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Outcome following the detachment of the tricuspid valve for ventricular septal defects closure

THESIS

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LISTE ARRÊTÉE LE 23/06/2021



DEDICATIONS





I dedicate this thesis to ...

To my loving mother NIZIGIYIMANA Libérate

You are the corner stone of my life, the closest person to my heart. I cannot find words strong enough to express the depth of my love. I owe you every achievement that I have ever made in my life. May the almighty God bless you with a good health and a very long life.

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ABBREVIATIONS



Abbreviations List

ASD	: Atrial septal defect
AV	: Atrio-ventricular
AVB	: Atrioventricular block
CPB	: Cardiopulmonary bypass
HF	: Heart failure
ICU	: Intensive care unit
LVH	: Left ventricular hypertrophy
NYHA	: New York Heart Association
PDA	: Patent ductus arteriosus
PS	: Pulmonary stenosis
RSR	: Regular sinus rhythm
RVH	: Right ventricular hypertrophy
SD	: Standard deviation
TOF	: Tetralogy of Fallot
TR	: Tricuspid regurgitation
TV	: Tricuspid valve
TVD	: Tricuspid valve detachment
VSD	: Ventricular septal defect



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INTRODUCTION



The ventricular septal defect (VSD) is a congenital malformation where there is a defect in the ventricular septum of the heart. The VSDs are the most common congenital structural heart disease, accounting for 30 to 40 % of all congenital heart diseases and 0.8 % of all live births [1]. They can be either isolated, associated with other congenital heart malformations, or a component of a more complex heart malformation such as the Tetralogy of Fallot (TOF).

Their diagnosis is easily and accurately performed by the transthoracic echocardiography coupled with the colour Doppler.

A significant number of VSD cases, depending on their size and location, may close spontaneously. However, if a spontaneous closure does not happen, either a surgical or a percutaneous device closure treatment is required in order to prevent complications such as heart failure, infective endocarditis, aortic regurgitation and pulmonary hypertension which is a corollary of the left-to-right shunt.

During the surgical treatment, the transatrial approach is nowadays the gold standard since it generates less scarring of the right ventricle and less risk of right bundle branch block than the right ventricular one.

In some cases, mostly in perimembranous and muscular infundibular VSDs, the sub-valvular apparatus of the tricuspid valve (TV) conceals the margins of the VSD.

Hence an inadequate exposure of the VSD which both carries a high risk of damage to the conduction system, injury of the tricuspid valve, residual leaks and makes it difficult for surgeons to establish suture lines if they undertake the surgery without addressing it.

Furthermore, in case of outlet extension of the VSD in an upper position, exerting too much traction on the TV will result in the distortion of the TV or the elongation of the chordae, hence generating a tricuspid regurgitation.

Therefore, in order to allow both an optimal exposure of the VSD, an easier access to the VSD and avoid a distortion of the tricuspid valve; a partial detachment of the tricuspid valve is required.

The partial detachment of the tricuspid valve from the annulus during a VSD closure was first described by Hudspeth et al in 1962[2]. Since then, this technique has been further improved and even extended to closure of VSDs in patients with more-complex malformations such as the TOF [3].

Some surgeons have even developed and started performing variants of this technique: either a radial incision of the septal leaflet or a partial detachment of the chordae from their septal attachments and flipping them over [4].

Yet despite numerous studies in favor of its safety and efficacy, there are surgeons still restraining themselves from using this technique over concerns that it may increase the risk of heart block, tricuspid valve regurgitation and longer operation time [5].

The purpose of this endeavour is to assess the long-term outcomes of the patients who underwent a surgical closure of their VSD with a tricuspid valve detachment (TVD) in the cardiovascular surgery department of the Mohammed VI teaching hospital; by mainly focusing on the following elements:

- The frequency of residual VSDs.
- The frequency and severity of the tricuspid regurgitation at long-term.
- The occurrence of complete atrio-ventricular blocks.



*PATIENTS
AND METHODS*



I. STUDY DESIGN

1. Type of study

We undertook a retrospective, single center and descriptive study of the preoperative, intraoperative and follow up data of 28 patients who underwent surgery for VSD closure using the TVD technique.

2. Duration of the study

The study spanned on a period of 10 years from July 2010 to August 2020.

3. Setting

The study took place in the Cardiovascular Surgery department, Arrazi Hospital, Mohammed VI University Teaching Medical Center.

Both the preoperative and postoperative follow-up echocardiographic assessment were performed by the cardiovascular medicine department of Mohammed VI University Teaching Medical Center.

The severity of TR was assessed by applying the qualitative and semiquantitative variables [6]:

- Qualitative variables included: the size of the jet area flow (small, moderate, or large); the convergence of the jet area flow (transient, intermediate and large); and the density of the jet area flow (partial/dense, parabolic, or triangular).
- Semiquantitative variables included the state of the vena contracta (mild, <0.5cm; moderate, 0.3 to 0.69cm; or severe, >0.9cm), and hepatic vein flow (systolic dominance, systolic blunting, or systolic flow reversal).

4. Follow-Up

All the patients underwent consultations at 30 postoperative days, at 3 months, at 6 months, and at 12 months. Then, they were seen annually for a maximum of 8 years.

II. METHODS

1. Inclusion criteria

The following inclusion criteria were set up:

- Patients who underwent surgery for isolated VSDs or VSDs associated with either ASD, PDA, or PS with a partial detachment of the septal leaflet extended or not to the anterior one.
- Patients who underwent a complete repair surgery of TOF during which the VSD was closed with partial TVD.
- Patients with at least 6 months follow-up data.

2. Exclusion criteria

The exclusion criteria were the following ones:

- Patients with very complex heart malformations such as complete atrioventricular defect or double output right ventricle.
- Patients lost to follow-up.
- Patients with unusable or lost medical records.

3. Data collection

- The preoperative data (epidemiology, medical and surgical history, clinical exams, paraclinical data) were provided by a thorough review of medical records in the cardiovascular surgery department archives.

- The follow-up data was provided by the records of outpatient follow-up consultations, gathered either directly from the patients or sent by phone instant messaging applications; due to the coronavirus pandemic context.
- The data from each patient was recorded in a patient information sheet required to perform our study. (Check in the appendices).

4. Statistical analysis

We recorded the collected data using Microsoft Excel 2016 version.

- The data analysis was performed using SPSS 21.0 version.
- Continuous variables were presented as mean \pm standard deviation, range, as mostly appropriate. Categorical data were presented as number of patients and relative percentage.

III. OPERATIVE TECHNIQUE AND TVD INDICATIONS

The surgical approach used for closing the VSD for all the patients in our series was via a right atriotomy.

First, the mediastinal access was achieved through a midline sternotomy (and partial or total thymectomy); followed by an inverted T pericardiotomy and its suspension.

For 2 (7.1%) of our patients who had a PDA, it was closed at this stage.

Then the CPB was established in a standard manner by an aorta-bicaval cannulation following heparinization. The CPB was conducted at mild hypothermia. A left atrial vent was inserted in the right superior pulmonary vein after the aortic cross clamping.

Diastolic arrest was achieved by an infusion of cold and antegrade blood cardioplegia into the aortic root every 25 minutes.

Therefore, with both total CPB and caval vein isolation, the right atrium was opened parallel to the atrioventricular groove.

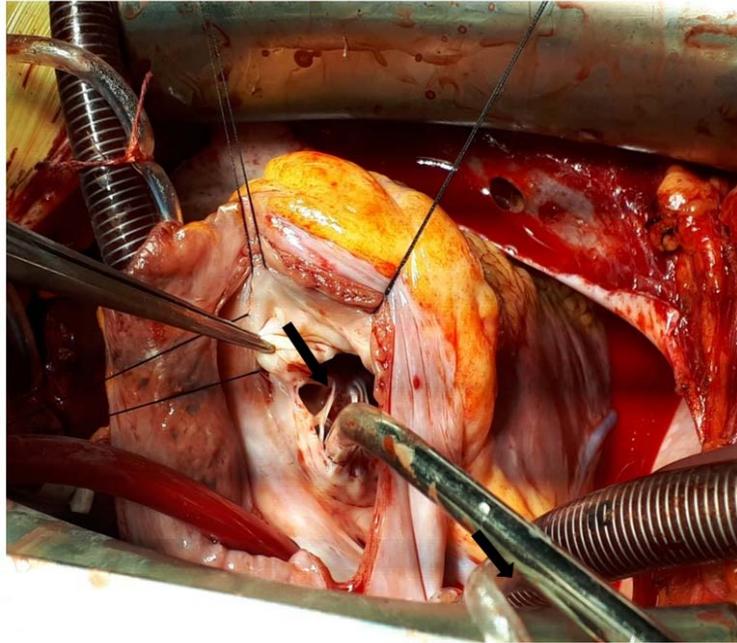


Figure 1: Intraoperative picture showing the chordae insertion (black arrow) on the anterior margin of the VSD after exposure of the right atrium / Cardiovascular Surgery Department – University hospital Mohammed VI – Marrakech

Then the VSD was fully exposed by retracting the anterior leaflet towards the right atrium appendage. The decision to perform a TVD was taken at this stage whenever the following circumstances arose:

- Chordal attachments of the tricuspid valve obscuring the margins of the defect.
- Aneurysm of the tricuspid valve disallowing an easy access to the defect.
- Upper position of the defect generating an excessive traction on the tricuspid valve leaflet.

The procedure continued by the partial detachment of the septal leaflet with an extension to the anterior one. The detachment is performed 2 to 3 mm away from the TV annulus in order to ease the further reattachment.

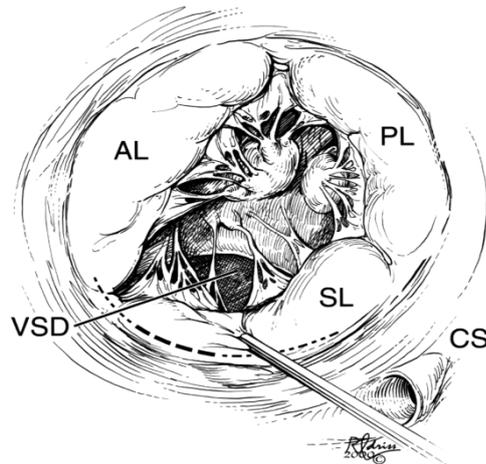


Figure 2: Drawing of a VSD. The dotted line is the site of the septal incision performed 2–3 mm away from the annulus. The incision is extended to the anterior leaflet [7].

No marking sutures for the TV were used in order to avoid lesions of the valve by overstretching it.

Then the borders of the defect were easily visualized. The VSD was closed with an autologous pericardium patch mostly (with a synthetic or a bovine pericardial patch in some cases) sutured using a continuous 5–0 Prolene starting at midpoint of the anterior margin. The leaflet was reattached along the line of incision using a continuous 7–0 Prolene suture.

After that, the tricuspid valve competence and coaptation was assessed by filling the right ventricle with a cold saline infusion (Figure 3).

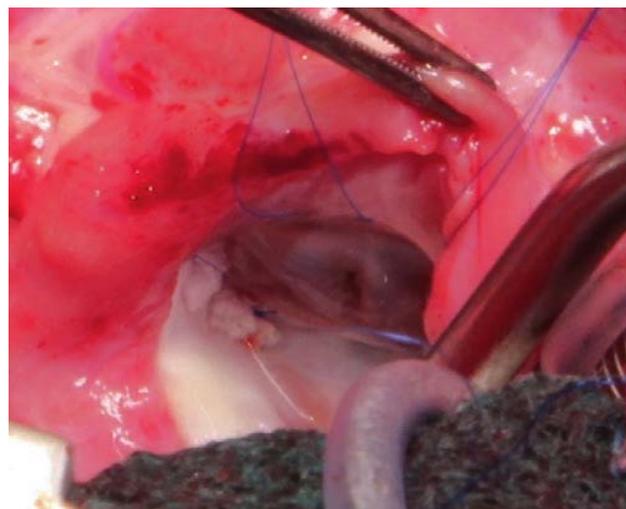


Figure 3: Saline pressure testing of the tricuspid valve shows a competent valve [8]

In some cases, after the closing of the VSD, additional procedures were carried out to address the associated cardiac malformations:

- Closure of an associated atrial defect.
- Enlargement of the pulmonary artery using a patch in case of an associated pulmonary stenosis and concomitant to an Infundibular resection and pulmonary commissurotomy in case of TOF.

Then, the right atrium was closed, the aortic cross clamp removed and the weaning from CPB performed. After bleeding control, the surgery was ended in the usual way.

IV. ETHICAL CONSIDERATIONS

We undertook a retrospective study. Thus, it does not require the formal approval of the patients in our series. Nevertheless, our study was performed in the strict respect of the patient privacy and anonymity.



RESULTS



I. EPIDEMIOLOGY

1. AGE

The mean age of our patients was 5.8 years with a standard deviation of 4.88 and a range from 9 months–old to 21 years–old.

Table I provides the age distribution of the patients in our case series.

Table I: Age distribution of our patients

Age group in years	Number of patients	Percentage
< 4	12	42.9 %
4 - 12	13	46.4 %
12-18	2	7.1 %
> 18	1	3.6 %
Total	28	100 %

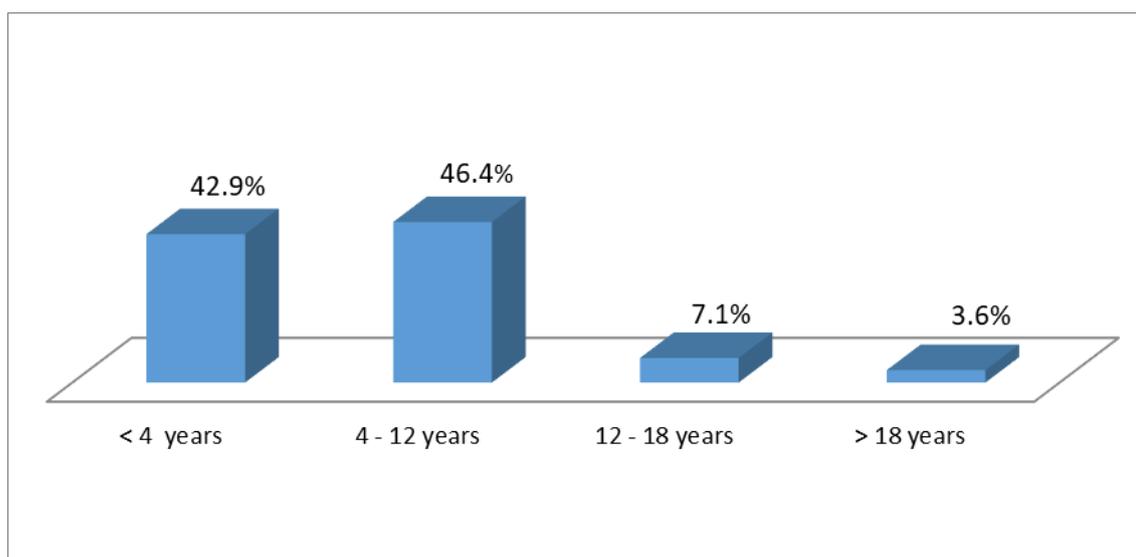


Figure 4: Age distribution of our patients

2. GENDER

In our study: 18 (64.3%) patients were male and 10 (35.7%) were female with a 1.77 sex ratio.

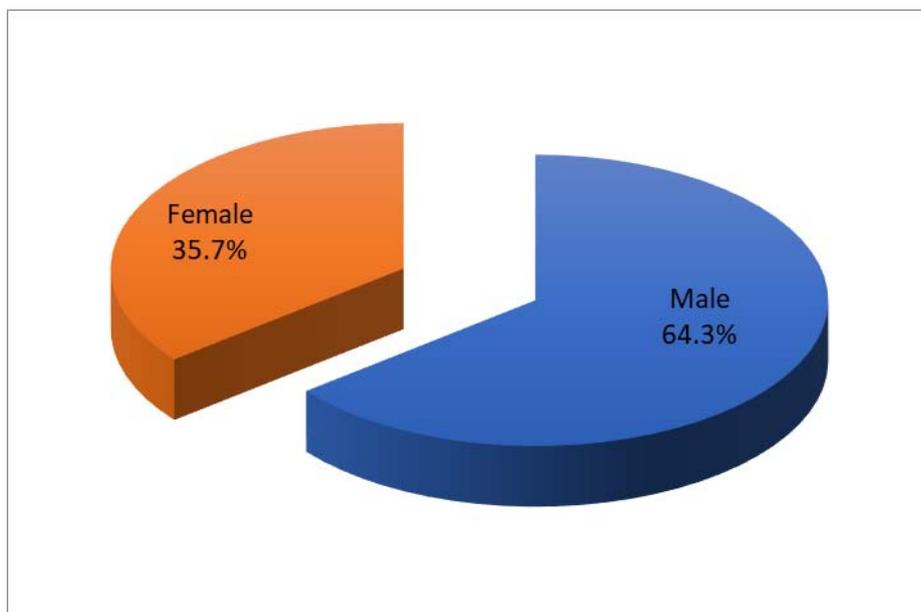


Figure 5: Gender distribution of our patients

II. CLINICAL DATA

1. CASE HISTORY

Among our patients:

- Eighteen (64.3%) had a history of recurrent respiratory infections.
- Twenty (71.4%) had been admitted at least once in Pediatrics service.
- Four (14.3%) had undergone a pulmonary artery banding procedure.

Table II: Medical history in our case series

	Number of patients	Percentage
Recurrent respiratory infections	18	64.3%
Pediatrics hospitalizations	20	71.4%
Pulmonary artery banding	4	14.3%

2. FUNCTIONAL SYMPTOMS

2.1. Heart failure

In our study, the heart failure (HF) severity was assessed using the modified Ross Heart failure (HF) classification:

- Seven (25%) patients had a class II Ross HF.
- Twenty (71.4%) patients had a class III Ross HF.
- One (3.6%) had a class IV Ross HF.

Table III: Heart failure in our case series

	Number of patients	Percentage
Class II Ross heart failure	7	25%
Class III Ross heart failure	20	71.4%
Class IV Ross heart failure	1	3.6%
TOTAL	28	100%

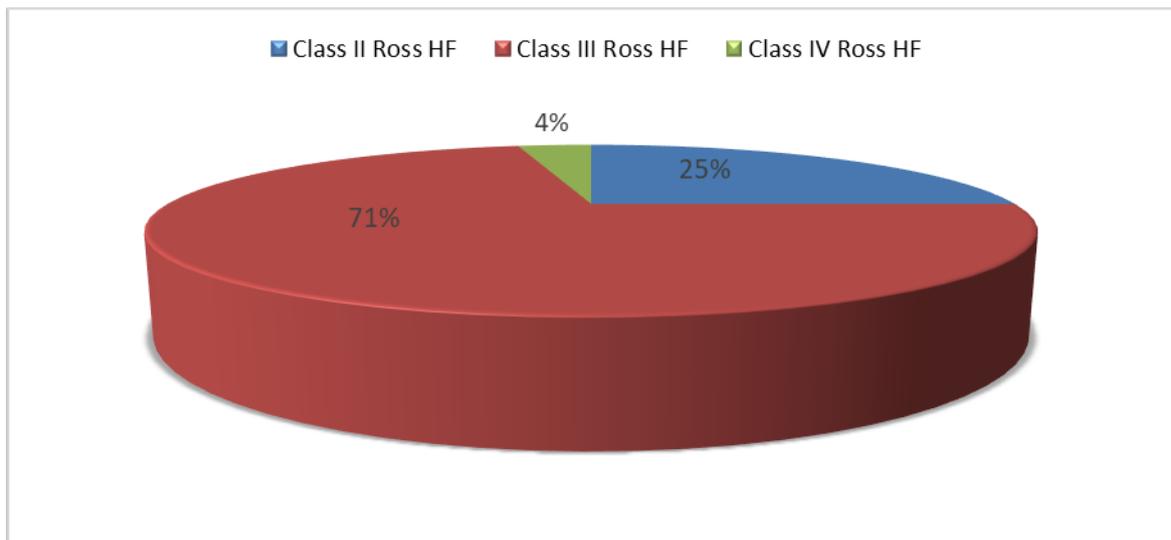


Figure 6: Heart failure in our case series

2.2. Height-weight growth delay

Another cardiac malformation symptom that calls out is height and weight growth delay. In this study, 12 patients had that symptom which accounts for 42.9%.

3. PHYSICAL SYMPTOMS

3.1. Weight

In this series, the mean weight before surgery was 18.57 kg with a standard deviation of 13.51. The patient with the lowest weight had 6 kg and the heaviest had 70 kg.

3.2. Heart rate, Oxygen saturation, heart failure syndrome

In our series:

- Twenty-six (92.9%) patients had a normal heart rate, while 2 (7.1%) patient had tachycardia.
- Nine (32.1%) patients had cyanosis, whilst 19 (67.9%) had a normal oxygen saturation.
- One (3.6%) patient had a global heart failure syndrome.

Table IV: Clinical signs prevalence in our case series

	Number of patients	Percentage
Tachycardia	2	7.1 %
Cyanosis	9	32.1 %
Global heart failure syndrome	1	3.6 %

3.3. Auscultation

The pan systolic murmur is the most characteristic heart murmur of the VSD. It was present in 17 (60.7%) of our patients. A pulmonary stenosis systolic murmur was found in 11 (39.3%) of the patients.

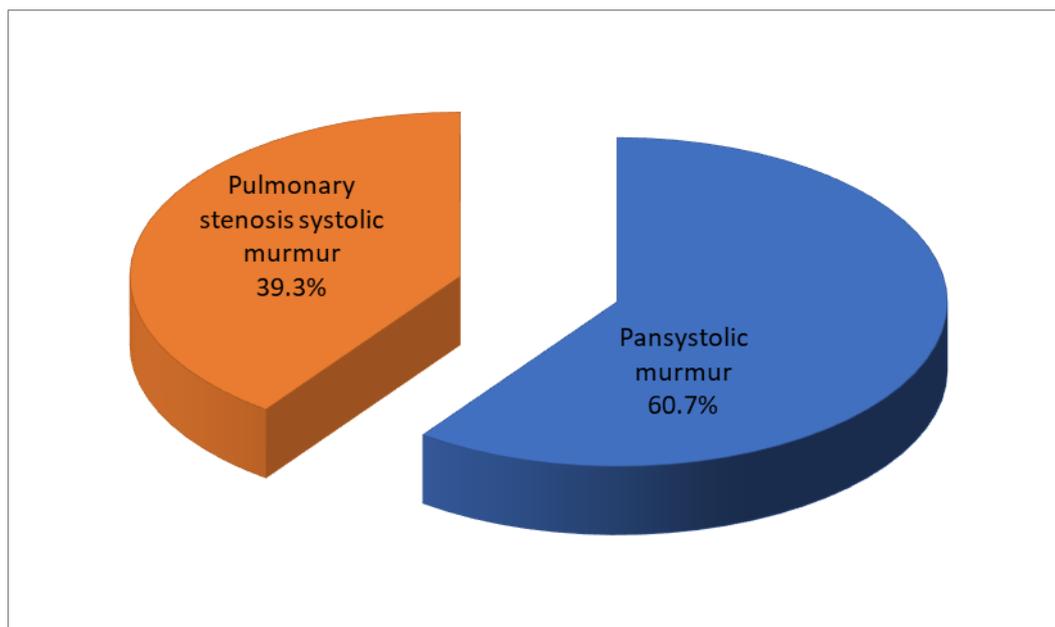


Figure 7: Heart murmur distribution in our series

III. PARACLINICAL DATA

1. ELECTROCARDIOGRAM

In our study:

- Eighteen (64.3%) patients had a regular sinus rhythm.
- Three (10.7%) patients had a regular sinus rhythm with an isolated left ventricular hypertrophy (LVH).
- Four (14.3%) patients had a regular sinus rhythm with a biventricular hypertrophy.
- Three (10.7%) patients had an incomplete right bundle branch block (RBB).

Table V: ECG assessment in our case series

ECG Assessment	Number of patients	Percentage
Regular sinus rhythm	18	64.3
RSR with LVH	3	10.7
RSR with LVH + RVH	4	14.3
Incomplete RBB	3	10.7

2. ECHOCARDIOGRAPHIC DATA

2.1. Type and diameter of the VSD

In our case series:

- Twenty-one (75%) patients had a perimembranous VSD.
- Five (17.8%) patients had a conoventricular VSD.
- One (3.6%) patient had both a muscular VSD and a perimembranous one.
- One (3.6%) patient had two muscular VSDs.

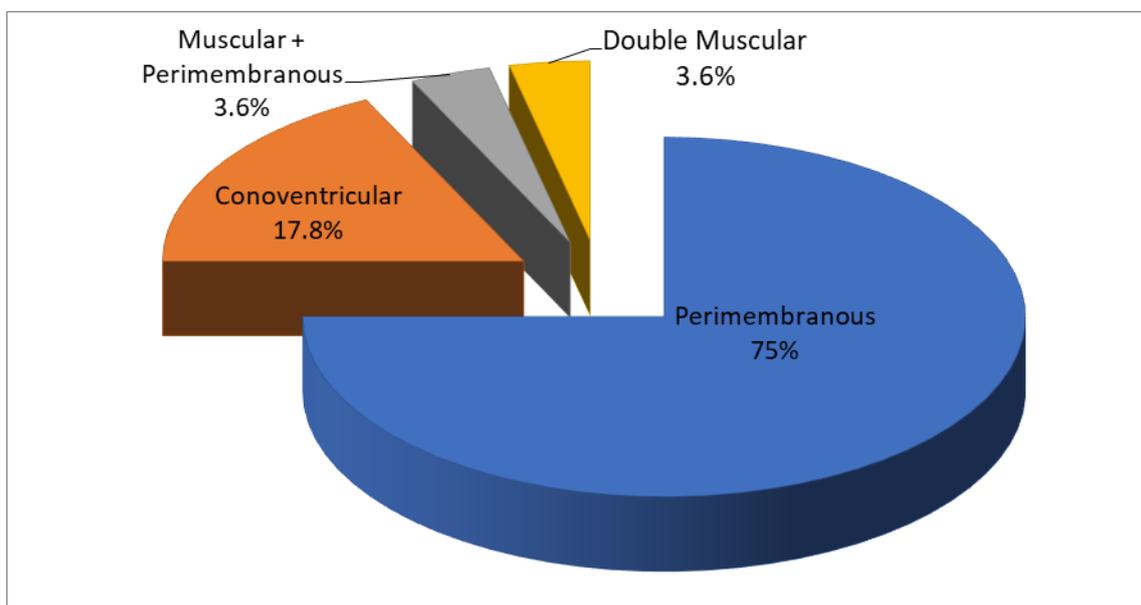


Figure 8: Type of VSD in our case series

About the size of the VSD, most of our patients had a large (diameter > 7 mm) VSD leading to an important Left-to-Right shunt. In our case series:

- Five (17.8%) patients had a VSD diameter less than 7 mm.
- Fifteen (53.6%) patients had a VSD diameter between 7 and 15 mm.
- Eight (28.6%) patients had a VSD diameter superior to 15 mm.

The mean diameter of the VSD in our series was $11.38 \text{ mm} \pm 4.83 \text{ mm}$ with a minimum of 3 mm and a maximum of 22 mm.

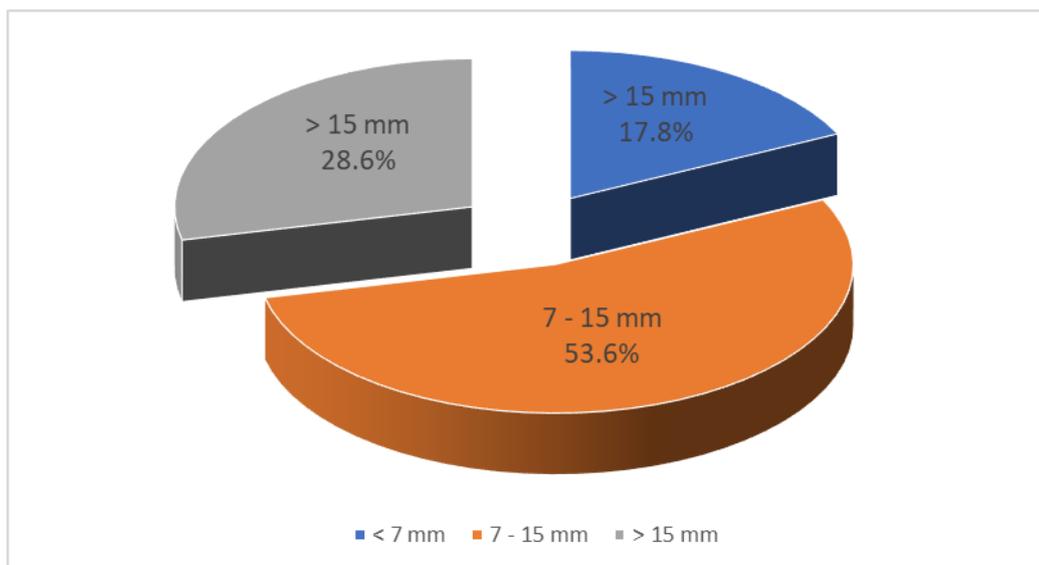


Figure 9: VSD diameter in our series

2.2. Associated cardiac defects

In our case series, the echocardiographic analysis showed that 12 (42.9%) of our patients had an isolated VSD. The remaining patients had the following associated cardiac malformations:

- Eight (28.6%) patients had the VSD as a component of the Fallot’s tetralogy.
- Four (14.3%) patients had an atrial septal defect (ASD).
- Four (14.3%) patients had a pulmonary stenosis.

Table VI: Associated cardiac defects in our case series

Associated cardiac defects	Number of patients	Percentage
Isolated VSD	12	42.8 %
Fallot’s tetralogy	8	28.6 %
Atrial septal defect	4	14.3 %
Pulmonary stenosis	4	14.3 %
Total	28	100 %

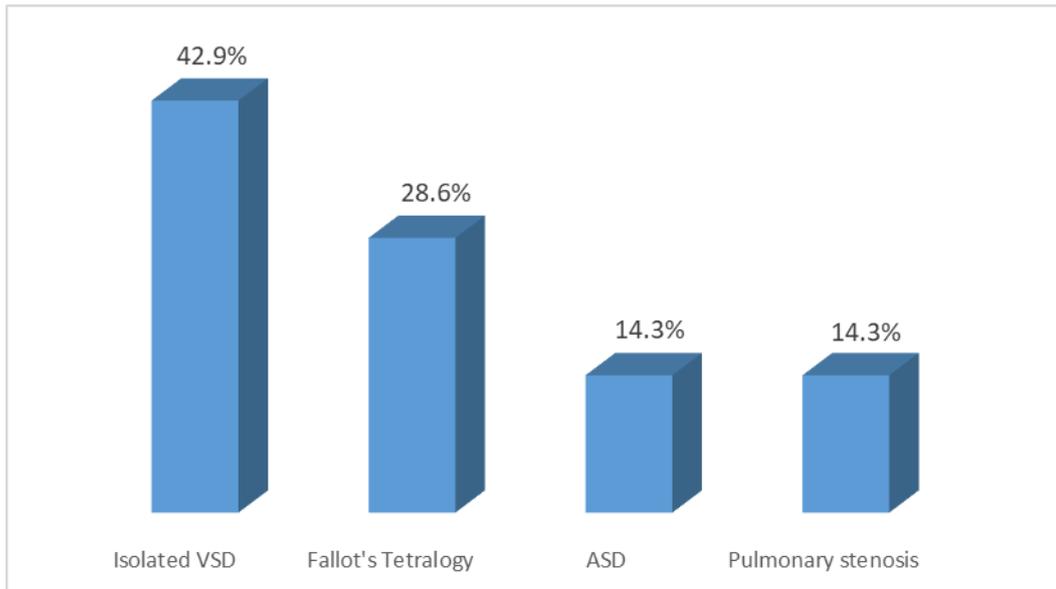


Figure 10: Associated cardiac defects in our case series

2.3. Preoperative tricuspid regurgitation assessment

The echocardiography exam also allowed the analysis of the tricuspid valve architecture looking for a pre-existing tricuspid regurgitation with the color-Doppler assessment providing the following scores:

- TR 0: No tricuspid regurgitation
- TR 1+: Trivial TR
- TR 2+: Mild TR
- TR 3+: Moderate TR
- TR 4+: Severe TR

In our case series:

- Seven (25%) patients had no tricuspid regurgitation
- Four (14.3%) patients had a trivial tricuspid regurgitation
- Thirteen (46.4%) patients had a mild tricuspid regurgitation
- Three (10.7%) patients had a moderate tricuspid regurgitation
- One (3.6%) patient had a severe tricuspid regurgitation caused by a tricuspid dysplasia.

Table VII: Distribution of our patients by the grade of preoperative TR

TR Grade	Number of patients	Percentage
TR 0	7	25%
TR 1+	4	14.3%
TR 2+	13	46.4%
TR 3+	3	10.7%
TR 4+	1	3.6%
Total	28	100 %

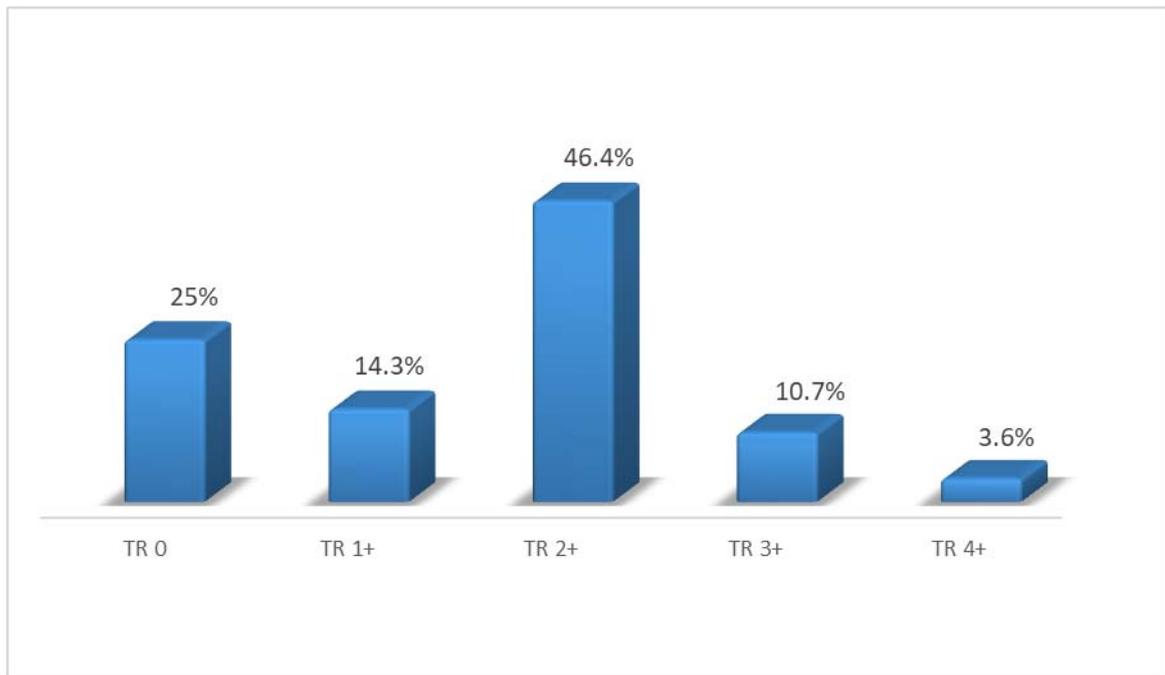


Figure 11: Distribution of our patients by the grade of preoperative TR

2.4. Pulmonary Hypertension

Another crucial element detected by the echocardiography was the pulmonary hypertension which is a decisive element while assessing the surgery indication.

A pulmonary artery systolic pressure > 35 mmHg is in favor of a pulmonary hypertension.

The pulmonary artery systolic pressure is estimated from both the measure of the pressure in the right atrium and the velocity of the tricuspid leak.

In our case series:

- Thirteen (46.4%) patients had a normal pulmonary artery systolic pressure (≤ 35 mmHg).
- Eight (28.6%) patients had a moderate pulmonary hypertension.
- Seven (25%) patients had a severe pulmonary hypertension.

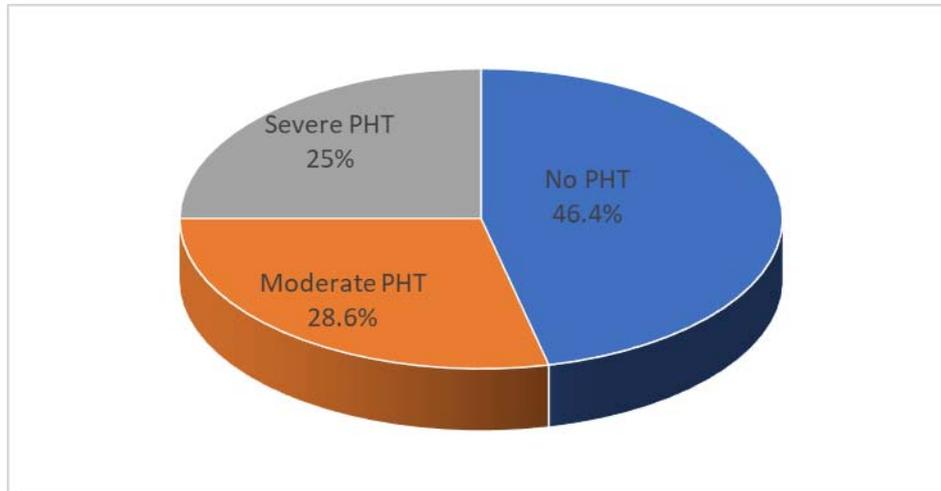


Figure 12: Distribution of pulmonary Hypertension in our case series

IV. SURGICAL TREATMENT

1. Intraoperative assessment

1.1. Type of VSD

The intraoperative assessment found the following types of VSDs:

- Twenty-one (75%) patients had a perimembranous VSD.
- Five (17.8%) patients had a conoventricular VSD.
- Two (7.2%) patients had a double VSD: both a muscular VSD and a perimembranous one.

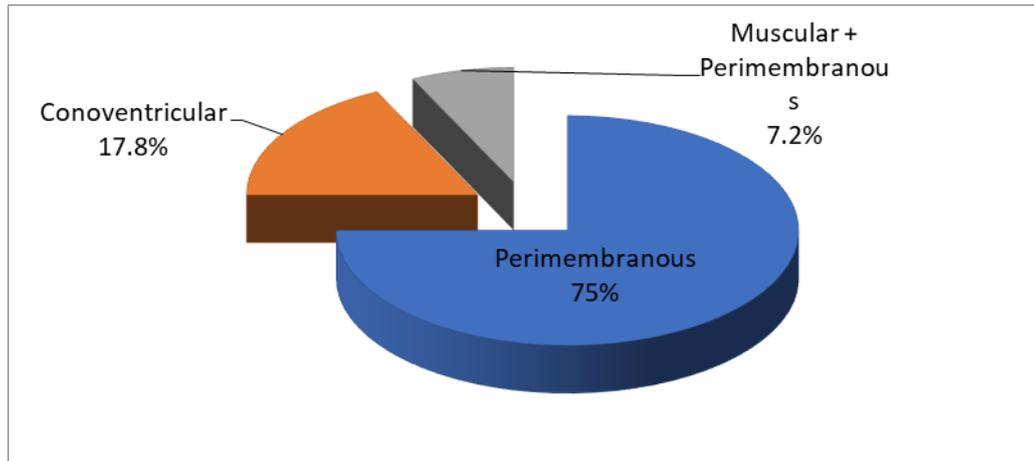


Figure 13: Intraoperative assessment of VSD Type in our study

1.2. Associated cardiac defects

The surgical exploration found the following associated cardiac defects as detailed in table 5.

Table VIII: Perioperative findings in our case series

Associated cardiac defects	Number of patients	Percentage
Atrial septal defect	9	32.1 %
Fallot's tetralogy	8	28.6 %
Pulmonary stenosis	4	14.3 %
Patent ductus arteriosus	2	7.1 %

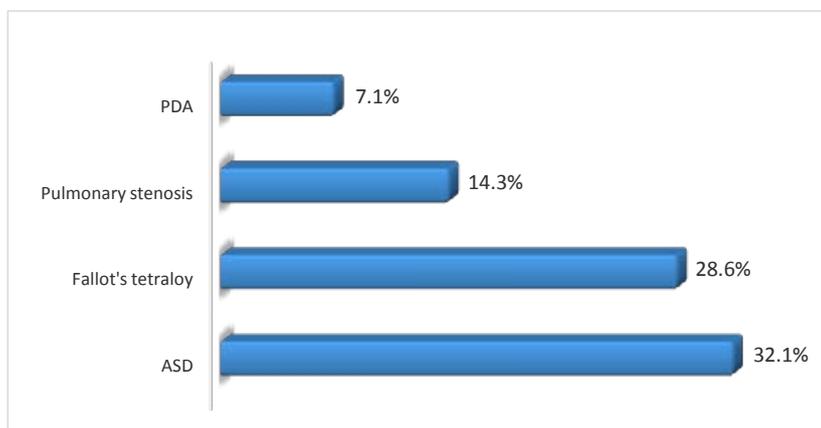


Figure 14: Perioperative findings in our case series

2. Surgical Procedures

2.1. Type of tricuspid valve detachment

A partial detachment of the tricuspid's septal leaflet was performed for 19 (67.9%) of our patients. For 2 (7.1%) patients it was the anterior leaflet that was partially detached. And 7 (25%) patients had a partial detachment of both the septal leaflet and a segment of the anterior one.

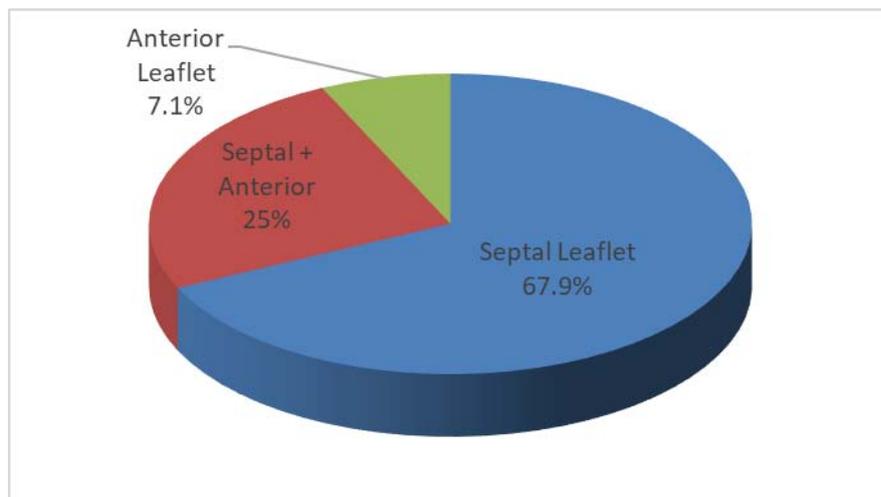


Figure 15: Type of TVD performed in our case series

2.2. Closure of the VSD

The VSD was closed using an autologous pericardium patch for 22 (78.6%) patients. A bovine pericardial patch was used for 4 (14.3%) patients and a synthetic one for 2 (7.1%) patients.

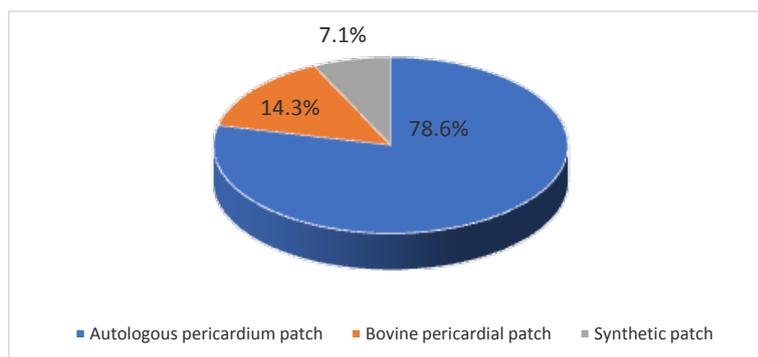


Figure 16: Type of patch used for the closure of the VSD in our case series

2.3. Additional procedures

The associated cardiac malformations in our patients generated additional surgical procedures to fix them.

- An atrial septal defect closure was performed for 9 (32.1%) patients.
- A patent ductus arteriosus ligation was performed for 2 (7.1%) patients.
- An infundibular stenosis resection was performed for 12 (42.9%) patients.
- A pulmonary artery enlargement was performed for 7 (25%) patients.
- A pulmonary commissurotomy was performed for 3 (10.7%) patients.

Table IX: Additional procedures in our case series

Procedure	Number of patients	Percentage
ASD closure	9	32.1 %
PDA ligation	2	7.1 %
Infundibular stenosis resection	12	42.9 %
Pulmonary artery enlargement	7	25 %
Pulmonary commissurotomy	3	10.7 %

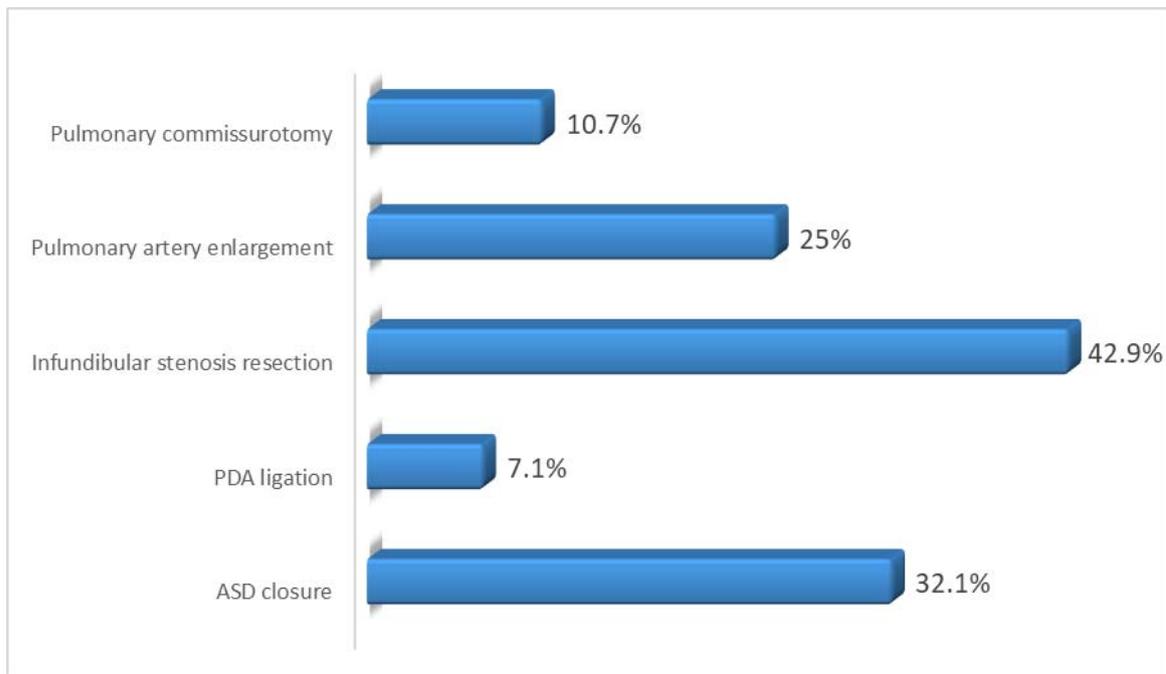


Figure 17: Additional procedures in our case series

2.4. Cardio-pulmonary bypass and aortic cross-clamp time

The mean cardiopulmonary bypass time was 111.25 min \pm 37.12 min with a minimum of 51 min and a maximum of 185 min.

The mean aortic cross-clamp time was 75.18 min \pm 27.67 min with a minimum of 42 min and a maximum of 142 min.

2.5. Tricuspid valve test

After the closure of the VSD and the following reattachment of the tricuspid valve, a tricuspid competence test was performed by filling the right ventricle with cold saline infusion. That was done in order to assess whether the valve is competent.

Twenty-five (89.3%) of our patients had no tricuspid leak while 3 (10.7%) patients had a trivial leak.

V. POSTOPERATIVE EVOLUTION

1. Immediate postoperative aftermath

1.1. Morbidity

During their ICU stay:

- Twenty (71.4%) patients did not suffer from any complication.
- Two (7.1%) patients developed sinus bradycardia in both cases that was managed by an electrostimulation. Neither of those patients required an implantation of a permanent pacemaker.
- One patient (3.6%) developed a sinus tachycardia that was managed by anti-arrhythmic drugs.
- Three (10.7%) patients suffered from infectious complications: 2 suffered from sepsis and one suffered from surgical-site infection. It was managed by antibiotics targeting the incriminated germ and vascular filling (for the sepsis).

- Four (17.9%) patients were subject to a postoperative hemorrhage that was managed by hemostatic agents and blood transfusion. No reoperation for massive and uncontrolled bleeding was required.

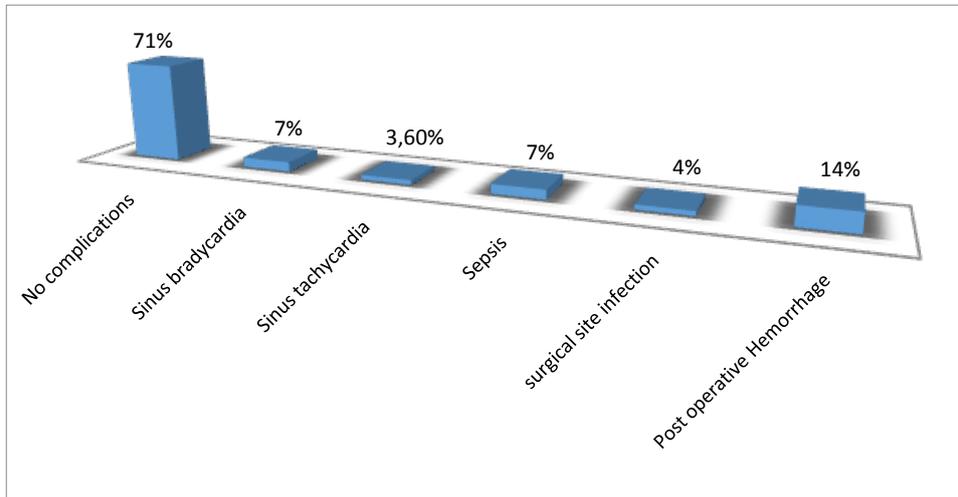


Figure 18: Surgery aftermath in our case series

1.2. Intubation time, ICU and hospital duration

In our case series, the mean intubation time was 4.57 ± 3.35 hours from a minimum of 1 hour to a maximum of 18 hours

The mean duration of ICU stay was 4.5 ± 2.6 days ranging from a minimum of 2 days to a maximum of 15 days.

The mean total hospital stay in our case series was 11 ± 4.25 days with a minimum of 7 days and a maximum of 22 days.

2. Postoperative assessment before discharge

2.1. Electrocardiogram

Before being discharged from the hospital, all patients had an electrocardiogram.

In our case series, all 28 (100%) patients had a regular sinus rhythm.

No atrioventricular block neither a transient nor a permanent one was recorded.

No Right bundle branch block neither complete nor incomplete was recorded as well.

2.2. Echocardiography

a. **Residual VSD**

The first key element analyzed by the echocardiography performed for all our patients before being discharged was whether or not they presented a residual ventricular septal defect.

And if it was the case to assess the following elements:

- The size of the eventual residual VSD.
- The importance of the residual left to right shunt.

That echocardiography found that:

- Twenty-two (78.6%) of our patients did not have a residual VSD.
- Six (21.4%) of our patients had a small, hemodynamically non-significant residual VSD.

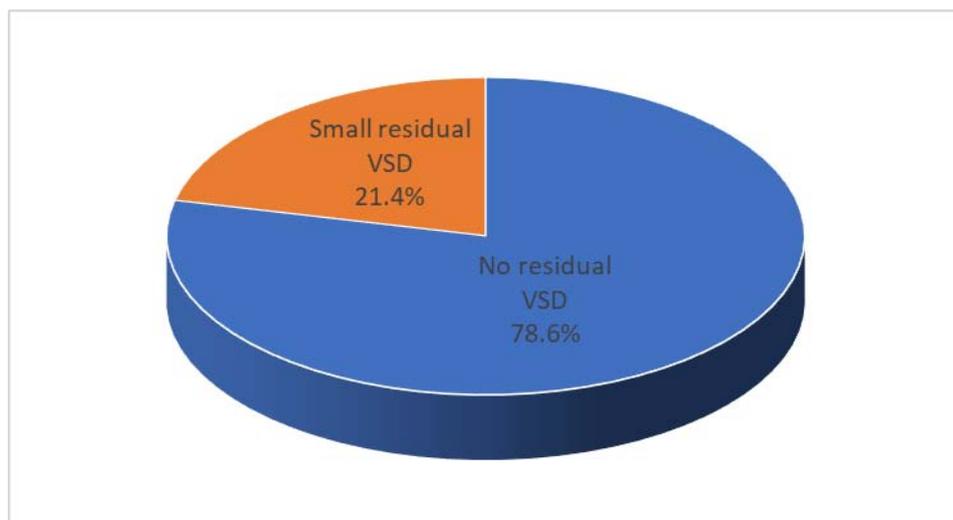


Figure 19: Occurrence of Residual VSD before discharge in our case series

b. Tricuspid Regurgitation

The analysis of the tricuspid valve is also of paramount importance in order to assert if there is not a tricuspid regurgitation induced by the procedure.

In our case series, the echocardiography found that:

- Nineteen (67.8%) patients had no tricuspid regurgitation.
- Eight (28.6%) patients had a trivial tricuspid regurgitation.
- One (3.6%) patient had a mild tricuspid regurgitation.

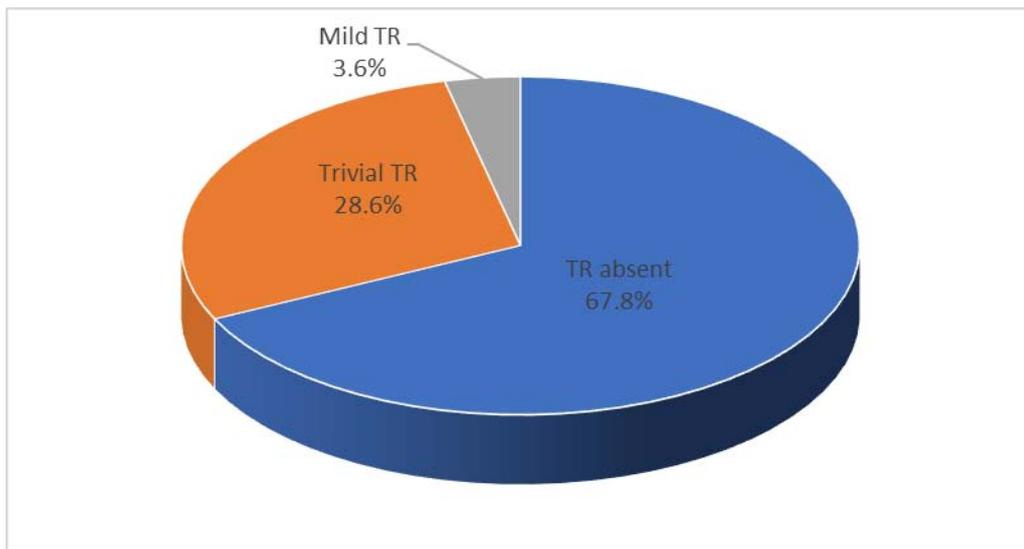


Figure 20: Occurrence of Tricuspid Regurgitation before discharge in our case series

c. Pulmonary hypertension

At the echocardiographic assessment before discharge:

All 28 (100%) patients had a normal (≤ 35 mmHg) pulmonary artery systolic pressure.

3. Postoperative assessment at 6 months follow-up

3.1. Electrocardiography

The electrocardiography performed after 6 months of follow-up found that:

- All 28 (100%) patients in our case series had a regular sinus rhythm.
- No AVB was recorded.
- No Right bundle branch block neither complete nor incomplete was recorded as well.

3.2. Echocardiography

a. Residual VSD

The echocardiography performed after 6 months of follow-up found that:

- Twenty-four (85.7%) of our patients did not have a residual VSD.
- Four (14.3%) of our patients had a small, hemodynamically non-significant residual VSD.

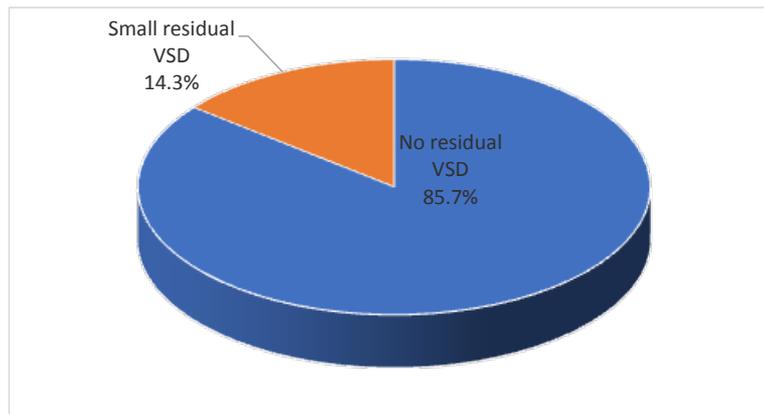


Figure 21: Occurrence of Residual VSD at 6 months follow up in our case series

b. Tricuspid Regurgitation

The analysis of the tricuspid valve by the echocardiography performed after 6 months follow-up found that:

- Twenty-four (85.7%) patients did not have tricuspid regurgitation.
- Two (7.1%) patients had a trivial tricuspid regurgitation.
- Two (7.1%) patients had a mild tricuspid regurgitation.

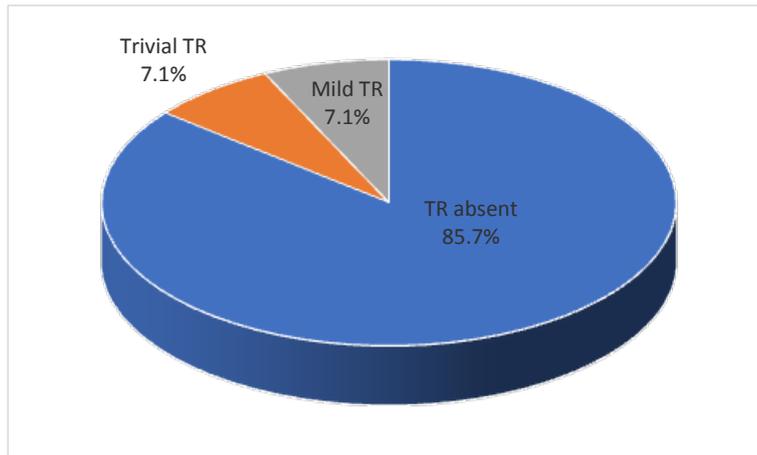


Figure 22: Occurrence of Tricuspid Regurgitation at 6 months follow up in our case series

c. Pulmonary hypertension

At the echocardiographic assessment after 6 months follow up:

All 28 (100%) patients had a normal (≤ 35 mmHg) pulmonary artery systolic pressure.

4. Long term follow-up assessment

The mean follow-up period in our study is 4.4 ± 2.5 years, with a minimum of 6 months follow up to a maximum of 8 years of follow-up.

4.1. Electrocardiogram

The electrocardiography performed at a mean follow-up of 4.4 years found that:

- All 28 (100%) patients in our case series had a regular sinus rhythm.
- No AVB was recorded.
- No Right bundle block neither complete nor incomplete was recorded as well.

4.2. Echocardiography

a. **Residual VSD**

The echocardiography performed at a mean follow-up of 4.4 years found that:

- Twenty-four (85.7%) patients did not have a residual VSD.
- Three (10.7%) patients had a small, hemodynamically non-significant residual VSD.
- One (3.6%) patient had a large VSD that required a reoperation.

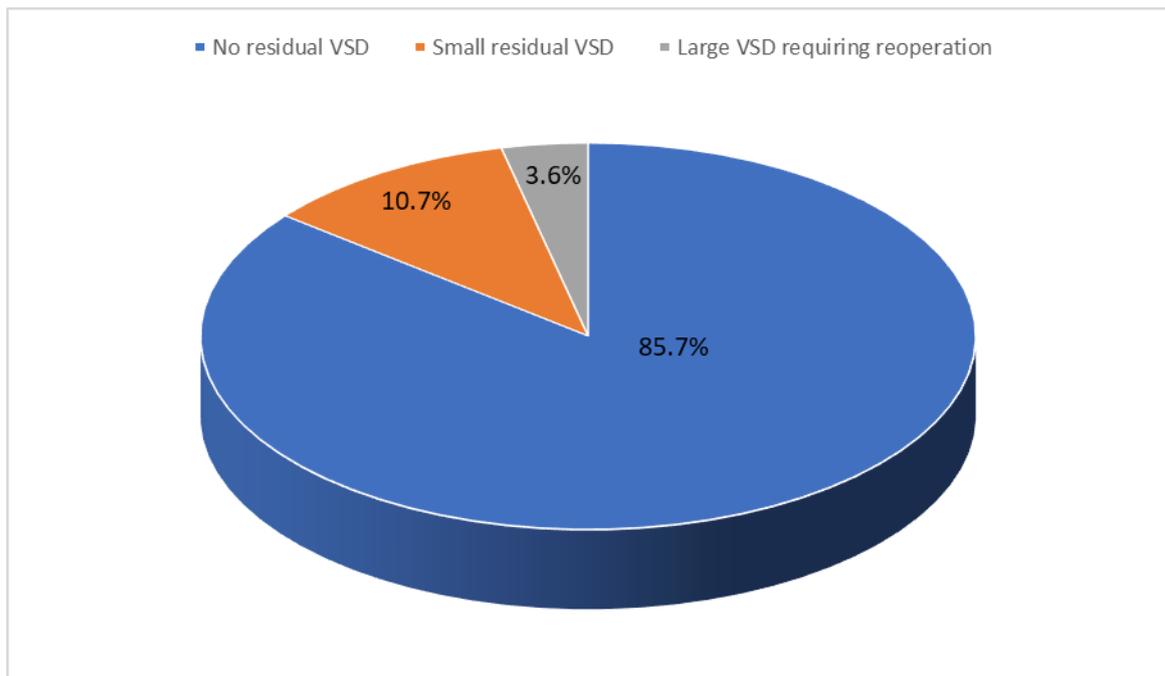


Figure 23: Occurrence of Residual VSD at long term follow up in our case series

b. **Tricuspid Regurgitation**

The tricuspid valve analysis during the echocardiography performed at a mean follow-up of 4.4 years found that:

- Twenty-five (89.3%) patients did not have a tricuspid regurgitation.
- Two (7.1%) patients had a trivial tricuspid regurgitation.
- One (3.6%) patient had a mild tricuspid regurgitation.

None of our patients had a tricuspid stenosis at the long-term follow-up echocardiogram.

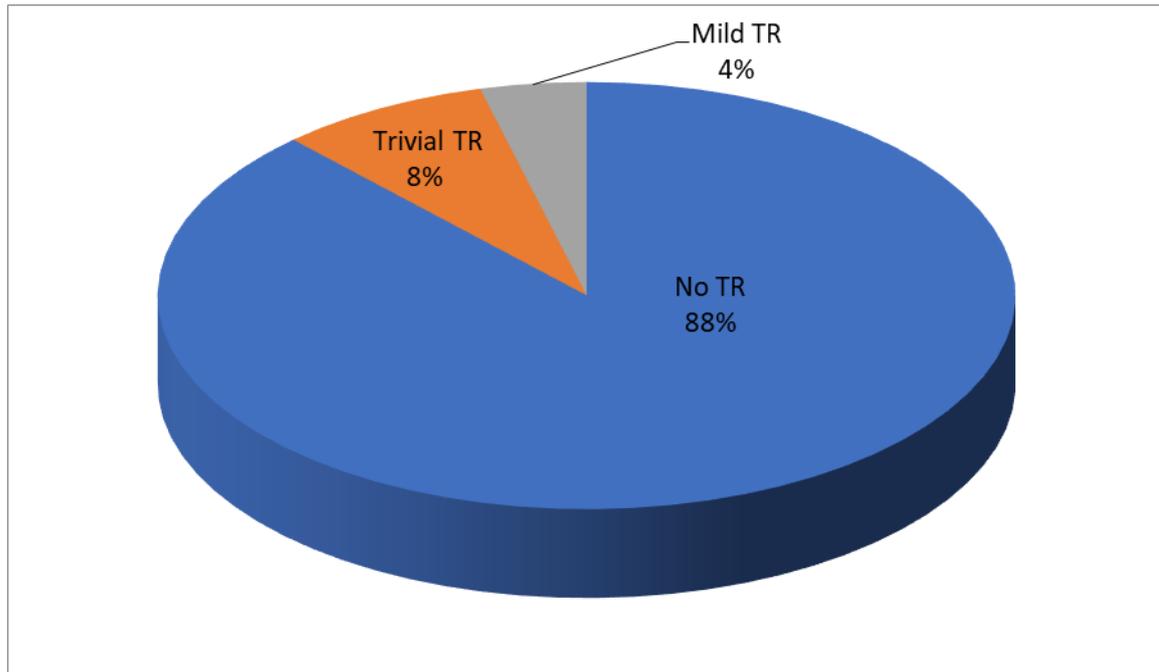


Figure 24: Occurrence of Tricuspid Regurgitation at long term follow up in our case series

c. Pulmonary hypertension

At the echocardiographic assessment for long term follow up:

All 28 (100%) patients had a normal (≤ 35 mmHg) pulmonary artery systolic pressure.



DISCUSSION



The ventricular septal defect is a congenital malformation where there is a defect in the interventricular septum of the heart.

According to the Anderson anatomic classification [9], VSDs are divided in 3 groups in regards of their respective position in the interventricular septum (Figure 25):

- Perimembranous VSDs: Due to a deficiency of the membranous septum, with an extension towards the inlet, either central trabecular or outlet portions of the septum.
- Muscular VSDs: they are totally surrounded by muscular tissue. They can be located in any portion of the septum. There are three main types of muscular VSDs: inlet VSDs, central trabecular VSDs and infundibular VSDs. They can be single or multiple in which case they constitute a “swiss cheese” type of muscular VSDs.
- Juxta-arterial defects: where there is a fibrous continuity between the aortic and pulmonary valves.

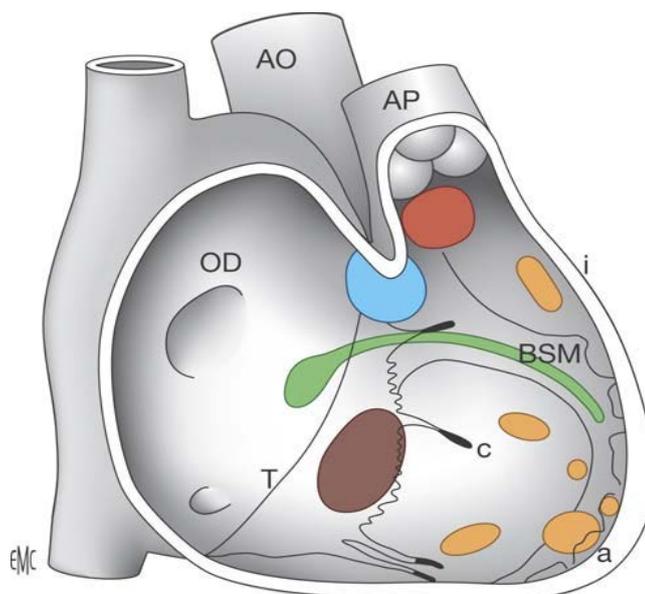


Figure 25: Picture of the interventricular septum seen from the right ventricle [10].

Red: Juxta-arterial VSD. Blue: Perimembranous VSD. Brown: inlet VSD.

Orange: Infundibular VSD (i), central trabecular (c), apical (a), apical (a). Green: AV node and Bundle of His.

During the first year of life, approximately 85 to 90 % of small, isolated and mostly muscular VSDs close spontaneously [7].

However, in case a spontaneous closure does not occur and in the presence of a large (>7mm) and hemodynamically significant VSD, a surgical or a percutaneous closure intervention must be performed.

The trans-catheter closure, when the anatomy of the VSD is favourable, is reserved for those in whom surgery is very risky due to severe pulmonary artery hypertension, multiple comorbidities and those with residual or recurrent VSDs after surgical closure. [8]

Complete surgical repair of the defect by patch closure is by far the most common approach.

Nonetheless, the differing anatomical variants require different surgical approaches. Thus, three surgical approaches are possible:

- Via a right atriotomy: the gold standard surgical approach for closure of perimembranous and muscular VSDs.
- Via a right ventriculotomy: mostly used for patients for whom the VSD is a component of the Fallot's tetralogy when there will be a need to perform a pulmonary artery enlargement as well.
- Via the main pulmonary artery or the aorta: for juxta-arterial defects.

For all patients in our study, a right atriotomy was performed because:

- It generates less scarring than a ventriculotomy.
- It sensibly decreases the risk of complete right bundle branch block.
- It preserves the right ventricular function.

After the right atriotomy is performed, a gentle traction of the anterosuperior leaflet helps exposing the rims of the defect.

However, in some circumstances the presence of thick, tight TV chordae or an aneurysm of the TV conceals the rims of the defect (Figure 26).



Figure 26: Perimembranous VSD with chordae attachments obscuring its rims [11].

Hence, an inadequate exposure disallowing an optimal closure of the defect and then carrying the risk of damage to the conduction system and residual VSD if the surgery is undertaken without addressing that issue.

Moreover, in case of outlet extension of the VSD in an upper position, exerting too much traction on the TV will result in the distortion of the TV with chordae elongation, hence generating a tricuspid regurgitation.

In front of all those situations, surgeons perform a partial detachment of the septal leaflet extended or not to the anterior one (Figure 27).

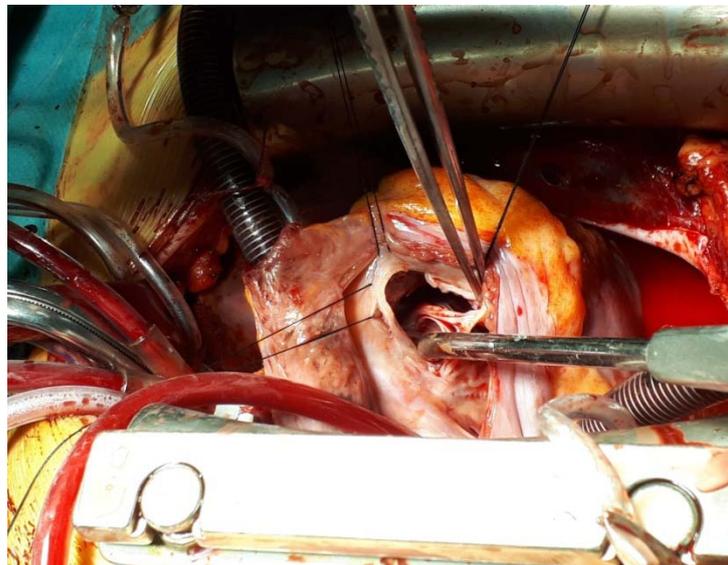


Figure 27: Partial detachment of the septal leaflet extended to the anterior leaflet/
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The partial detachment of the TV provides both an optimal exposure of the VSD margins and prevent from exerting too much tension on the TV.

The partial detachment of the TV will allow an optimal closure of the defect, prevent the tricuspid regurgitation, and complete heart block [12].

New variants to this technique have been developed:

- A radial incision of the septal leaflet
- A detachment of the chordae from their septal attachments and flipping them over.

Despite numerous studies in favour of the safety and effectiveness of this method, there are still surgeons restraining themselves from using it [5].

We undertook this study to assess the outcomes of patients who underwent VSD closure using tricuspid valve detachment by mainly focusing on the following elements:

- The frequency of residual VSDs.
- The frequency and severity of the tricuspid regurgitation at long-term.
- The occurrence of complete atrio-ventricular blocks.

I. AGE AND GENDER

1. AGE

The average age in our series was 5.8 ± 4.88 years old ranging from 9 months to 21 years old.

It was closer to the series of ZHAO et al (13) and sensibly higher than the series of authors such as SASSON et al (14), LUCCHESI et al (15), BILEN et al (16).

While the age of the study population of RIAZ (17) series was much higher than in our study.

The age of our population study was sensibly higher than in most studies which were undertaken in western developed countries where the diagnosis of congenital heart malformations is achieved much earlier (in some cases in antenatal); hence allowing an early management in specialised paediatric cardiac surgery centers.

Table X: Age of patients (Literature review)

AUTHORS	YEAR OF PUBLICATION	COUNTRY	Mean Age \pm SD (years)
BILEN et al (16)	2020	TURKEY	1.92 \pm 1.83
LUCCHESE et al (15)	2016	ITALY	1.28 \pm 1.01
SASSON et al (14)	2006	ISRAEL	3.36 \pm 3.2
ZHAO et al (13)	2003	CHINA	4.6 \pm 1.5
RIAZ et al (17)	2017	PAKISTAN	13.38 \pm 6.91
OUR CASE SERIES	2021	MOROCCO	5.8 \pm 4.88

2. GENDER

In our study; 64.3% of our patients were male with a 1.77 sex ratio.

However, there is no gender predominance regarding the occurrence of VSDs [10]. Therefore, the male larger population in our study is entirely fortuitous.

That male predominance was also found in the studies of Fraser et al (18), Pourmoghadam et al (19), and Lucchese et al (15) whereas Bilen et al (16) study found a female predominance.

Table XI: Gender distribution of patients (Literature review)

AUTHORS	YEAR OF PUBLICATION	COUNTRY	SEX RATIO M/F
BILEN et al (16)	2020	TURKEY	0.69
FRASER et al (18)	2018	USA	1.51
POURMOGHADAM et al (19)	2018	USA	1.41
LUCCHESE et al (15)	2016	ITALY	1.52
OUR CASE SERIES	2021	MOROCCO	1.77

II. TYPE OF VSD

75% of our patients were suffering from a perimembranous VSD. Other authors such as Russell et al (4), Weymann et al (20), Giordano et al (21) and Bang et al (22) also found that the majority of the patients in their respective series were admitted for a perimembranous VSDs closure.

This is explained by the fact that perimembranous VSDs account for around 20 to 35 % of the total VSD but make up the vast majority of VSDs requiring a surgical closure [10].

The reason behind that fact is the very low potential of perimembranous VSDs to close spontaneously particularly in case of moderate to large ones [10].

Moreover, the perimembranous VSDs are located between the septal part of the tricuspid annulus and the insertion of the papillary muscle of the tricuspid valve (see Figure 25).

Table XII: Percentage of patients with perimembranous VSD

AUTHORS	YEAR OF PUBLICATION	COUNTRY	PERIMEMBRANOUS VSD %
GIORDANO et al (21)	2018	ITALY	87.6 %
BANG JH et al (22)	2016	SOUTH KOREA	95.9 %
WEYMANN et al (20)	2013	GERMANY	90 %
RUSSELL et al (4)	2011	USA	98.3 %
OUR CASE SERIES	2021	MOROCCO	75 %

III. CARDIOPULMONARY BYPASS AND AORTIC CROSS-CLAMP TIME

There have been concerns that TVD increases significantly the CPB time but that remains a controversial issue. Temporary TVD may decrease the operation time by easing the placing and suturing process of the patch. However, this technique requires additional CPB time for the reattachment of the septal (and/or anterior) leaflet of the tricuspid valve.

Nonetheless, in our context, the TV reattachment was performed using the same continuous suture of the patch placed as a “sandwich” between the annulus and the detached leaflet. That process spared operative time.

The mean CPB time in our study was 111.25 ± 37.12 min and the mean aortic cross clamp time was 75.18 ± 27.67 min.

The cross-clamp time in our study was higher than in the literature since we included in our study patients for whom the VSD was a component of Fallot’s tetralogy. Those patients will require additional heavy surgical procedures such as the pulmonary artery enlargement, the infundibular resection, and the pulmonary commissurotomy.

Table XIII: Mean CPB time in various studies

AUTHORS	YEAR OF PUBLICATION	COUNTRY	MEAN Cross-Clamp TIME \pm SD (min)
POURMOGHADAM et al (19)	2018	USA	73 \pm 20
GIORDANO et al (21)	2018	ITALY	63 \pm 9
RIAZ et al (17)	2017	PAKISTAN	67.91 \pm 27.3
BANG JH et al (22)	2016	SOUTH KOREA	60.0 \pm 22.1
WEYMANN et al (20)	2013	GERMANY	50.7 \pm 12.1
OUR CASE SERIES	2021	MOROCCO	75.18 \pm 27.67

IV. RESIDUAL VSD

The TVD technique provides an optimal exposure of all the VSD margins, which will allow a complete and easy repair.

Indeed, temporary TVD provides a clear view of the edges between the conal septum, the aortic annulus and the ventriculo–infundibular fold, thus minimizing the incidence of residual defects [16]. The temporary TVD also allows a more accurate suture placement, especially in case of multiple chordal attachments crossing over the VSD and inserted at the edge of the defect.

It is very crucial to achieve that complete repair in order to avoid residual defects. Residual hemodynamically significant defects generate severe complications impacting morbidity and mortality such as low cardiac output, pulmonary hypertensive crisis, and infectious endocarditis associated with the risks of the subsequent reoperation.

In our study, at a mean follow-up of 4.4 years: 4(14.3%) patients had a residual VSD. 1(3.6%) patient had a large residual VSD that required a reoperation. The other 3(10.7%) patients had small, hemodynamically meaningless residual defects.

Our results are similar to those reported in published international studies where most authors reported no residual VSD or small hemodynamically meaningless one after surgical closure of VSDs with the TVD technique.

Table XIV: Percentage of patients with no residual VSD and small, non-significant one

AUTHORS	YEAR OF PUBLICATION	COUNTRY	% OF PATIENTS WITH NO RESIDUAL VSD AND SMALL, NON-SIGNIFICANT ONE
BILEN et al (16)	2020	TURKEY	100 %
POURMOGHADAM et al (19)	2018	USA	100 %
FRASER et al (18)	2018	USA	97.6 %
BANG JH et al (22)	2016	SOUTH KOREA	98 %
WEYMANN et al (20)	2013	GERMANY	100 %
OUR CASE SERIES	2021	MOROCCO	96.4 %

Moreover, Russell et al (4), Aeba et al (23), and Gaynor et al (7) included in their series patients with residual VSDs after a first surgery performed without TVD. Their respective reoperation was carried out with TVD and provided a successful and definitive closure.

V. TRICUSPID REGURGITATION

There have been concerns about the function of the tricuspid valve after temporary detachment of the septal leaflet extended or not to the anterior one. Those concerns are the following:

- Tricuspid regurgitation induced by the procedure
- Growth impairment after the reattachment that generates tricuspid stenosis.

However, it is the other way round: the partial detachment of the tricuspid valve not only provides an optimal exposure of the VSDs margins, but it also allows the preservation of the architecture of the tricuspid valve (one of the major goals of the partial TVD). This assertion is based on the fact that when the VSD is located in an upper position with an outlet extension, it requires exerting a severe traction on the tricuspid valve to improve the exposure which will lead to the distortion and elongation of the chordae of the tricuspid valve.

In our case series, the TVD provided good results since 25 (89.3%) of our patients had no tricuspid regurgitation, 2 (7.1%) patients had a trivial TR and 1 (3.6%) patient had a mild TR. No patient developed more than mild TR at a mean follow-up of 4.4 years.

Our results corroborate most studies on this issue even in series with much younger patients.

Bilen et al (16) determined with a mean follow-up of 36.38 months that 88% of their 50 patients in the TVD group had none or trivial TR while 12 % had a mild TR. With a series of 26 patients in the TVD group, Pourmoghadam et al (19) also found with a median follow-up of 2.2 years that 64 % had no TR while the remaining 36 % had a trivial to mild TR. With a larger series of 83 patients in the TVD group, Fraser et al (18) determined with a median follow-up of 4.4 years that 7 (8.4 %) patients had no TR, 75 (90.4%) patients had a trivial to mild TR and 1 (1.2%) patient had a moderate TR.

Table XV: Percentage of patients with more than mild TR (Literature review)

AUTHORS	YEAR OF PUBLICATION	COUNTRY	NUMBER OF PATIENTS IN THE TVD GROUP	MEAN / MEDIAN AGE (months)	% OF PATIENTS WITH MORE THAN MILD TR (TR 2+)
BILEN et al (16)	2020	TURKEY	50	23.26	0 %
FRASER et al (18)	2018	USA	83	7.56	1.2 %
POURMOGHADAM et al (19)	2018	USA	26	6.77	0 %
BANG JH et al (22)	2016	SOUTH KOREA	49	1.97	2 %
WEYMANN et al (20)	2013	GERMANY	20	6	0 %
OUR CASE SERIES	2021	MOROCCO	28	60	0 %

In our case series, the tricuspid function was even improved after surgery (Figure 28). This is explained by the disappearance of pulmonary hypertension after the closure of the VSD, the associated tricuspid plasty performed in some cases and the decrease of the annulus diameter induced by the procedure.

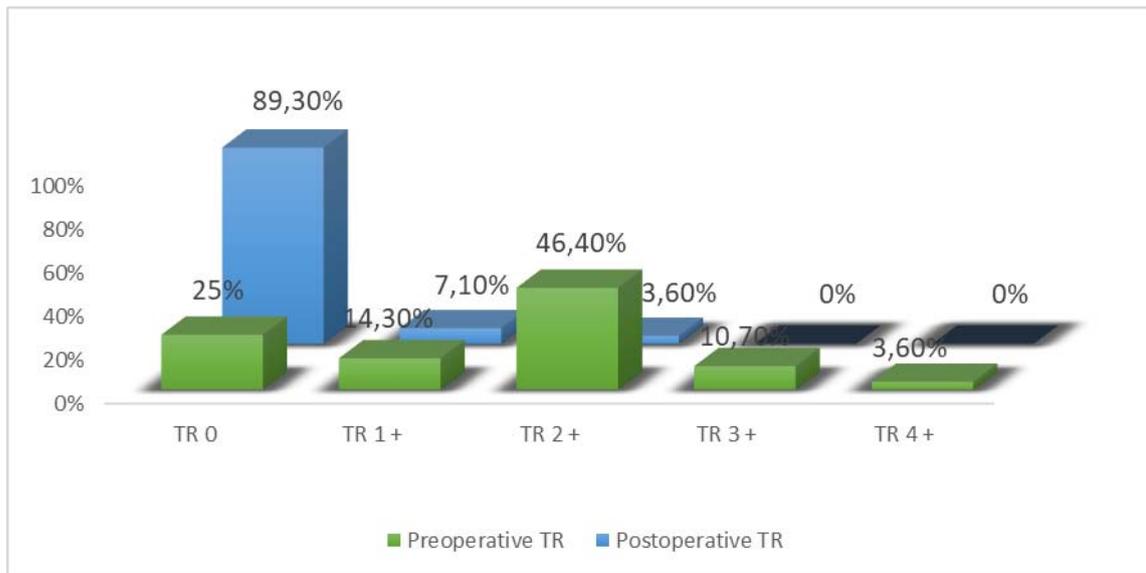


Figure 28: Comparison between the levels of preoperative and postoperative TR

No tricuspid valve stenosis was recorded neither in our study at the long-term follow-up nor in the literature. Hence, we can conclude that it is a more subjective fear than an actual cause of concern.

VI. COMPLETE HEART BLOCK

During surgical closure of perimembranous and inlet VSDs, the proximity of the conduction system with the risk of damaging it is an important source of concern for the surgeons.

However, complete heart block is a rare but very serious complication. Andersen et al. undertook a study with a large cohort of 2079 patients who were operated for VSD closure and reported an incidence of third-degree atrioventricular block less than 1% (23).

In our series, we did not report any complete heart block in any of our patients. Only 2 (7.1%) patients suffered from heart arrhythmia (sinus bradycardia) that did not require permanent pacemaker.

Our results are similar to those found in other studies. Pourmoghadam et al (19), Bang et al (22), Lucchese et al. (15), Weymann et al (20) did not report any complete heart block requiring permanent pacemaker implantation in their studies neither.

Table XVI: Number of patients with complete heart block

AUTHORS	YEAR OF PUBLICATION	COUNTRY	NUMBER OF PATIENTS IN THE TVD GROUP	NUMBER OF PATIENTS WITH COMPLETE HEART BLOCK
POURMOGHADAM et al (19)	2018	USA	26	None
FRASER et al (18)	2018	USA	83	None
BANG JH et al (22)	2016	SOUTH KOREA	49	None
LUCCHESE et al (15)	2016	ITALY	68	None
WEYMANN et al (20)	2013	GERMANY	20	None
OUR CASE SERIES	2021	MOROCCO	28	None

VII. LIMITATIONS OF OUR STUDY

Our study proved the long-term positive outcomes of patients who underwent partial detachment of the tricuspid valve during the surgical closure of their VSDs.

Nevertheless, our study had some limitations that limited the power of our study:

- The retrospective design: in evidence-based medicine, the benefits and disadvantages of a treatment are best assessed with prospective double-blinded studies.

Those kinds of studies are very hard to undertake since the decision to perform or not the detachment is made intraoperatively by the surgeon. It would be very difficult to determine before surgical intervention the patients in need of a TVD and even more challenging to randomize them.

- The small number of patients in our study that do not allow us to draw a definitive conclusion on this issue.
- The absence of a comparison groups of patients who underwent VSD closure without TVD.



CONCLUSION



This is a retrospective, single center and descriptive study of the data of 28 patients who underwent surgery for VSD closure spanning on a period of 10 years from July 2010 to August 2020.

The aim of this study was to assess the long-term outcomes of the TVD on patients who underwent a surgical closure of their VSDs.

The use of the TVD did not result in an increased postoperative morbidity since there was neither any death nor acute complications.

In our study, the use of the TVD produced a definitive closure for all our patients except for one.

At the long-term follow-up, the long-term function of the tricuspid valve was not compromised since none of our patients had more than mild tricuspid regurgitation.

No AV block was recorded neither in postoperative care nor at the long-term follow-up.

Hence, the TVD is an effective method for VSD closure since it allows an optimal closure of the VSD by reliably enhancing the exposure of the VSD rims. Therefore, avoiding the dangerous risk of residual VSD.

The TVD is also a safe method for VSD closure since it prevents both the distortion of the tricuspid valve and the damage to the conduction system.

Our overall results corroborate those found in international published series regarding this issue.

Therefore, we recommend the use of this valuable technique whenever indications for it arise during VSD surgical closure.

Nevertheless, the limitations of our study require further large, multi-center, randomized controlled studies to uproot all concerns about this method once and for all.



ANNEX



Patient's information sheet

THESIS: 'OUTCOME FOLLOWING THE TRICUSPID VALVE DETACHMENT FOR VENTRICULAR SEPTAL DEFECTS CLOSURE'

I. Presurgical assessment

1. Patient's identity:

– Patient's name and surname:

– Age:

– Gender:

M

F

2. Case History

– Recurrent respiratory infections: YES NO

– Pulmonary artery banding: YES NO

– Pediatrics Hospitalizations: YES NO

3. Functional symptoms

– Breastfeeding tiredness: YES NO

– Dyspnea: YES (class I II III IV) NO

– Height-weight growth delay: YES NO

4. Physical symptoms

– Weight (kg):

– Heart rate: Normal Tachycardia

– Cyanosis: YES NO

– Heart murmur: YES (type/location) NO

– Global or right heart failure syndrome: YES NO

5. Paraclinical data

5.1. Electrocardiogram:

– NSR (normal sinus rhythm) YES NO

– RV Hypertrophy: YES NO

– LV Hypertrophy: YES NO

– Right bundle branch block: YES (Complete/Incomplete) NO

5.2. Echocardiography:

– VSD: Number: Type Size:

– Isolated: YES NO

- If not, other cardiac congenital anomalies associated with the VSD:

Fallot Tetralogy	Pulmonary stenosis	PDA (patent ductus arteriosus)
ASD		
- Preoperative TR: TR 0 TR 1+ TR 2+ TR 3+ TR 4+
- Pulmonary artery pressure: Normal Pulmonary hypertension
- In case of pulmonary hypertension: moderate severe fixed

II. Surgical treatment:

1. Intraoperative assessment:

- VSD: Number: Type: Size:
- Isolated: YES NO
- If not, other cardiac congenital anomalies associated with the VSD:

Tetralogy of Fallot (TOF)	Pulmonary stenosis
PDA (patent ductus arteriosus)	ASD

2. Surgical procedures:

- Tricuspid valve detachment: Septal Leaflet Anterior Leaflet
- Patch used for the VSD closure: Autologous pericardium Synthetic Biologic
- Additional procedures:
 - Infundibular stenosis resection: YES NO
 - Pulmonary commissurotomy: YES NO
 - Pulmonary artery enlargement: YES NO
 - ASD closure: YES NO
 - Patent ductus arteriosus ligation: YES NO
- Cardiopulmonary bypass time (min):
- Aortic cross-clamp time (min):
- Tricuspid test at the end of the intervention: Tricuspid valve not leaking Tricuspid leak
 - In case of tricuspid leak: Trivial leak Mild leak Moderate leak

III. Postoperative Evolution

1. Immediate postoperative aftermath:

- Surgery Aftermath: Simple Complications
 - Types of complications: Death AVB Heart Arrhythmia
 - Infectious complications Bleeding Hemodynamic disorders
- Intubation time (hours):
- Intensive care unit stay (days):
- Hospitalization stay (days):

2. Postoperative assessment before discharge:

2.1. Electrocardiogram:

–NSR (normal sinus rhythm):	YES	NO
–AVB :	YES	NO
• If yes, the AVB is:	Transient	Permanent (Pacemaker placed)
–Right bundle block:	YES (Complete/incomplete)	NO

2.2. Echocardiography:

–Residual VSD:	YES	NO		
• If Yes:	Small	Medium	Large, requiring reoperation	
–Tricuspid Insufficiency:	YES	NO		
• If Yes:	Trivial	Mild	Moderate	Severe
–Pulmonary hypertension:	YES	NO		
• If Yes:	Mild	Moderate	Severe	

3. Postoperative assessment at 6 months:

3.1. Electrocardiogram:

–NSR (normal sinus rhythm):	YES	NO
–AVB :	YES	NO
• If yes, the AVB is:	Transient	Permanent (Pacemaker placed)
–Right bundle block:	YES (Complete/incomplete)	NO

3.2. Echocardiography:

–Residual VSD:	YES	NO		
• If Yes:	Small	Medium	Large, requiring reoperation	
–Tricuspid Regurgitation:	YES	NO		
• If Yes:	Trivial	Mild	Moderate	Severe
–Pulmonary hypertension:	YES	NO		
• If Yes:	Mild	Moderate	Severe	

4. Long term follow-up:

–Time lapse between Surgery and latest follow up (Years):

4.1. Electrocardiogram:

–NSR (normal sinus rhythm):	YES	NO
–AVB:	YES	NO
• If yes, the AVB is:	Transient	Permanent (Pacemaker placed)
–Right bundle block:	YES (Complete/incomplete)	NO

4.2. Echocardiography:

- Residual VSD: YES NO
 - If Yes: Small Medium Large, requiring reoperation
- Tricuspid Regurgitation: YES NO
 - If Yes: Trivial Mild Moderate Severe
- Pulmonary hypertension: YES NO
 - If Yes: Mild Moderate Severe



ABSTRACTS



Abstract

Introduction: the ventricular septal defect is a congenital malformation where there is a defect in the interventricular septum of the heart. During the surgical treatment, a right atriotomy approach is the gold standard. However, in some cases the chordae attachments conceal the margins of the VSD or the VSD has an outlet extension in an upper position.

Therefore, a partial TVD is performed to allow both an optimal exposure of the VSD and avoid a distortion of the TV or conduction tissue injury.

The purpose of this endeavour is to assess the long-term outcomes of the patients who underwent surgery for VSD closure of their VSDs with a partial TVD by mainly focusing on the following elements: the frequency of residual VSDs, the frequency and severity of the TR at long-term and the occurrence of complete AVB.

Patients and Methods: we undertook a retrospective, single center and descriptive study of the data of 28 patients who underwent surgery for VSD closure spanning on a period of 10 years from July 2010 to August 2020 in the cardiovascular surgery department at the University hospital Mohammed VI. The patients were followed-up at 1, 3, 6 and 12 months and annually up to 8 years postoperatively. The collected data was recorded using Microsoft Excel 2010 and analysed using SPSS 21.0 version.

Results: the mean age was 5.8 ± 4.88 years with a 1.77 sex ratio. In addition, 21 (75%) patients had a perimembranous VSD and the mean VSD diameter was 11.38 ± 4.83 mm. The VSD was isolated for 12 (42.8%) patients, a component of the Fallot's tetralogy for 8 (28.6%) patients, associated with an ASD for 4 (14.3%) patients and with a pulmonary stenosis for 4 (14.3%) patients. The autologous pericardium patch was used for closing the VSD for 22 (78.6%) patients. There was neither any death nor a complete heart block recorded during ICU or hospital stay after surgery. And no severe TR was recorded before discharge.

At a mean follow-up of 4.4 ± 2.5 years: no AVB was found, 24 (85.7%) patients did not have a residual VSD while 3 (10.7%) had a small, hemodynamically meaningless one and 1(3.6%) patient had a large residual VSD requiring reoperation. In addition, 25 (89.3%) patients did not have a TR, 2 (7.1%) patients had a trivial TR (TR1+) and 1(3.6%) patient had a mild TR (TR2+).

Conclusion: Our results are in accordance with the literature. We recommend this technique for the surgical closure of the VSD as we have seen that it provides good results in regards to the optimal and definitive closure of the VSD without an increased risk of neither severe TR nor damage to the conduction tissue.

Résumé

Introduction : La communication interventriculaire est une malformation congénitale caractérisée par la présence d'un défaut dans le septum interventriculaire du cœur. Lors du traitement chirurgical, l'atriotomie droite est la voie d'abord de référence. Néanmoins, dans certains cas les bords de la CIV sont masqués par l'insertion des cordages ou la CIV a une extension infundibulaire dans la partie supérieure du septum.

D'où le besoin d'avoir recours au détachement partiel de la valve tricuspide afin de garantir une meilleure exposition de la CIV mais aussi pour éviter d'endommager la valve tricuspide ou de léser le tissu de conduction.

Le but de ce travail est d'évaluer les résultats à long terme de la désinsertion de la valve tricuspide chez des patients opérés pour fermeture de CIV avec un détachement partiel de la valve tricuspide en se focalisant surtout sur les éléments suivants : la fréquence des CIV résiduelles, la fréquence de l'insuffisance tricuspide à long terme ainsi que la fréquence des blocs auriculo-ventriculaires.

Matériels et méthodes : il s'agit d'une étude rétrospective, monocentrée, et descriptive des données de 28 patients opérés pour fermeture de CIV sur une période de 10 ans allant de Juillet 2010 à Août 2020 dans le service de chirurgie cardiovasculaire du CHU Mohammed VI. Les patients ont été revus à 1, 3, 6 et 12 mois post-opératoires puis annuellement jusqu'à 8 ans. Les données collectées ont été enregistrées sur Microsoft Excel 2010 puis analysées avec le logiciel SPSS version 21.0.

Résultats : l'âge moyen était de $5,8 \pm 4,88$ ans avec un sex-ratio de 1,77. Aussi, 21 (75%) patients avaient une CIV périmembraneuse avec une taille moyenne de la CIV de $11,38 \pm 4,83$ mm. La CIV était isolée chez 12 (42,8%) patients, était une composante d'une tétralogie de Fallot chez 8 (28,6%) patients, associée à une communication interauriculaire chez 4 (14,3%) patients et à une sténose pulmonaire chez 4 (14,3%) patients. Le patch péricardique autologue a été utilisé

pour fermer la CIV chez 22 (78.6%) patients. Aucun décès ni complications sévères ne sont apparus lors du séjour en soins intensifs ou en hospitalisation postopératoire. Aucun cas d'insuffisance tricuspide avant la sortie n'a été enregistrée non plus.

Avec un suivi moyen de $4,4 \pm 2,5$ as : aucun patient n'a développé un bloc auriculo-ventriculaire, 24 (85,7%) patients n'avaient pas de CIV résiduelle tandis que 3 (10.7%) patients avaient une CIV résiduelle minimale n'occasionnant pas de shunt et 1 (3.6%) patient avait une CIV résiduelle large nécessitant une reopération. De plus, 25 (89.3%) patients n'avaient pas d'insuffisance tricuspide, 2 (7.1%) patients avaient une insuffisance tricuspide insignifiante et 1 (3.6%) patient avait une insuffisance tricuspide minimale.

Conclusion : Nos résultats sont en accord avec les données de la littérature. Nous recommandons l'utilisation de cette technique puisqu'elle permet une fermeture optimale et définitive de la CIV sans entraîner un risque accru ni d'insuffisance tricuspide ni de lésion du tissu de conduction.

ملخص

المقدمة:الاتصال البطيني هو عيب خلقي يتميز بوجود خلل على شكل ثقب في الحاجز بين البطينين للقلب يؤدي إلى اتصالهما. أثناء العلاج الجراحي ، يعتبر شق الأذين الأيمن هو الأسلوب الأكثر إستعمالاً. ومع ذلك ، في بعض الحالات ، يتم حجب حواف هذا الإتصال بسبب تموقع حبال الصمام ثلاثي الشرف او ان لهذا الصمام امتداد نحو الجزء العلوي من الحاجز .

ومن هنا تأتي الحاجة إلى اللجوء إلى الفصل الجزئي للصمام ثلاثي الشرف من أجل ضمان انكشاف أفضل لهذا الإتصال البطيني ولكن أيضاً لتجنب إتلاف الصمام ثلاثي الشرف أو إتلاف أنسجة التوصيل الكهربائي للقلب. الهدف من هذا العمل هو تقييم النتائج طويلة المدى لدى المرضى الذين خضعوا لجراحة إغلاق الإتصال التشوهي الخلفي بين البطينين بإستعمال الفصل الجزئي للصمام ثلاثي الشرف من خلال التركيز بشكل أساسي على العناصر التالية: عدد حالات الإتصال التشوهي الخلفي بين البطينين، عدد حالات قصور ثلاثي الشرف على المدى البعيد وكذلك تواتر حالات الحصار الأذينية البطينية.

المواد والطرق: هذه دراسة بأثر رجعي ، لمركز واحد ، وصفية لبيانات 28 مريضاً تم إجراء جراحة إغلاق الإتصال التشوهي الخلفي بين البطينين على مدى 10 سنوات من يوليو 2010 إلى أغسطس 2020 في قسم جراحة القلب والأوعية الدموية في المستشفى الجامعي محمد السادس. تمت مراجعة المرضى في الشهر الأول، الثالث، السادس و الثاني عشر بعد الجراحة ثم سنوياً لمدة تصل إلى 8 سنوات. تم تسجيل البيانات التي تم جمعها في نظام إكسيل 2010 المعلوماتي ثم تحليلها باستخدام برنامج SPSS الإصدار 21.0 .

النتائج: كان متوسط العمر 4.88 ± 5.8 سنة بنسبة جنس الذكور/الإناث 1.77. كان لدى 21 (75%) مريضاً إتصال بمتوسط حجم يبلغ 4.83 ± 11.38 ملم. في 12 مريضاً (42.8%) لم يكن لديهم تشوهات إضافية ما عدا الإتصال البطيني. كان هذا الإتصال البطيني أحد مكونات رباعية فالو في 8 (28.6%) حالات ، مرتبط بالتواصل بين الأذنين لدى 4 (14.3%) مرضى وتضييق رئوي لدى 4 (14.3%) آخرين. تم استخدام رقعة التامور الذاتية لإغلاق الإتصال لدى 22 مريضاً (78.6%). لم تحدث وفاة أو مضاعفات خطيرة في العناية المركزة أو الاستشفاء بعد الجراحة. لم يتم تسجيل أي حالة قصور لصمام ثلاثي الشرفات قبل مغادرة المرضى للمستشفى.

بمتوسط متابعة 2.5 ± 4.4 : لم يصب أي مريض بإحصار أذيني بطيني ، لم يكن لدى 24 (85.7%) مريض أي إتصال متبق، بينما تبقى لدى 3 (10.7%) مرضى إتصال صغير دون أي تأثير على المريض. ومريض

واحد (3.6%) تبين أن الإتصال المتبقي يحتاج إعادة الجراحة . بالإضافة إلى ذلك ، لم يكن لدى 25 (89.3%) من المرضى قصور للصمام ثلاثي الشرفات ، بينما مريضين (7.1%) يعانون من قصور غير ملحوظ في الصمام ثلاثي الشرف و مريض واحد (3.6%) يعاني من قصور من الحد الأدنى من الصمام ثلاثي الشرف .

الخلاصة: نتائجنا تتفق مع البيانات الموجودة في الأدبيات . نوصي باستخدام هذه التقنية لأنها تتيح الإغلاق الأمثل والنهائي للإتصال التشوهي الخلقي بين البطينين دون التسبب في حدوث خطر إضافي لقصور الصمام ثلاثي الشرفات أو تلف أنسجة التوصيل الكهربائي القلبي .



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قسم الطبيب

أقسم بالله العظيم

أن أراقب الله في مهنتي.

وأن أصون حياة الإنسان في كافة أطوارها في كل الظروف

والأحوال باذلاً وسعي في انقاذها من الهلاك والمرض

والألم والقلق.

وأن أحفظ للناس كرامتهم، وأستر عورتهم، وأكتم سرهم.

وأن أكون على الدوام من وسائل رحمة الله، باذلاً رعايتي الطبية للقريب والبعيد،

للصالح والطالح، والصديق والعدو.

وأن أثار على طلب العلم، أسخره لنفع الإنسان .. لا لأذاه.

وأن أوقر من علمني، وأعلم من يصغرنني، وأكون أخاً لكل زميل في المهنة الطبية

متعاونين على البر والتقوى.

وأن تكون حياتي مصداق إيماني في سري وعلانيتي، نقيّة مما يشينها تجاه

الله ورسوله والمؤمنين.

والله على ما أقول شهيدا



كلية الطب
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FACULTÉ DE MÉDECINE
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نتائج الفصل الجزئي للصمام ثلاثي الشرف أثناء إغلاق الإتصال الخلقي بين البطينين

الأطروحة

قدمت ونوقشت علانية يوم 2021/12/02

من طرف

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المزداد في 28 ماي 1992 في بوروندي

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فصل الصمام ثلاثي الشرف - إتصال تشوهي خلقي بين البطينين - نتائج.

اللجنة

الرئيس

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السيدة

أستاذة في طب الأطفال

المشرف

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الحكم

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السيد

أستاذ مبرز في جراحة القلب والشرابين