

# Multimodality imaging and hybrid treatment of pulmonary artery stenosis in a patient with high risk of airway compression

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Patients with congenital heart defects and hypoplastic pulmonary arteries often require multiple surgical and percutaneous interventions. In those with pulmonary artery stenosis and the risk of compression of adjacent airways, bronchoscopic guidance may reduce complications [1]. A hybrid approach combining the strengths of surgical and transcatheter treatments during one anesthetic procedure, enables effective conduction of complex procedures [2]. Recent technological advancements provide multiple imaging techniques that allow a patient-tailored approach [3–5].

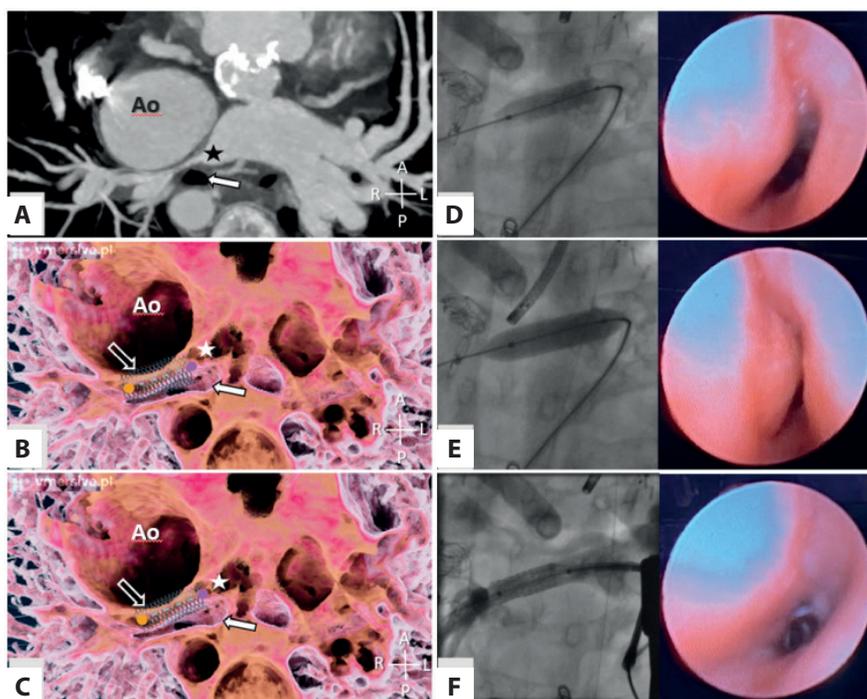
We present application of multimodality imaging, including computed tomography, virtual reality, and bronchoscopy for the planning and guidance of hybrid pulmonary artery stenting in a complex congenital heart defect.

A 13-year-old girl (42 kg), diagnosed with tetralogy of Fallot, pulmonary atresia, pulmonary arteries hypoplasia, and major aortopulmonary collateral arteries, after surgical correction with a right ventricle-to-pulmonary artery conduit (Contegra 12 mm) and collateral unifocalization, was referred by an outpatient clinic. On admission, an echocardiogram showed severe right ventricular hypertrophy, moderate tricuspid regurgitation with a high gradient (130 mm Hg), and significant conduit narrowing consistent with supra-systemic pressure in the right ventricle. A computed tomography scan revealed concentric calcification of the conduit and severe tubular narrowing of the medial and distal part of the right pulmonary artery (Figure 1A). The artery coursed between the major lobar bronchus and the ascending aorta, posing

the risk of airway compression in the case of stent implantation.

The routine computed tomography scans were additionally analyzed with VMersive software (VR-Learning, Warszawa, Poland) to prepare a three-dimensional virtual model, enabling simulation of various stent placement options and assessment of interaction with adjacent structures (Figure 1B, C; Supplementary material, Video S1).

After discussion at a multidisciplinary meeting, the patient was qualified for hybrid pulmonary artery dilatation and conduit replacement. Through a midline thoracotomy, a short vascular sheath (7 Fr) was introduced in the distal part of the degenerated conduit. A 10 × 30 mm PowerFlex balloon (Cordis) was advanced and gradually inflated in the narrow right pulmonary artery with simultaneous bronchoscopic evaluation of the right bronchus. Already at the subnominal pressure, a partial bronchial occlusion was observed (Figure 1D), and further balloon inflation to 8 atmospheres caused significant compression of the bronchus (Figure 1E), which was confirmed preprocedurally by virtual reality simulation with a 10 mm stent. Subsequently, an 8 × 20 mm Formula stent (Cook Medical) was gradually inflated with simultaneous visualization of the right bronchus, providing optimal vessel diameter and pulmonary blood flow while minimizing compression of the adjacent airway (Figure 1F). The position of the stent and improved blood flow through the pulmonary artery were confirmed by final angiography (Figure 1F). Next, the heavily calcified conduit was replaced with a 27 mm



**Figure 1.** Application of multimodality imaging, including computed tomography, virtual reality, and bronchoscopy for planning and guidance of hybrid right pulmonary artery stenting in a patient at risk of bronchial compression. **A.** Computed tomography scan: (cross-sectional view at the level of pulmonary arteries): right pulmonary artery – star, lobar bronchus – white arrow. **B.** Virtual reality simulation (cross-sectional view at the level of pulmonary arteries): a 10 × 20 mm stent – empty arrow, right pulmonary artery – star, lobar bronchus – white arrow. **C.** Virtual reality simulation (cross-sectional view at the level of pulmonary arteries): 8 × 20 mm stent – empty arrow, right pulmonary artery – star, lobar bronchus – white arrow. **D.** On the left side – posterior-anterior fluoroscopic view: a 10 × 30 mm balloon catheter inflated in the right pulmonary artery to 1 atmosphere; on the right side – bronchoscopic view: partially compressed lobar bronchus. **E.** On the left side – posterior-anterior fluoroscopic view: a 10 × 30 mm balloon catheter expanded in the right pulmonary artery to 8 atmospheres; on the right side – bronchoscopic view: near total compression of the lobar bronchus. **F.** On the left side – fluoroscopic posterior-anterior view: an 8 × 20 mm stent implanted into the right pulmonary artery; on the right side – bronchoscopic scan: patent lobar bronchus

Abbreviations: Ao, ascending aorta; A, anterior; P, posterior; R, right; L, left

Hancock II bioprosthetic valve (Medtronic). The postoperative course was uneventful. In a 5-month follow-up, echocardiography confirmed mild tricuspid valve regurgitation with a gradient of 55 mm Hg and unobstructed flow in the right pulmonary artery stent.

In cases of a risk of airway compression, multimodality imaging including routine computed tomography and bronchoscopy as well as more advanced virtual reality simulation, enables the selection of the optimal stent diameter reducing the risk of airway compression.

### Supplementary material

Supplementary material is available at [https://journals.viamedica.pl/kardiologia\\_polska](https://journals.viamedica.pl/kardiologia_polska).

### Article information

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