos et al,13 TCA confers an advantage over clamping and bypass by eliminating the need for proximal aortic manipulation, providing a dry, bloodless field, and decreasing the incidence of paraplegia by hypothermic protection of the spinal cord and central nervous system.3,6,12,14,16 However, other reported series3

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A statistically significant difference in mortality occurred between the 2 groups. The overall 30-day mortality rate for patients undergoing surgery via TCA was 5% (2/39) and stayed the same for the hospital mortality rate for patients undergoing surgery via TCA was 5% (2/39) and stayed the same for the hospital mortality rate for patients undergoing surgery via LHB (Figure 1). In the TCA group, 2 deaths occurred. One patient with a descending thoracic aneurysm died intraoperatively of pump failure, subsequent to rupture and hemorrhage. Another patient in the TCA group, who had a thoracoabdominal aneurysm, died on the fifth postoperative day subsequent to multiorgan failure. In the LHB group, 4 deaths occurred: 2 patients with chronic type B dissections and 2 with thoracoabdominal aneurysms. In the 2 patients with chronic type B dissections, one died intraoperatively due to pump failure subsequent to arrhythmia (ventricular tachycardia/fibrillation), whereas the other patient (who had a chronic type B dissection) died on the first postoperative day due to arrhythmia (ventricular tachycardia/fibrillation). Of the 2 patients with thoracoabdominal aneurysms, one died on the 18th postoperative day subsequent to hemorrhage, whereas the other died on the 20th postoperative day subsequent to renal failure.

NEUROLOGIC COMPLICATIONS

No significant difference in neurologic complications between the 2 groups was observed. Paraplegia occurred in 1 (3%) of 39 patients undergoing surgery via TCA compared with 1 (5%) of 20 patients undergoing LHB (P = .99) (Figure 2). The patient undergoing surgery via TCA had a chronic type B dissection, whereas the patient undergoing surgery via LHB had an acute type B dissection. Postoperative hemiparesis, with return to normal neurologic function before discharge, was found in 3 (8%) of 39 patients undergoing surgery via TCA and in 1 (5%) of 20 patients undergoing LHB (P > .99). Stroke with a resulting focal neurologic deficit occurred in 4 (10%) of the 39 patients undergoing TCA vs 1 (5%) of the 20 patients undergoing LHB (P = .65). Interestingly, among the
patients undergoing surgery via TCA with neurologic sequelae, all had chronic type B dissections. The one patient who suffered neurologic complications in the LHB group had a thoracoabdominal aneurysm.

PULMONARY DYSFUNCTION

No significant difference was noted between the 2 groups with respect to pulmonary dysfunction. Respiratory failure that required prolonged (>48 hours) mechanical ventilation was required in 6 (15%) of the 39 patients undergoing TCA, whereas 4 (20%) of the 20 patients undergoing LHB required prolonged ventilatory support ($P=.72$). Tracheostomy was required in 4 (10%) of the 39 patients undergoing TCA and in 2 (10%) of the 20 patients in the LHB group ($P > .99$).

RENAAL DYSFUNCTION

Renal failure with resultant elevated creatinine levels occurred in no patients undergoing TCA in contrast to 3 (15%) of the 20 patients in the LHB group ($P = .04$).

Table 3. TCA Times for All Aortic Diseases Treated by TCA

<table>
<thead>
<tr>
<th>Type of Aortic Disease</th>
<th>Average (Range) Time in TCA Group, min</th>
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<tr>
<td>Descending aneurysm</td>
<td>35.8 (16-51)</td>
<td>149.5 (100-178)</td>
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<td>Thoracoabdominal aneurysm</td>
<td>36.6 (5-57)</td>
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<tr>
<td>Acute type B</td>
<td>46.0 (35-57)</td>
<td>127.5 (121-134)</td>
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<tr>
<td>Coarctation</td>
<td>35.0 (35)</td>
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Abbreviations: CPB, cardiopulmonary bypass; LHB, left heart bypass; TCA, total circulatory arrest.

Figure 1. Thirty-day operative mortality decreased from 20% (4/20) with left heart bypass (LHB) to 5% (2/39) with total circulatory arrest (TCA) ($P = .04$).

Figure 2. Postoperative paraplegia decreased from 5% (1/20) with left heart bypass (LHB) to 3% (1/39) with total circulatory arrest (TCA) ($P > .99$).

Figure 3. Postoperative renal dysfunction was defined as a creatinine level 1.5 times the preoperative level or higher.

COMMENT

The decision to use TCA depends on a number of factors. Most studies that evaluate TCA report the use of this technique only in select cases and do not use TCA as their routine approach in the resection of the distal aortic arch and descending thoracic aortic dissections or thoracoabdominal aneurysms. In fact, it is usually considered the exception rather than the common practice for most surgeons.

Often TCA is used when the patient is deemed at high risk for potential neurologic complications, such as the risk of paraplegia from spinal cord ischemic injury in patients with extensive descending thoracic aortic aneurysms or in patients with Crawford type I, II, or III thoracoabdominal aortic aneurysms. Certainly, another circumstance that calls for the use of TCA is the presence of atherosclerosis, where the patient's aorta is severely calcified and cannot be safely cross-clamped for

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fear of possible embolic complications and stroke. Also, the issues of renal failure and mortality following TCA, compared with other techniques, are controversial and important topics with respect to thoracic and thoracoabdominal aortic repair. Some studies have suggested that the rate of renal failure remains high following these procedures and that it may even have an association with increased mortality in this patient population.

We reviewed our results for all operations performed on the distal aortic arch, descending thoracic aorta, and thoracoabdominal aorta at our institution. We compared outcomes between our previous technique of LHB from 1989 to 1994 and results after our switch to the routine use of profound hypothermic TCA from 1994 to 2001 for the same conditions. Although our 2 study groups are separated by almost a decade, we believe this comparison provides useful information regarding the safety and efficacy of our technique.

Profound hypothermic TCA has been used by many surgeons for a variety of conditions. Its use has often been described in the replacement of the aortic arch, descending thoracic aorta, and thoracoabdominal aorta. In addition, other authors have reported extensively on the use of hypothermic TCA and the advantages conferred by this technique.

Debate exists over mortality associated with the use TCA. Some studies, such as the one by Safi et al, cite a higher mortality rate associated with the use of hypothermic TCA, whereas other studies note a decreased mortality rate or at least no increase or difference in mortality with or without the use of TCA. In our series, we found a significant difference in mortality between the TCA and LHB groups, with patients undergoing TCA having a mortality rate of only 5% compared with 20% in patients undergoing LHB.

Hypothermia has been shown to increase the tolerance of neurologic tissue to ischemia, namely, a decrease in spinal cord susceptibility to ischemic damage and paralysis. This added protection and increased duration of tolerable spinal cord ischemia conferred by hypothermia allows for more time to reimplant lumbar and intercostal vessels. The profound hypothermia also provides protection for the brain, with decreased cerebral ischemic injury. Our study did not show a significant difference between TCA and LHB with respect to neurologic sequelae.

A notable benefit provided by TCA in addition to brain and spinal cord protection is the added protection of the kidneys and abdominal viscera in the surgical repair of the aortic arch and descending thoracic aortic dissections and thoracoabdominal aortic aneurysms. Some studies have not shown an improvement in renal protection with the use of TCA and report the incidence of renal failure that occurs with this surgery as remaining high and having an association with high early and late mortality rates.

The use of TCA in our study completely eliminated the incidence of postoperative renal failure. The difference in renal failure was statistically significant between the 2 groups, with a 0% rate of renal failure in patients undergoing TCA compared with a 15% rate of renal failure with LHB (P=.04).

In summary, this single institution comparison of results between profound hypothermic TCA and LHB techniques provides useful information regarding the safety and efficacy of our technique in the resection of the distal aortic arch, descending thoracic aortic dissections, and thoracoabdominal aneurysms. We observed that the use of TCA in the resection of the distal aortic arch and descending thoracoabdominal aorta has eliminated renal failure and significantly decreased the 30-day operative mortality. Furthermore, we observed no difference in neurologic outcomes even though we did not use additional adjuncts for spinal cord protection in patients undergoing TCA. We recommend the routine use of TCA and believe that this technique is safe, has good results, and should be used for patients who require distal aortic arch and descending and thoracoabdominal aortic surgery.

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Previous Presentation: This study was presented at the 75th Annual Session of the Pacific Coast Surgical Association; February 15, 2004; Maui, Hawaii; and is published after peer review and discussion.

REFERENCES


