Introduction and objectives. Ruptured sinus of Valsalva aneurysm to right cardiac chambers is an uncommon lesion in Western countries. The prognosis is usually serious unless the condition is promptly treated surgically. For this reason an accurate anatomical and functional evaluation is necessary. The main purpose of this report is to compare the usefulness of multiplane transesophageal echocardiography with transthoracic echocardiography and angiography in the preoperative evaluation of ruptured sinus of Valsalva aneurysm to right chambers.

Patients and method. Since January 1990, 9 patients (mean age 36.3 ± 18 years, 6 males) with ruptured sinus of Valsalva aneurysm to right chambers were studied. The pathogenesis was congenital aneurysm in 6 patients, aortic prothesis endocarditis in one and two cases of iatrogenia: during a percutaneous mitral valvuloplasty and after cardiac surgery. Transthoracic echocardiography was performed in all cases, transesophageal echocardiography in 7 and angiography in 8. Two patients died before surgery, and 7 were successfully operated on.

Results. Transesophageal echocardiography was more useful when compared to transthoracic echocardiography and angiography in detecting: a) the fistula; b) the sinus involved; c) the right chamber affected; d) congenital aneurysm morphology and size; e) aneurysm prolapse through a ventricular septal defect, and f) the identification of other cardiac congenital or acquired anomalies.

Conclusions. Multiplane TEE is the most accurate tool in the preoperative evaluation of ruptured sinus of Valsalva aneurysm to right chambers.

Key words: Congenital heart diseases. Fistula. Echocardiography. Surgery.

INTRODUCTION

Sinus of Valsalva fistulas to right chambers (SVFRC) are an infrequent pathology in surgical series in Western countries,1-3 their prevalence is much

Ecocardiografía transesofágica multiplana en la valoración preoperatoria de fistulas de senos de Valsalva en cavidades derechas

Introducción y objetivos. Las fistulas de senos de Valsalva a cámaras cardíacas derechas son una enfermedad infrecuente en el mundo occidental. El pronóstico suele ser grave y en la mayoría de los casos el tratamien-to quirúrgico precoz es resolutivo. Es, por tanto, imprescindible una valoración preoperatoria anatómica y funcio-nal precisa. El objetivo de este trabajo es comparar la utilidad de la ecocardiografía transesofágica multiplana con la ecocardiografía transtorácica y la angiociografía en la valoración preoperatoria de las fistulas de los se-nos de Valsalva a cámaras derechas.

Resultados. El ecocardiograma transesofágico fue más útil que la ecocardiografía transtorácica y la angiociografía en: a) detección de la fistula; b) localización exacta del seno de Valsalva afectado; c) puerta de entra-da de la fistula en cavidades derechas; d) tamaño y mor-fología de los aneurismas congénitos; e) prolapse del aneurisma a través de una comunicación interventricular, y f) identificación de otras anomalías cardíacas, congénit-as o adquiridas asociadas.

Conclusiones. La ETE multiplana es la técnica de imagen que mayor información aporta en la valoración preoperatoria de las fistulas de los senos de Valsalva en las cavidades derechas.


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higher in Asian populations. Once it has developed, the fistula originates a rapidly progressive left-to-right shunt that generally is manifested by congestive heart failure refractory to medical treatment. The ruptured aneurysm can be repaired surgically with excellent immediate and long-term results, so surgery should be performed without delay to prevent more morbidity and mortality. The diagnosis may be suspected on the basis of clinical manifestations and confirmed by cardiac catheterization and aortography, but in many cases AC does not clearly define the underlying defect or accompanying lesions. Recently it has been reported that TEE can be very useful for the preoperative assessment of patients with this disease. The purpose of this study is to compare the effectiveness of TEE with TTE and AC in the diagnosis and preoperative assessment of patients with SVFRC.

PATIENTS AND METHOD
Study population

From January 1990 to October 2000, 9 patients with SVFRC were documented in our service. The diagnosis was confirmed in the surgical intervention in 7 patients, but 2 patients did not undergo surgery and the diagnosis was based only on echocardiographic and angiocardiographic findings. The clinical and surgical protocols, echocardiographic and angiohemodynamic findings, and long-term evolution of all patients were reviewed.

Echocardiographic assessment

TTE was performed in all patients and multiplane TEE was carried out in. The studies were made with Sonos 2000, 2500 or 5500 equipment (Agilent Technologies, Andover, MA). TTE was performed with a 2.5-MHz probe or a multifrequency probe, with or without second harmonic imaging. The standard planes were studied from the parasternal, apical, and subcostal positions with bidimensional and Doppler color imaging. The size and morphology of the aortic root, degree of insufficiency of the aortic valve, and existence of a shunt between the aortic root and right chambers were assessed. The presence of accompanying lesions, especially malformations of the aortic valve or sinuses of Valsalva, endocardial vegetations, and defects in the interventricular septum, was evaluated. The size and function of the cardiac chambers were measured in all patients using the M-mode technique guided by the bidimensional image, and the systolic pulmonary artery pressure and pulmonary-to-systemic blood flow ratio were estimated using previously established methods.

Multiplane TEE was carried out with a multiplane probe and multifrequency transducer of 5/3.5 MHz with pulsed Doppler, continuous, and color capabilities. The probe was placed in the esophagus and the cross-sectional plane of the aortic root was analyzed using a transducer rotation of 30° to 45°, and the longitudinal plane with a transducer rotation of 120° to 150°. In the cross-sectional plane the morphology of the three sinuses of Valsalva and their relation with neighboring structures was analyzed, especially the right ventricular outflow tract, right atrium, tricuspid valve, and interatrial septum. In the longitudinal plane, the anatomy of the right coronary and non-coronary sinuses of Valsalva, their relation with the right ventricular outflow tract and left atrium, and the degree of aortic valve insufficiency were analyzed. The transducers were rotated continuously between the two planes described, varying the anteflexion and probe depth to better assess the anatomy of the aortic root and related structures. In addition, a transgastric examination was made to localize the outflow tracts of both ventricles in a disposition longitudinal to the ultrasonic beam in order to assess the infundibular septum, degree of aortic valve insufficiency, and pressure gradient in the right ventricular outflow tract.

RESULTS
Pathogenesis and clinical manifestations

The mean age of patients was 36.3 ± 18 years (range, 12-58 years). There were 6 men and 3 women. The fistula originated in the right sinus of Valsalva in 6 cases and in the non-coronary sinus in 3. In 4 patients the fistula communicated the aortic root with the right ventricular outflow tract, and in the other 5 patients it opened onto the right atrium. All the fistulas that opened onto the right ventricular outflow tract originated in the right coronary sinus of Valsalva, but of the 5 fistulas communicating with the right atrium, 2 originated in...
the right sinus of Valsalva and 3 in the non-coronary sinus. The cause of the fistula was rupture of a congenital aneurysm of a sinus of Valsalva in 6 cases, aortic endocarditis in 1, and iatrogenesis in 2.

Two patients had a VSD associated with a subarterial fistula. One patient had a bicuspid aortic valve and previously corrected aortic coarctation. The other patient had severe subvalvular pulmonic stenosis due to a fibromuscular band. In one patient the fistula was produced by prosthetic aortic valve endocarditis. Of the patients with an iatrogenic fistula, one originated during attempted percutaneous mitral valvuloplasty for severe mitral stenosis, and the other was the consequence of aortic valve replacement. In the latter case, extensive dissection of the interatrial septum occurred in the postoperative phase, forming a false chamber that perforated the right atrium.

In 8 patients, the fistula produced a large left-to-right shunt with a Qp/Qs ratio > 2. Only the patient with an iatrogenic fistula after mitral valvuloplasty had a small shunt, with Qp/Qs < 1.5. The 8 patients with a large left-to-right shunt presented symptoms of congestive heart failure as the initial manifestation, with symptoms of right heart failure predominating over those of left heart failure. The cause of the fistulas, main lesions associated, and clinical pictures are summarized in table 1. Two patients died before surgery: one patient, who refused surgery, died of congestive heart failure a few months after diagnosis; the other patient, who had prosthetic valve endocarditis, died of sepsis, cerebral embolism, and multiorgan failure. The remaining 7 patients were treated surgically as priority patients. No perioperative complications occurred. All the patients who underwent surgery survived the intervention and are alive after a mean follow-up time of 48 ± 34 months.

**Echocardiographic findings**

TTE detected a shunt between the aortic root and right chambers in 7 patients (78%) and was valuable in determining the size and function of the cardiac cavities, degree of aortic insufficiency, systolic pulmonary artery pressure, and pulmonary-to-systemic flow ratio. However, it was less effective in identifying the beginning and end of the fistula, or in diagnosing congenital aneurysm and its morphology. Of the 2 cases of subarterial VSD, TTE identified only one (Table 2).
TEE (Table 2) identified the fistula, sinus of Valsalva involved, and drainage orifice of the fistula in the right atrium or right ventricle in all the cases (Figure 1). The most useful view was the cross-sectional plane of the aortic root obtained with a rotation of 30° to 60°. In this plane, the morphology and number of aortic leaflets and location of the fistula could always be visualized (Figure 2). The morphology and size of the congenital aneurysm were clearly determined in every case. In the only patient with VSD in which TEE was performed, the prolapse of the aneurysm through the septal defect was visible (Figure 3). The aneurysm that prolapsed through the VSD and perforated the right ventricular outflow tract had a special mobility. In diastole it was spherical because the pressure in the aortic root was greater, but in systole it collapsed under the pressure of flow from the left ventricle through the VSD (Figure 3). In contrast, aneurysms not associated with a VSD had a spherical morphology in both systole and diastole because the pressure is higher in the aortic root than in the drainage chamber throughout the cardiac cycle (Figure 2). Finally, TEE made it possible to delimit other coexisting anomalies, such as subvalvular pulmonic stenosis or patent foramen ovale and, in the case of endocarditis, the perivalvular extension of the infection. The findings of TEE were confirmed in all the patients who underwent surgery.

In comparison with AC, TEE also was more effective in:

a) diagnosing the fistula and differentiating it from a sinus of Valsalva prolapse through a VSD (syndrome of Laubry);
b) identifying the sinus of Valsalva affected and the cardiac drainage chamber;
c) determining the cause of the fistula and the underlying mechanism;
d) visualizing the morphology of congenital aneurysms, and
e) defining the associated congenital or acquired cardiac anomalies (Table 2).

DISCUSSION

This study describes the etiopathogenesis, clinical...
course, and diagnosis of 9 patients with SVFRC followed-up in our center in the last 10 years, with special emphasis on the usefulness of multiplane TEE in the preoperative assessment of this entity.

Etiopathogenesis

Sinus of Valsalva fistula to right chambers is an uncommon entity in the Western world. 1-5 We found 9 cases in almost 50,000 patients studied echocardiographically in the same period, a prevalence of less than 0.02%. The prevalence is much higher in Asian countries, ranging from 0.96 to 1.5% of cardiac surgery procedures with extracorporeal circula-

tion 4 and reaching 0.2% of all echocardiographic studies. 8

The most frequent cause of SVFRC is perforation of a congenital sinus of Valsalva aneurysm, but other causes have been described, including infections (endocarditis, luetic aortitis) and traumatic or iatrogenic dissection. 1-6,11,12 In our series, the underlying cause was congenital aneurysm of a sinus of Valsalva in 6 patients (67%), infective (prosthetic valve endocarditis) in 1 patient, and iatrogenic in 2: percutaneous mitral valvuloplasty and dissection of the interatrial septum after surgery for aortic valve replacement. To our knowledge, these two iatrogenic causes of sinus of Valsalva fistula to right chambers have not yet been described.

Most patients with SVFRC have a rapidly pro-

gressive, voluminous left-to-right shunt that is po-

orly tolerated. Eight of our patients had a large shunt with Qp/Qs > 2. The clinical presentation was similar in all the patients, consisting of symptoms and signs of predominantly right heart failure. Given the gravity of the clinical condition, surgical intervention should not be delayed. Before surgery, diagnostic techniques should be used to confirm the clinical suspicion, differentiate it from other causes of continuous murmur, 13,14 and obtain as much exact information as possible about the origin and destination of the fistula, underlying cause, and effect on function ventricular.

Associated lesions

In patients with congenital aneurysm, associated lesions are not uncommon. Two of our patients had

Fig. 3 Case 5: TEE with a plane visualizing the right ventricular out-

flow tract (RVOT), subpulmonic VSD (long arrow), and prolapse of a right sinus of Valsalva aneurysm through the VSD. The aneurysm opens into the RVOT (short arrow). It is dilated and rounded in dias-
tole (D) and collapsed (arrowhead) in systole (S). Ao indicates aorta; PV, pulmonic valve.
a subarterial VSD, 1 had aortic coarctation and bi-
cuspid aortic valve, and 1 had subinfundibular pul-
monic stenosis (double-chambered right ventricle).
The frequent association of these congenital ano-
malies, especially VSD, has been reported in other
series. These congenital anomalies make the
preoperative diagnostic assessment more difficult.

Another factor of diagnostic confusion is the pre-
sence of aortic insufficiency. Two patients in our
series had severe aortic insufficiency dependent on
the aneurysm. Aortic valve insufficiency is com-
mon in patients with sinus of Valsalva aneurysm
that has ruptured into the right chambers, regard-
less of the cause. In at least 10% to 20% of cases,
aortic insufficiency requires prosthetic valve repla-
cement or aortic valvuloplasty at the time of sur-
gery. 3,6

Cardiac catheterization

The use of different diagnostic methods in
SVFRC has changed in recent decades. Initially, AC
was the fundamental diagnostic method. 15 In 1967
De Bakey, 16 described a series of 35 cases of fistulized
sinus of Valsalva aneurysms diagnosed by aor-
tography. In 1975, Meyer et al 1 published a series
of 45 patients who underwent surgery after cathete-
rization and AC, which was inconclusive in 15 ca-
ases. AC had many limitations in our series. It did not
detect the fistula in 2 cases and was not very useful
in precisely identifying the drainage chamber of the
fistula into the right heart and the sinus of Valsalva
affected. It also failed to delimit the associated le-
sions in 2 patients. However, cardiac catheterization
and AC were very useful in assessing aortic insuf-
siciency and determining pulmonary pressure and re-
sistance and the degree of left-to-right shunt.

Transthoracic echocardiography

In 1974, Rothbaum et al 17 reported echocardi-
ographic findings of ruptured sinus of Valsalva
aneurysms. Since then, 18-27 numerous publica-
tions have appeared, demonstrating the usefulness of bi-
dimensional and Doppler echocardiography in the
assessment of these fistulas. In our series, conven-
tional echocardiography with Doppler color was
performed in all patients and initially allowed the
identification of a shunt between the aortic root
and right chambers in 78% of the cases. TTE also
was very useful in assessing the hemodynamic re-
percussions (Qp/Qs, pulmonary artery pressure)
and degree of associated aortic insufficiency.
However, it was insufficient in determining the
size and morphology of the congenital aneurysms,
exactly delimiting the beginning and end of the fis-
tula, and diagnosing other associated congenital or
acquired lesions. Chiang et al 27 demonstrated that
bidimensional TTE failed to detect up to 42% of
genital sinuses of Valsalva aneurysms, although
this deficit could be reduced to 25% with contrast
injection. Doppler color increases the sensitivity of
transthoracic echocardiography, but it may fail to
detect smaller or unruptured aneurysms. The grea-
test limitation of this technique is difficulty in
identifying VSD because it masks flows 8 .

Nonetheless, several publications 3,28 have dem-
Onstrated that surgical repair can be carried out in se-
lected patients using bidimensional and Doppler
echocardiography studies, without need for pre-
vious catheterization.

Multiplane transesophageal
echocardiography

The usefulness of TEE in the preoperative assess-
ment of SVFRC has been demonstrated in publica-
tions of isolated cases. 12,23,29-37 Its usefulness has
been compared to conventional echocardiography
and angiography in only one Asian series of
23 patients in which multiplane TEE was perfor-
mation 10 cases. 38 In our series preoperative TEE
was performed in 7 cases. This technique proved
highly sensitive in the identification of the fistula,
sinus of Valsalva involved, and cardiac drainage
chamber. The size and morphology of the congeni-
tal aneurysm could be evaluated in all the cases. In
addition, TEE easily differentiated isolated perfora-
tion of a congenital sinus of Valsalva aneurysm and
perforation of an aneurysm prolapsed through a sub-
arterial VSD. The aneurysm prolapsed through the
VSD had a very different morphology in systole
and diastole. During diastole the aneurysm was dis-
tended and spherical due to the higher pressure in
the aortic root, but during systole the aneurysm col-
lapsed due to the high-pressure shunt from the left
to the right ventricle (Figure 3). This dynamic be-

behavior of sinus of Valsalva aneurysms perforated
through a VSD has not been described previously.
TEE was also more useful in assessing other asso-
ciated congenital lesions, but it was not superior to
TEE or aortography in assessing the degree of aor-
tic insufficiency or left-to-right shunt. 38

CONCLUSIONS

SVFRC are an entity with a very low prevalence,
frequently congenital, and in most cases require
early surgical treatment. This diagnosis should be
suspected in patients with a continuous cardiac mur-
mur, particularly if symptoms of congestive heart failure of rapid onset are present. Bidimensional echocardiography with Doppler color in most cases can confirm the diagnosis and provide a hemodynamic assessment of the degree of left-to-right shunt and/or aortic insufficiency. Multiplane TEE is the most useful diagnostic method for the assessment of the etiopathogenesis and anatomy of these fistulas, facilitating the election of the optimal surgical approach and treatment. Although cardiac catheterization has been shown to be less effective in diagnosing SVFRC, it continues to be useful in selected patients. However, it should not be considered the first-choice diagnostic method, but instead a complementary technique.

REFERENCES


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