

12-1-1991

Post-operative complications in pediatric cardiacsurgery

Peerawat Leepraditvan

Viroj sueblingvong

Chule thisyakorn

Chotima Pathmanad

Pairoj Chotvittayatarakorn

See next page for additional authors

Follow this and additional works at: <https://digital.car.chula.ac.th/clmjjournal>



Part of the [Medicine and Health Sciences Commons](#)

Recommended Citation

Leepraditvan, Peerawat; sueblingvong, Viroj; thisyakorn, Chule; Pathmanad, Chotima; Chotvittayatarakorn, Pairoj; Lertsapcharoen, Pornthep; Lauhakunakorn, Preecha; Sanpradit, Meunmai; Kurowat, Yothin; and Benjachonlamash, Vichai (1991) "Post-operative complications in pediatric cardiacsurgery," *Chulalongkorn Medical Journal*: Vol. 35: Iss. 12, Article 5.

Available at: <https://digital.car.chula.ac.th/clmjjournal/vol35/iss12/5>

This Article is brought to you for free and open access by the Chulalongkorn Journal Online (CUJO) at Chula Digital Collections. It has been accepted for inclusion in Chulalongkorn Medical Journal by an authorized editor of Chula Digital Collections. For more information, please contact ChulaDC@car.chula.ac.th.

Post-operative complications in pediatric cardiac surgery

Authors

Peerawat Leepraditvan, Viroj sueblingvong, Chule thisyakorn, Chotima Pathmanad, Pairoj Chotvittayatarakorn, Pornthep Lertsapcharoen, Preecha Lauhakunakorn, Meunmai Sanpradit, Yothin Kurowat, and Vichai Benjachonlamash

Post-operative complications in pediatric cardiac surgery*

Peerawat Leepraditvan** Viroj sueblingvong**
Chule thisyakorn** Chotima Pathmanad**
Pairoj Chotvittayatarakorn** Pornthep Lertsapcharoen**
Preecha Lauhakunakorn** Meunmai Sanpradit***
Yothin Kurowat*** Vichai Benjachonlamash***

Leepraditvan P, Sueblingvong V, Thisyakorn C, Pathmanad C, Chotvittayatarakorn P, Lertsapcharoen P, Lauhakunakorn P, Sanpradit M, Kurowat Y, Benjachonlamash V. Post-operative complications in pediatric cardiac surgery. Chula Med J 1991 Dec; 35(12): 811-822

Cardiac surgery was performed on 212 pediatric patients during the period July 1989 to June 1991 at Chulalongkorn Hospital; 42 patients underwent palliative surgery and 170 corrective surgery. The causes of death were: low cardiac output (12 cases), congestive heart failure (4 cases), pulmonary edema (2 cases), hemopericardium (1 case), intravascular hemolysis with renal failure (1 case), brain edema (1 case), hyperkalemia (1 case), pneumonia with bleeding from tracheostomy site (1 case) and ventricular fibrillation (1 case). Post-operative complications can be reduced if operations are done cautiously and prudent post-operative precautions with proper stepwise management are carried out.

Key words : Post-operative complications, Pediatric cardiac surgery.

Reprint request : Leepraditvan P, Department of Pediatrics, Faculty of Medicine, Chulalongkorn University, Bangkok 10330, Thailand.

Received for publication. August 8, 1991.

* Supported by grants from the Cardiac Children's Foundation of Thailand under the Royal Patronage of H.R.H. Princess Galyani Vadhana.

** Department of Pediatrics, Faculty of Medicine, Chulalongkorn University.

*** Department of surgery, Faculty of Medicine, Chulalongkorn University.

พีรวัดน์ ลีประดิษฐวรรณ, วิโรจน์ ลีปถลินวงศ์, จุล ทิสยากร, โชติมา ปัทมานันท์, ไพโรจน์ โชติวิทยาธารากร, พรเทพ เลิศทรัพย์เจริญ, ปรีชา เลาทคุณากร, เหมือนหมาย สรรประดิษฐ์, โยธิน คุโรวาท, วิชัย เบญจขลมาศ. ภาวะแทรกซ้อนหลังการผ่าตัดหัวใจในผู้ป่วยเด็ก. จุฬาลงกรณ์เวชสาร 2534 ธันวาคม; 35(12): 811-822

ได้ศึกษาผู้ป่วยเด็กที่เป็นโรคหัวใจเพื่อดูภาวะแทรกซ้อนหลังการผ่าตัดหัวใจ ในภาควิชากุมารเวชศาสตร์ โรงพยาบาลจุฬาลงกรณ์ ระหว่างเดือนกรกฎาคม พ.ศ. 2532 ถึงเดือนมิถุนายน พ.ศ. 2534 จำนวน 212 ราย, เป็นการผ่าตัดแบบซ่อมแซมชั่วคราว 42 รายและสมบูรณ์แบบ (แก่ทุกส่วน) 170 ราย มีภาวะแทรกซ้อนหลังการผ่าตัด 73 ราย (ร้อยละ 33.4), ผู้ป่วยเสียชีวิต 24 ราย (ร้อยละ 11.3) โดยเสียชีวิตจากช็อคจากหัวใจ 12 ราย, หัวใจล้มเหลว 4 ราย, ปอดบวมนำ 2 ราย, เลือดออกในเยื่อหุ้มหัวใจ 1 ราย, เม็ดเลือดแดงแตกร่วมกับไตล้มเหลว 1 ราย, สมองบวม 1 ราย, สารโปแตสเซียมสูงเกิน 1 ราย, ปอดบวมร่วมกับเลือดออกตำแหน่งที่ทำเจาะคอ 1 ราย และกล้ามเนื้อหัวใจเต้นพริ้ว 1 ราย ภาวะแทรกซ้อนหลังการผ่าตัดสามารถลดลงได้ถ้าผู้ป่วยได้รับการระมัดระวังอย่างถี่ถ้วนเรื่องผ่าตัด และการดูแลรักษาหลังผ่าตัดอย่างรอบคอบตามขั้นตอนทุกจุด

Post-operative complications are unexpected events related to surgery.⁽¹⁾ Sometimes complications are severe enough to cause mortality. The purpose of this paper is to report the early post-operative complications that occurred in the first month after pediatric cardiac surgery at Chulalongkorn Hospital.

Materials and Results

From July 1989 to June 1991, 237 patients admitted to the Department of Pediatrics, Chulalongkorn Hospital underwent cardiac surgery. The records of only 212 of these patients were available for this study. Twenty-four patients (11.3%) died after surgery. These patients are divided into three

groups: congenital acyanotic heart diseases, congenital cyanotic heart diseases and acquired heart diseases.

1. Congenital acyanotic heart diseases

1.1 Ventricular septal defect (VSD)

This group consisted of pure VSD (24 cases) and VSD associated with other lesions included; pulmonary stenosis (4 cases), dysplastic pulmonary valve (1 cases), aortic insufficiency (2 cases), atrial septal defect (ASD) (1 case) and patent ductus arteriosus (1 case). The overall number of patients in this group were 33 cases; 16 patients had post-operative complications (47%) and five died (14.7%) (Table 1).

Table 1. Post-operative complications in 16 cases of VSD.

Case no.	Age	Diagnosis	Operation	Postop. comp.	Result
1	5 yrs	VSD, PS	Closure VSD, pulmonary valvulotomy	PPS, residual PG across PV	Survived
2	6 yrs	VSD	Closure VSD	Hemopericardium	Expired
3	7 yrs	Multiple VSD, PDA	Closure VSD, Ligate PDA	Residual left to right shunt	Survived
4	12 yrs	VSD, ASD PH	Closure ASD and VSD, Tricuspid annulo.	PPS	Survived
5	3 yrs	VSD (cushion)	Closure VSD	Residual left to right shunt	Survived
6	6 yrs	VSD, MI, TI Post PA banding	Closure VSD, debanding PA, MV and TV annulo.	RBBB, Hemothorax	Survived
7	13 yrs	VSD, PH	Closure VSD	Intravascular hemolysis, renal failure	Expired
8	5 yrs	VSD	Closure VSD	Wound infection	Survived
9	1 yr	VSD	Closure VSD	Low CO, Pneumonia	Expired
10	1 yr	VSD	Closure VSD	Low CO	Expired
11	3.5 yrs	VSD	Closure VSD	Pneumonia	Survived
12	13 yrs	VSD (cushion)	Closure VSD	RBBB	Survived
13	6 yrs	VSD, AI	Closure VSD, repair aortic valve	Convulsion	Expired

Case no.	Age	Diagnosis	Operation	Postop. comp.	Result
14	4 yrs	VSD (cushion)	Closure VSD	Residual left to right shunt, PPS	Survived
15	9 yrs	VSD	Closure VSD	PPS	Survived
16	11 yrs	VSD, Dys- plastic PV	Closure VSD, PVR	Osteomyelitis of the sternum	Survived

Abbreviations: PS = Pulmonary stenosis; PPS = Post-pericardiectomy syndrome; PG = Pressure gradient; PV = Pulmonary valve; PDA = Patent ductus arteriosus; ASD = Atrial septal defect; PH = Pulmonary hypertension; MI = Mitral insufficiency; TI = Tricuspid insufficiency; PA = Pulmonary artery; MV = Mitral valve; TV = Tricuspid valve; RBBB = Right bundle branch block; CO = Cardiac output; AI = Aortic insufficiency; PVR = Pulmonary valve replacement; annulo. = annuloplasty.

Residual left to right shunt persisted in cases no. 3 and 5. Case no. 3 had three muscular VSDs. Only two VSDs could be closed during surgery, the location of the other defect made it too difficult to be closed.

Hemothorax developed after surgery in case no. 6 from tearing of the superior vena cava (SVC) caused by venipuncture with Cavafix. Follow-up EKG showed RBBB.

Case no. 2 developed hypotension from hemopericardium. Reoperation was necessary to stop bleeding. The patient had signs of low cardiac output and finally expired.

Case no. 7 died from intravascular hemolysis and renal failure. Intravascular hemolysis might have been due to prolonged cardiopulmonary bypass or trauma to red blood cells due to the use of a Dacron patch.

Cases no. 9 and 10, both less than one year of age, succumbed from low cardiac output.

Case no. 13 developed convulsion and became unconscious after surgery. CT scan showed diffuse brain edema which might have been due to an air embolism. The patient eventually died.

1.2 Atrial septal defect (ASD)

This group comprised 23 cases of secundum ASD, two cases of primum ASD, one case of both primum and secundum ASDs, one case of secundum ASD associated with PS and four cases of PDA. The total number of patients in this group was 31. There were seven cases with post-operative complications (22.5%) including one death (3%) (Table 2).

In case no. 1, EKG after cardiac surgery showed RBBB. The etiology of RBBB in this case was unknown.

Case no. 3 developed right pneumothorax, the cause of which was uncertain.

Case no. 4 presented with signs of pneumonia and heart failure from the large PDA. The patient developed pulmonary edema during operation and expired. Cause of death might have been fluid overload because she received 100 ml of fluid during the operation (body weight 3 kilograms).

Case no. 5 had a large hematoma at the Cavafix site and developed hypotension associated with hemothorax and hemopericardium. Prolonged shock was most likely due to a large amount of concealed bleeding at the Cavafix site, with right femoral vein puncture.

1.3 Patent ductus arteriosus (PDA)

There were 49 cases in this group. Twenty-four cases (49%) had post-operative complications. Twenty-two cases developed significant and severe hypertension by criteria of the Report of the Second Task Force on Blood Pressure Control in Children.⁽²⁾ Fourteen of the 22 cases received diuretics or vasodilators to control blood pressure. In the majority of cases, blood pressure dropped to the normal range within three days. The other eight cases did not receive any drugs and blood pressure decreased spontaneously within one week. The cause of post-operative hypertension in PDA patients was not studied.

In the other two cases, one developed transient phrenic nerve palsy which returned to normal one week later; this complication might have been due to traction during operation.⁽¹⁾ The other patient developed pneumonia. There was no mortality in this group.

1.4 Pulmonary stenosis (PS)

There were 10 cases in this group. Only moderated and severe cases were operated upon; four cases (40%) had post-operative complications and three died (30%) (Table 3).

Table 2. Post-operative complications in ASD group.

Case no.	Age	Diagnosis	Operation	Postop. comp.	Result
1	6 yrs	ASD secundum	Closure ASD	RBBB	Survived
2	8 yrs	ASD secundum	Closure ASD	Arrhythmia (Low RA rhythm with nodal escape beat)	Survived
3	11 yrs	ASD secundum	Closure ASD	Pneumothorax	Survived
4	21 days	ASDsecundum PI, TI, PH	D&S PDA	Pulmonary edema	Expired
5	7 yrs	ASD secundum PS	Closure ASD Pulmonary valvulotomy	Retroperitoneal hematoma, hemothorax, hemopericardium and pneumonia	Survived
6	8 yrs	ASD secundum Cleft MV, MI TI, PH	Closure ASD Repair MV	Residual MI	Survived
7	14 yrs	ASD secundum	Closure ASD	RLL atelectasis	Survived

Abbreviations are the same as in Table 1, plus: PI = Pulmonary insufficiency; RA = Right atrium; D&S PDA = Division and suture PDA; RLL = Right lower lobe.

Table 3. Post-operative complications in PS group.

Case no.	Age	Diagnosis	Operation	Postop. comp.	Result
1	9/12 yrs	Infundibular, valvular PS	Infundibulectomy, pulm. valvulotomy	Low CO	Expired
2	3.5 yrs	Infundibular, valvular PS	Infundibulectomy	RBBB + LAH	Survived
3	6/12 yrs	Severe PS, small RV	B-H, Waterston shunt	CHF, Pneumonia	Expired
4	3 yrs	Severe PS	Pulm. valvulotomy, tricusp. annulo.	Pulm. edema	Expired

Abbreviations are the same as in Table 2, plus: RVOFT enlarge = Right ventricular outflow tract enlargement; tricusp. annulo. = tricuspid annuloplasty; LAH = Left anterior hemiblock; B-H = Blalock-Hanlon operation.

Case no. 1 developed low cardiac output until expiration.

In case no. 2, the EKG after surgery showed RBBB + LAH, which might have been due to injury during operation.

Case no. 3 developed congestive heart failure and pneumonia from the large shunt and expired.

Case no. 4 was in good condition until the third day after surgery. He developed dyspnea, cough, hypotension with frothy sputum from the endotracheal tube and died.

2. Congenital cyanotic heart diseases

2.1 Tetralogy of Fallot (TOF)

This group comprised two subgroups: the

subgroup that underwent total correction (23 cases) and the subgroup that had systemic-to-pulmonary artery shunt surgery (18 cases).

In the subgroup that had total correction (Table 4), there were three deaths (13%). EKG showed RBBB in 13 of the 14 cases obtained (92.8%).

Table 4. Post-operative complications in TOF group who underwent total correction.

Cose no.	Age	Diagnosis	Operation	Postop. comp.	Result
1	9 yrs	TOF	Total correction	Pleural effusion	Survived
2	3.5 yrs	TOF	Total correction	Pleural effusion	Survived
3	13 yrs	TOF	Total correction	PPS	Survived
4	11 yrs	TOF	Total correction	Low CO	Survived
5	9 yrs	TOF	Total correction	Rt. Pneumothorax	Survived
6	14 yrs	TOF, post Rt. B-T	Total correction	Low CO	Expired
7	7 yrs	TOF	Total correction	Complete AV block	Survived
8	4 yrs	TOF	Total correction	Low CO	Expired
9	12 yrs	TOF, Post Rt. B-T	Total correction	RUL atelectasis	Survived
10	8 yrs	TOF	Total correction	Low CO	Expired
11	14 yrs	TOF	Total correction	Pleural effusion	Survived
12	10 yrs	TOF	Total correction	Pleural effusion Wound infection	Survived
13	5 yrs	TOF	Total correction	PPS	Survived

Abbreviations are the same as in Table 3, plus: Rt. = Right; B-T = Blalock-Taussig shunt; RUL = Right upper lobe.

Pleural effusion was detected after surgery in cases no. 1, 2, 11 and 12. It may be found in severe TOF with small main pulmonary artery and small left ventricle after total corrective surgery.

Case no. 4, 6, 8 and 10 developed low cardiac output after surgery because of a small left ventricle. Case no. 4 survived, but cases no. 6, 8 and 10 died.

Complete atrioventricular block was detected after surgery in case no. 7 so he underwent a permanent pacemaker implantation.

In the subgroup of TOF that had systemic-to-pulmonary artery shunt operation (18 cases), there were 15 cases of TOF and three cases of VSD with pulmonary atresia. Every case underwent a modified Blalock-Taussig shunt. There were four cases with post-operative complications: two cases with pleural effusion, one with wound infection and another one

with shunt obstruction. There was no mortality in this subgroup.

2.2 Complete transposition of the great arteries (TGA)

There were six cases in this group; Three cases (50%) died after surgery (Table 5).

Case no. 3 developed low cardiac output and metabolic acidosis, which persisted until he died.

Case no. 5 developed heart failure after surgery. An echocardiogram showed left ventricular dysfunction. She died in the second week after operation. The cause of left ventricular dysfunction may have been due to the small size of the VSD and restricted pulmonary artery from banding.

Case no. 6 developed cardiopulmonary arrest after surgery. Serum electrolytes showed potassium 9.2 mEq/L. The patient died on the second post-operative day.

Table 5. Post-operative complications in complete TGA group.

Case no.	Age	Diagnosis	Operation	Postop. comp.	Result
1	30 days	TGA, VSD, PDA	Ligate PDA, PA banding, atrial septectomy	None	Survived
2	9 yrs	TGA, VSD, PS PDA, Post B-H	Rastelli op.	Pleural effusion	Survived
3	24 days	TGA, VSD, PDA	Ligate PDA, PA banding, atrial septectomy	Low CO	Expired
4	5 yrs	Simple TGA Post B-H	Mustard op.	Pleural effusion, pneumonia	Survived
5	1 yr	TGA, VSD, PDA TA	Ligate PDA, PA banding, atrial septectomy	LV dysfunction	Expired
6	4 yrs	TGA, VSD, PS Post B-H	Rastelli op.	Cardiac arrest, hyperkalemia	Expired

Abbreviations are the same as in Table 4, plus: op. = operation; TA = Tricuspid atresia; LV = Left ventricle.

2.3 Tricuspid atresia (TA)

There were five cases in this group: one had corrective surgery (Fontan operation) and the other four palliative surgery. The patient who had the Fontan operation expired (Table 6).

2.4 Double outlet right ventricle (DORV)

There were four cases in this group, two had corrective surgery and the other two had palliative surgery. One of the two cases who had corrective surgery died (Table 7).

Table 6. Tricuspid atresia group.

Case no.	Age	Diagnosis	Operation	Postop. comp.	Result
1	3 yrs	TA, PA, Post B-H & Rt. B-T	Modified Lt. B-T	None	Survived
2	3.75 yrs	TA, ASD, VSD PS	B-H, B-T	None	Survived
3	1 yr	TA, VSD	B-H, PA banding	None	Survived
4	6 yrs	TA, TGA, PS, Post B-H	Fontan op.	Low CO, metabolic acidosis	Expired
5	2 yrs	TA, TGA, PS, Post B-H, Central shunt	Modified Lt. B-T	Wound infection	Survived

Abbreviations are the same as in Tables 3 and 4, plus: Lt. = left.

Table 7. Double outlet right ventricle group.

Case no.	Age	Diagnosis	Operation	Postop. comp.	Result
1	2 yrs	DORV, ASD PS	Closure VSD & ASD infundibulectomy	RBBB	Survived
2	13 yrs	DORV, PS	Rastelli op.	Paraplegia, Pneumonia	Expired
3	7/12 yrs	DORV	PA banding	Lt. lower lobe atelectasis	Survived
4	4/12 yrs	DORV	PA banding	None	Survived

Case no. 2 developed paraplegia after surgery.- The cause may have been due to spinal cord ischemia during cardiopulmonary bypass. She developed pneumonia later and died from bleeding at the tracheostomy site.

2.5 Persistent truncus arteriosus

There was only one case, aged seven years,-classified as truncus arteriosus type I.⁽³⁾ The patient was in good condition after total corrective surgery until the third day after operation. Four hours after removal of the endotracheal tube, he developed dyspnea, hypotension and metabolic acidosis, which persisted until he died. The cause of death may have

been due to right heart failure from severe pulmonary hypertension.

2.6 Total anomalous pulmonary venous return (TAPVR)

There was only one case, aged one year, who had TAPVR (supracardiac type) and PDA. A week after total correction and PDA ligation, she developed fever; an echocardiogram showed pericardial-effusion compatible with post-pericardiotomy syndrome. The patient responded well to acetyl salicylic acid.

2.7 Left-sided obstruction

There were five cases in this group (Table 8).-

Table 8. Left-sided obstruction group.

Case no.	Age	Diagnosis	Operation	Postop. comp.	Result
1	7 yrs	Interrupted aortic arch, PDA	Lt. subclavian to DAO bypass graft, ligate PDA	None	Survived
2	10 days	Hypo. LV, COAT, PDA	Distal PA banding	Arrhythmia, renal failure	Survived
3	20 days	Hypo. LV	Distal PA banding	Cardiac arrest	Expired
4	4 yrs	COAT	Coarctectomy	Postcoarctectomy syndrome	Survived
5	2 yrs	Cong. MS, VSD PDA, Interrupted aortic arch	Mitral annulo. and commis., repair interrupted aortic arch, closure VSD, D&S PDA	Low CO	Expired

Abbreviations are the same as in Table 5, plus: DAO = Descending aorta; Hypo. LV = Hypoplastic left ventricle; Cong. MS = Congenital mitral stenosis; commis. = commissurotomy; D&S PDA = Division and suture PDA.

Case no. 2 developed frequent premature ventricular contractions (PVC) and renal failure after surgery. The PVC may have been due to myocardial ischemia from the underlying disease. The patient was discharged from hospital in spite of the PVCs.

Case no. 3 developed cardiac arrest and expired during operation. The cause of death was due to poor coronary perfusion from the underlying disease.

Case no. 5 developed low cardiac output and expired later. Death might have been due to left heart failure.

2.8 Complex heart diseases

There were 11 cases in this group: one case had corrective surgery and 10 had palliative surgery. Three patients (27.3%) died after operation (Table 9).

Table 9. Complex heart diseases group.

Case no.	Age	Diagnosis	Operation	Postop. comp.	Result
1	3 yrs	Dextrocardia SA, SV, PS, TGA	Modified Lt. B-T	None	Survived
2	4/12 yrs	SA, VSD, PA TGA	Modified B-T	CHF	Expired
3	2/12 yrs	MA, DORV, TGA, VSD, PS	B-H	None	Survived
4	17 days	Hypo. LV and MV, DORV, PDA, ASD, PS	Waterston	Low CO	Expired
5	9 yrs	AV canal, DORV PS, MI	Lt. B-T	None	Survived
6	2/12 yrs	MA, SV, TGA	B-H and PA banding	None	Survived
7	6/12 yrs	SV, TA, PS	B-H, Waterston	Pneumonia	Survived
8	6/12 yrs	Dextroposition SV, TA, ASD TGA, PS	Fontan op.	Low CO	Expired
9	4/12 yrs	SV, TA, PA, PDA	Modified Lt. B-T	None	Survived
10	4 yrs	SV	PA banding	None	Survived
11	11 days	SV, TGA, ASD PA, PDA	Rt. B-T	Wound infection	Survived

Abbreviations are the same as in Table 8, plus: MA = Mitral atresia; SV = Single ventricle; SA = Single atrium.

3. Acquired heart disease

3.1 Rheumatic heart disease (RHD)

There were nine cases in this group. They had abnormality of mitral and/or aortic valves. There were three cases who had post-operative complications.

The first case, RHD with MS and mitral insufficiency (MI), underwent open mitral commissurotomy and annuloplasty. An echocardiogram after surgery showed residual MI and MS.

The second case, RHD with MI, tricuspid insufficiency (TI) and atrial fibrillation, underwent

mitral and tricuspid annuloplasty. He developed left lower lobe atelectasis and left pleural effusion after surgery.

The other case, RHD with MI, TI and atrial fibrillation, underwent mitral and tricuspid annuloplasty. Three days after operation, she complained of abdominal and leg pains. The femoral pulses could not be palpated on either side. The aortogram showed embolism at the infrarenal level of the aorta. Embolectomy was performed with excellent results.

3.2 Miscellaneous

There were five cases in this group and one died (Table 10).

Table 10. Miscellaneous group.

Case no.	Age	Diagnosis	Operation	Postop. comp.	Result
1	1 yr	Cong. complete AV block	Pacemaker implantation	None	Survived
2	6/12 yrs	AV canal, PDA Peri. effusion	Peri. window	None	Survived
3	9 yrs	MI	MVR	None	Survived
4	2 days	Intracardiac tumor	Excision tumor	Low CO	Expired
5	13 yrs	IE of MV, MI	Repair MV	None	Survived

Abbreviations are the same as in Table 9, plus: Peri. = Pericardial; MVR = Mitral valve replacement; IE = Infective endocarditis.

Case no. 4 had an intracardiac tumor at the outflow tract of the left ventricle. EKG showed an ischemic pattern. She developed low cardiac output, hypothermia and metabolic acidosis after excision of the tumor and expired later.

Discussion

Post-operative complications found often in this study included:

1. Right bundle branch block (RBBB)

RBBB is the result of delayed activation of the right ventricle. A characteristic QRS pattern defines RBBB: 1. QRS prolonged for age; 2. An RSR' or rR' pattern in leads V3R and V1, with the late positive deflection indicative of delayed right ventricle activation; 3. A broad S wave in leads 1 and V6.⁽⁴⁾

For patients who had undergone ventriculotomy, 84-100% would have RBBB pattern in the electrocardiograms.^(5,6) Compared with this study, 13 out of 14 (92.8%) cases developed RBBB after undergoing total correction for TOF. One developed complete atrioventricular block. RBBB was caused by a large incision right ventriculotomy for right ventricular outflow tract enlargement.⁽⁶⁻¹⁰⁾ Among the patients who had follow-up EKG, there was one who developed RBBB and left anterior hemiblock (the criteria for diagnosis being the same as RBBB plus frontal plane QRS axis leftward -30 degrees) after infundibulectomy and right ventricular outflow tract enlargement. RBBB and left anterior hemiblock occurred in about 7% of patients undergoing ventricular septal defect closure.^(5,11) It is necessary to follow up these patients closely because of the possible

development of complete atrioventricular block.^(12,13) More precise understanding of location of the cardiac conduction system has made this complication a rare occurrence.

2. Post-pericardiotomy syndrome (PPS)

In this study, only six out of 126 (4.8%) cases who had the pericardium opened developed this syndrome. This complication can occur in up to 27-30% of post-operative patients.^(14,15) The reason why fewer cases were diagnosed in our series may be due to under-diagnosis; those patients with mild symptoms and signs might have gone undetected. Those who had this syndrome usually developed fever and chest pain at the end of the first week. Physical examination showed pericardial friction rub. Laboratory findings showed enlarged cardiac silhouette and pleural effusion on the chest roentgenogram; EKG would show elevation of S-T segment and echocardiogram demonstrated pericardial effusion.⁽¹⁶⁾ All cases in this study responded well to acetyl salicylic acid.

3. Low cardiac output

Low cardiac output is a condition in which the heart cannot adequately pump the blood supplying the various organs. Patients develop poor skin perfusion, decreased blood pressure and urine output of less than 0.5 ml/kg/hr.⁽¹⁷⁾

This complication is often found in: 1. patients with left to right shunt, particularly VSD with pulmonary hypertension, who had operative mortality higher than VSD without pulmonary hypertension,⁽¹⁸⁾ 2. severe TOF cases with small left ventricles who underwent total correction; and 3. small infants who could not tolerate the operation and anesthesia well.

Cardiopulmonary bypass and almost all anesthetic drugs suppress myocardial contractility.⁽¹⁹⁾ Ventriculotomy also reduces myocardial contraction causing poor cardiac contraction.

The condition of the patients before surgery is another factor that affects post-operative complications. Chronic volume overload may increase mortality. Low cardiac output is the most common cause of death in our series; it is a complication that is very difficult to treat. However appropriate use of inotropic drugs with or without vasodilators may often be very beneficial.

4. Hypertension

This complication is found in post-operative division and suture of PDA. The cause is unknown. Hypertension may be caused by increased volume by compensation shunting to the lungs. Pre-operatively the patients do not develop hypertension because the lungs are large reservoirs; after PDA ligation, blood volume remains increased, therefore blood pressure increases.^(20,21) Another possible explanation is that the patients with PDA developed vasoconstriction of systemic arterioles (increased peripheral resistance). They may not develop hypertension pre-operatively because of the large reservoirs (the lungs); after PDA ligation, "latent hypertension" emerges.⁽²²⁾

In this study, hypertension usually did not last longer than one week (3 days in most cases). Luckily this complication is normally not severe and easily controlled with diuretics and/or vasodilators.

5. Infection

Sternal wound infection was found in five of all the patients (2.36%) which is nearly equal to that in 2.7% of patients who underwent heart surgery, as reported by others.⁽²³⁾ One of the causes of wound contamination is carelessness in sterile technique. In addition, tissue hypoxia in patients with cyanotic heart disease causes poor wound healing. Strict aseptic technique would certainly lower the occurrence of this complication.

Ten of the patients (4.72%) developed atelectasis and/or pneumonia after surgery. This post-operative complication is due to pain secondary to a midline sternotomy or thoracotomy incision, causing the patient to reduce lung expansion and to cough, leading to atelectasis and pneumonia.

6. Arrhythmia

Arrhythmias can be caused by injury to the SA node during cannulation for bypass⁽¹⁷⁾, from myocardial ischemia or electrolyte imbalance, e.g.

hyperkalemia, hypokalemia. Careful cannulation during operation and close monitoring of the serum electrolytes would decrease the risk of this complication.

7. Miscellaneous

There was one case (RHD) with MI, TI and atrial fibrillation who developed embolism at the infrarenal level of the aorta after open mitral and tricuspid annuloplasty. The cause of the embolism was not known but this kind of complication may occur in open heart surgery.⁽²⁴⁾

One case, VSD with AI, developed convulsion after closing VSD and repairing the aortic valve. The cause of convulsion was not known.

Some of the post-operative complications mentioned above are common and are difficult to prevent. But some iatrogenic complications are undoubtedly preventable: for example, extreme caution during placement of either an intravenous or an intraarterial catheter would certainly prevent bleeding and contamination.

Good post-operative care is very important. The medical staff team consisting of thoracic surgeons, anesthesiologists, pediatric cardiologists and intensive care nurses must observe every patient in the post-operative period very closely so that preventable complications could be prevented or treated early in order to avoid severe complications that could cause mortality. Hopefully in the future, with improved surgical techniques and better post-operative care; we would be able to operate successfully and save more lives of those children especially infants suffering from heart diseases.

References

1. Morriss MJH, McNamara DG. Residua, sequelae and complications of heart surgery. In: Garson A Jr, Bricker JT, McNamara DG, eds. The Science and Practice of Pediatric Cardiology. Philadelphia: Lea & Febiger, 1990. 2024-43
2. Task Force on Blood Pressure Control in Children. Report of the second task force on blood pressure control in children. *Pediatric* 1987 Jan; 79(1): 1-25
3. Collett RW, Edwards JE. Persistent truncus arteriosus: a classification according to anatomic types. *Surg Clin North Am* 1949 Aug; 29(4): 1245-70
4. Silka MJ. Bundle branch block. In: Garson A Jr, Bricker JT, McNamara DG, eds. The Science

- and Practise of Pediatric Cardiology. Philadelphia: Lea & Febiger 1990. 1786-99
5. Chesler E, Beck W, Schrire V. Left anterior hemoblock and right bundle branch block before and after surgical repair of tetralogy of Fallot. *Am Heart J* 1972 Jul; 84(1): 45-52
 6. Gelband H, Waldo AL, Kaiser GA, Bowman FO Jr, Malm JR, Hoffman BF. Etiology of right bundle-branch block in patients undergoing total correction of tetralogy of Fallot. *Circulation* 1971 Dec; 44(6): 1022-33
 7. Yabek SM, Jarmakani JM, Roberts NK. Diagnosis of trifascicular damage following tetralogy of Fallot and ventricular septal defect repair. *Circulation* 1977 Jan; 55(1): 23-7
 8. Horowitz LN, Alexander JA, Edmunds LN. Postoperative right bundle branch block: Identification of three levels of block. *Circulation* 1980 Aug; 62(2): 319-28
 9. Zimmerman HA, Oliveira JM, Noqueira C, Mendelsohn C, Kay EB. The electrocardiogram in open heart surgery: disturbances in right ventricle conduction. *J Thorac Cardiovasc Surg* 1958 Jul; 36(1): 12-22
 10. Sandheimer HM, Izukawa T, Olley PM, Trusler GA, Mustard WT. Conduction disturbances after total correction of tetralogy of Fallot. *Am Heart J* 1976 Sep; 92(3): 278-82
 11. Kulbertus HE, Coyne JJ, Hallidie-Smith KA. Conduction disturbances before and after surgical closure of ventricular septal defect. *Am Heart J* 1969 Jan; 77(1) : 123-31
 12. Krongrad E. Prognosis for patients with congenital heart disease and postoperative intraventricular conduction defects. *Circulation* 1978 May; 57(5): 867-70
 13. Godman MJ, Robert NK, Izukawa T. Late postoperative conduction disturbances after repair of ventricular septal defect and tetralogy of Fallot. *Circulation* 1974 Feb; 49(2): 214-21
 14. Engle MA, McCabe JC, Ebert PA, Zabriskie J. The postpericardiotomy syndrome and anti-heart antibodies. *Circulation* 1974 Mar; 49(3): 401-6
 15. Engle MA, Zabriskie JB, Senterfit LB, Gay WA Jr, O'Loughlin JE, Ehlers KH. Viral illness and the postpericardiotomy syndrome: A prospective study in children. *Circulation* 1980 Dec; 62(6): 1151-8
 16. Engle MA. Postoperative problems. In: Adams FH, Emmanouillides GC, Reimenchneider TA, eds. *Moss' Heart Disease in Infants, Children, and Adolescents*. Baltimore: Williams & Wilkins, 1989. 964-72
 17. Bell TJ. Postoperative care. In: Garson A Jr, Bricker JT, McNamara DG, eds. *The Science and Practice of Pediatric Cardiology*. Philadelphia: Lea & Febiger, 1990. 2251-66
 18. Allen HD, Anderson RC, Noren GR, Moller JH. Postoperative follow-up of the patients with ventricular septal defect. *Circulation* 1974 Sep; 50(3): 465-71
 19. Cooper JR, Keats AS. Anesthesia and cardiopulmonary bypass. In: Garson A Jr, Bricker JT, McNamara DG, eds. *The Science and Practice of Pediatric Cardiology*. Philadelphia: Lea & Febiger, 1990. 2289-304
 20. Taylor BE, Pollack AA, Burchell HB, Clagett OT, Wood EH. Studies of the pulmonary and systemic arterial pressure in cases of patent ductus arteriosus with special reference to effects of surgical closure. *J Clin Invest* 1950 Jun; 29: 745-53
 21. Holman E, Gerbode F, Purdy A. The patent ductus: A review of seventy-five cases with surgical treatment, including an aneurysm of the ductus and one of the pulmonary artery. *J Thorac Cardiovasc Surg* 1953 Feb; 25(2): 111-42
 22. Taylor FH, Robicsek F, Sanger PW, Stam RE, Rees TT. Systemic hypertension complicating the ligation of patent ductus arteriosus. *J Thorac Cardiovasc Surg* 1960 Jul; 40(1): 43-6
 23. Ulicny KS Jr, Hiratzka LF, Williams RB, Grunkumeier GL, Flege JB Jr, Wright CB, Callard GM, Mitts DL, Dunn EJ. Sternotomy infection : Poor prediction by acute phase response and delayed hypersensitivity. *Ann Thorac Surg* 1990 Dec; 50(6) : 949-58
 24. El-Said GM, El-Reface MM. Rheumatic heart disease. In: Garson A Jr, Bricker JT, McNamara DG, eds. *The Science and Practice of Pediatric Cardiology*. Philadelphia: Lea & Febiger, 1990. 1502-26