Percutaneous Fetal Cardiac Catheterization Technique for Stenting the Foramen Ovale in a Midgestation Lamb Model

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**Background**—Intact or highly restricted intra-atrial septum can be reliably diagnosed in the human fetus as early as 22 to 24 weeks of gestation. Fetal interventions targeting the atrial septum have used a direct approach through the atrial wall. Here, we report stenting of the foramen ovale with a large, open-cell stent via percutaneous access through the fetal hepatic vein in a sheep model.

**Methods and Results**—In 5 fetal sheep of 109 to 111 days of gestation (term, 147 days), the fetal hepatic vein was punctured percutaneously under ultrasound guidance and a 13.3-cm 14-gauge intravenous catheter was inserted. After catheterization of the inferior vena cava, right atrium, foramen ovale, and left atrium with a guidewire and 1.8F to 2.6F tapered catheter, a self-expandable, 8x12-mm flexible open-cell stent was positioned in an unrestricted foramen ovale. Flow and fetal well-being were documented for 45 minutes after the procedure. Access to the left atrium was achieved in all 5 animals and all survived. In 4 animals, the stent was successfully positioned in the foramen ovale. One fetus was born at term and euthanized on day 3: postmortem examination confirmed the patency of the stent. The other 3 fetuses were well after being monitored by ultrasound for 45 minutes. In 1 animal, the stent dislodged immediately after release obstructing the mitral valve. This fetus developed ascites and was euthanized after 4 days.

**Conclusions**—It is feasible to safely advance a large diameter, self-expandable, open-cell design stent into the fetal atrial septum via a percutaneous access route through the fetal hepatic vein. (Circ Cardiovasc Interv. 2015;8:e001967. DOI: 10.1161/CIRCINTERVENTIONS.114.001967.)

Key Words: atrial septum ■ cardiac catheterization ■ fetal heart ■ foramen ovale ■ hypoplastic left heart syndrome ■ stent

There are potentially several indications to open the atrial septum in a human fetus. The most common is established hypoplastic left heart syndrome (HLHS) with an intact or highly restrictive intra-atrial septum (IAS), preventing sufficient left to right flow, which in turn might lead to clinically significant changes in the lung parenchyma and pulmonary vasculature.1 Others include primary premature closure or restriction of the foramen ovale (FO) restricting the normal right to left flow, which commonly results in right to left ventricle discrepancy and mild to moderate hypoplasia of the mitral and aortic valves, as well as the aortic arch, and the well-described constellation of mitral regurgitation, aortic stenosis, IAS, and severe left atrial (LA) dilation.2

Although being a rare condition that accounts for <4% of congenital heart defects, HLHS still carries a significant mortality and is responsible for 23% of all deaths caused by congenital heart disease in the first year of life. Among patients with HLHS, those with a restricted FO and restricted intra-atrial communication, and those with an intact IAS with no intra-atrial communication, have a particularly poor outcome and an in-hospital mortality rate exceeding 65%.1,3

Restricted intra-atrial communication or an intact atrial septum can be reliably diagnosed as early as 22 to 24 weeks of gestation, either by direct visualization on prenatal ultrasound or by analysis of prenatal pulmonary vein flow patterns, which is predictive for postnatal LA hypertension.4 Consequently, fetal intervention with the goal of decompressing the LA by direct transcardiac puncture of the atrial septum followed by balloon dilatation of the FO has been performed and reported, mostly as a single-center experience.5–7 Despite these fetal interventions, outcomes have not improved significantly, and...
WHAT IS KNOWN

• In human fetuses with hypoplastic left heart syndrome, an intact or highly restrictive intratrial septum is one of the most important risk factors for poor outcome after birth and can be reliably diagnosed with ultrasound as early as 22 to 24 weeks of gestation.

• Prenatal opening of the atrial septum has been proposed as a means of preventing these complications by avoiding critical neonatal hypoxemia and potentially preventing the pulmonary lymphangiectasia and pulmonary vein muscularization that result from prolonged left atrial hypertension in utero.

• Despite the use of current transatrial fetal intervention techniques, outcomes have not improved significantly, and there is an ongoing discussion about how best to create a persistent and adequately sized atrial septal defect.

WHAT THE STUDY ADDS

• Percutaneous transhepatic access to the fetal heart in this animal model was associated with low procedure-related mortality and high technical success, largely independent of fetal positioning, and enabled safe delivery of 4F devices through a 14-gauge access.

• The open-cell, self-expandable stent design allowed advancement of stents with diameters of 7 to 10 mm and lengths of 12 to 24 mm through a 4F delivery system, substantially larger than the current transatrial approach, in which the stent diameter is limited to 2 to 3 mm.

Results

Access and Positioning of the Stent

Access to the fetal venous system was obtained using a percutaneous puncture through the maternal abdominal and uterine wall and into the fetal abdomen; all under continuous ultrasound guidance. Depending on the position of the fetus and the ease of access, the RHV or LHV was selected for puncture and sheath insertion. In all fetuses, hepatic access and sheath insertion were achieved using a 13.3-cm 14-gauge intravenous catheter (BD Angiocath; Becton Dickinson, North Ryde, Australia) inserted into the fetal RHV or LHV with the 14.0-cm needle in situ as previously described. Once venous access was achieved, and the catheter sheath was positioned close to the junction of the hepatic vein and IVC, the needle was removed leaving the catheter sheath in situ. The internal diameter of the sheath allows 4F access. Under ultrasound guidance, a 1.8F to 2.6F tapered catheter (FineCross MG; Terumo, Macquarie Park, Australia) was inserted into the sheath, over a 0.014-inch guidewire, which was curled at the tip (Hi Torque Balance Middelweight Universal; Abbott Vascular, Santa Clara, CA), and catherization of the RA, FO, and LA was performed. Once the coronary catheter tip and guidewire were visible in the LA, the Balance Middelweight-wire was exchanged for a stiffer 0.014-inch guidewire (Hi Torque Extra S’port; Abbott Vascular, Santa Clara, CA). The FineCross catheter was then removed, leaving the guidewire in the LA, and a 4F delivery system for a self-expandable, open-cell design, flexible stent (8x12-mm Superflex DS; OptiMed, Ettlingen, Germany) was advanced through the FO. The distal port of the stent was then opened in the LA, and the delivery system was carefully withdrawn to allow opening of the proximal portion of the stent in the RA (Figure 1). The delivery catheter and guidewire were then withdrawn completely, and flow through the stent was documented with color Doppler ultrasound. On removal of the sheath, the intrahepatic portion of the 14-gauge intravenous catheter entry canal was embolized to reduce the risk of intra-abdominal hemorrhage in the fetus (Gelfoam; Pharmacia & Upjohn Company, MI; Movie 1 in the Data Supplement).

Access to the fetal circulation was achieved in 5/5 cases, and all fetuses survived the intervention. In 3 cases, access to the IVC was achieved via the RHV: the IVC diameters were 5.3, 5.4, and 6.5 mm, and the distances along the IVC from the RHV to the RA were 27, 30, and 31 mm. In 2 cases, access to the IVC was achieved via the LHV: the LHV diameters were 4.2 and 5.0 mm, and the distance along the IVC from the LHV to the RA was 32 mm in both cases. The IVC (n=5) and FO (n=5) had median (range) diameters of 7.4 (6.3–7.7) mm and 7.0 (6.3–8.0) mm, respectively. Ultrasound scanning, the sole form of imaging used in all cases, provided adequate imaging of the fetal heart, catheter,
guidewires, and stent. The stent was positioned by direct ultrasound visualization within the sonographic landmarks of the FO. The stent was successfully positioned in the FO in 4 of the 5 animals (Figure 1). The unsuccessful case was in the first animal, in which the stent became dislodged immediately after being advanced out of the delivery catheter and became caught in the mitral valve, resulting in partial obstruction of LV inflow and moderate to severe mitral regurgitation. Although the fetus showed no signs of acute deterioration or injury to the heart, the animal developed increasing ascites over the next few days and was euthanized 4 days post procedure. In the 4 successful cases, the stable stent position and Doppler flow were observed over a period of 45 minutes after insertion of the stent. After careful exclusion of procedure-related complications such as hemopericardium or ascites, 3 of the 4 successful animals underwent an additional experimental protocol. One of these animals died acutely because of a complication arising during the additional protocol: immediate postmortem examination revealing bodyweight of 1920 g and the stent positioned in the FO. The other 2 were euthanized 3 weeks later according to the additional experimental protocol: bodyweights of 4570 and 4660 g, both stents fixed within the FO on postmortem examination. One of the 4 animals was returned to the animal housing facility and delivered spontaneously at term without any complications (birth weight 5310 g). Postmortem examination after euthanasia of the lamb on day 3 of life showed the stent securely positioned in the atrial septum with a patent lumen (Figure 2).

**Flow Through the Stent**

Unrestricted flow through the stent was demonstrated in all animals using color Doppler immediately after the procedure, and also on day 3 after stent insertion in the animal that was allowed to proceed to term delivery (Figure 3).

**Discussion**

Postnatal management and prognosis of infants with HLHS have improved significantly over recent decades. Advances in interventional and hybrid therapy for congenital heart disease are raising expectations in regard to the efficacy and safety of in utero interventions and their ability to provide a positive risk–benefit ratio when compared with postnatal interventions. Because the almost uniformly fatal prognosis of children with HLHS-IAS, this group is an ideal population...
to benefit from novel in utero therapies. Decompression of the LA in utero, close to delivery, might enable improved postnatal adaptation and greatly reduce immediate postnatal mortality. However, the long-term outcome of these late in utero interventions close to delivery, despite initial success, remains disappointing.\textsuperscript{15,16} Ideally, by decompressing the LA earlier in gestation, the presence of pulmonary lymphangiectasia and pulmonary vein muscularization at birth could be avoided. This injury to the pulmonary vasculature and lymphatic system\textsuperscript{17,18} limits the successful transition in many patients, toward a univentricular circulation in later life. The timing of the development of the pulmonary vascular and lymphatic changes, and its ability to normalize once the causative insult, LA hypertension, and pulmonary venous congestion secondary to IAS is removed, is not clearly determined. In 1 study in which 4 fetuses with HLHS-IAS underwent atrial decompression at 28 to 35 weeks of gestation, all had histological evidence of pulmonary lymphangiectasia and pulmonary vein muscularization at birth.\textsuperscript{19} There are 2 explanations for the persistence of these changes at birth, despite apparent atrial decompression: either the damage occurred before the intervention and did not reverse or the atrial decompression was insufficient, possibly because of the relatively small stent size, which was limited to 2.75 or 3.0 mm, or because of the restenosis of the interatrial communication which was noted in some cases. We are hoping that with the much larger stent used in our techniques that full and prolonged atrial decompression will result in better pulmonary vasculature at birth.

The current transcardiac approach to create a sufficient interatrial communication by accessing the heart with a relatively large introducer/sheath (18 gauge) through the paper-thin wall of the atria has 3 major drawbacks:

1. High risk of bleeding, cardiac tamponade, and the need for in utero resuscitation.\textsuperscript{5–7}
2. High rate of stent dislocation. Although a balloon-mounted stent prevents septal recoil and reclosure of the interatrial communication,\textsuperscript{6} this is frequently hampered by stent dislocation, especially because of the need to retrieve the balloon after delivery of the stent.\textsuperscript{7}
3. Limited stent diameter that can be delivered through 18-gauge access (2–3 mm diameter).\(^7\)

We propose that an alternative access route and novel stent materials may have the potential to reduce the risk of in utero LA decompression and may, if applied early enough, prevent damage to the pulmonary vasculature and the microscopic system. Our transhepatic access to the fetal heart has shown a low procedure-related mortality rate, a high technical success rate, is largely independent of fetal positioning, and enables safe delivery of 4F devices through a 14-gauge access. To demonstrate the feasibility of FO access in an animal model equivalent in size to a 31- to 32-week human fetus, which has a weight of 1900 to 2000 g,\(^19\) we used the fetal lamb at 110 days of gestation.\(^20\) At this stage, the fetal sheep FO is wide open with little to no septum primum for perforation and the anchorage of an adequately sized stent. Therefore, the procedures simulating perforation and stenting of the FO as performed in humans were performed in 2 separate steps. First, in a previous publication, we have shown that diathermy of the fetal cardiac tissue using the percutaneous transhepatic approach under ultrasound guidance is a feasible method to create perforations.\(^11\) Second, because IAS has been reported as showing recoil of the septum after balloon dilation alone,\(^6\) we have addressed that by stent insertion, which is necessary to ensure sustained patency of the created intra-atrial communication.\(^11\)

In this study, we used self-expandable sinus-superflex-DS (Optimed) stents with a length of 12 mm and a diameter of 8 mm. The size was chosen based on the measurement of the FO and the distance between the posterior LA wall and the anterior RA wall. The unrestricted and significant atrial communication in these nondiseased fetal lambs make stent placement extremely challenging and resulted in dislocation of the stent in the first animal. Nonetheless, we expect the risk for this complication to be minimal when stenting a restrictive or formed in humans were performed in 2 separate steps. First, the open-cell design (Figure 2) prevents the stent from slipping and improves fixation within the atrial septum, as demonstrated in the present study, in which large non-restricted FO of 5 to 7 mm were successfully stented.

• A high opening pressure is achieved by the self-expandable stent without the need for balloon inflation. If further dilatation of the restrictive FO is required, balloon dilation within the open-cell, self-expandable stent followed by balloon retrieval is expected to be feasible without risk of stent dislodgement, as both ends of the stent would have expanded to be much wider than its midportion at the atrial septum. In contrast, retrieval of the deflated balloon in balloon-mounted stents induces a high risk of stent slipping and dislodgement because the fixation in the thin atrial septum is relatively weak, because of minimal contact area between the stent and the thin atrial septum, and uniform diameter of the stent.

• Sonographic views of the fetal heart structures are not obscured by our intravascular and intracardiac approach, whereas the needles used in the transatrial approach may impede views or cause ultrasound artifacts resulting in loss of imaging detail.

The size of the atrial septal defect created and the stent type used are critical for patency and postnatal outcome in HLHS-IAS.\(^6,9\) Because embolization of the intrahepatic section of the sheath entry tract is feasible in our transhepatic approach to minimize the risk of hemorrhage once the sheath is removed, the capability to deliver large, open-cell designed stents through a 4F sheath may improve the efficacy (most interventions could be completed within 45 minutes, including access to the fetal circulation) and safety of the procedure when compared with the use of small, balloon-mounted coronary stents, which are at an increased risk of early stent occlusion and stent embolization.\(^9,15\)

Even with timely postnatal treatment of HLHS-IAS after birth to decompress the LA, mortality before and after surgical reconstruction is still double that of HLHS infants with naturally open FO.\(^22\) Death is typically related to ongoing hypoxemia, which may be because of the development of pulmonary vascular and parenchymal changes in utero, as a result of the long-standing elevated pulmonary venous pressure and reduced forward flow into the pulmonary arteries. As such, creating an atrial septal communication after birth is probably too late to mitigate the pulmonary pathological process, and an alternative such as noninvasive creation of atrial septal defect by histotripsy is still not clinically available yet.\(^23\)

Paucity of an animal model of HLHS-IAS currently prevents us from conducting an experiment that includes perforation of an intact septum with the subsequent placement of a stent. In the sheep model at the gestational age we used, the large size of the fetal FO with the little area of septum available for stent placement outside the FO renders intraseptal positioning of an 8-mm stent impossible. Nevertheless, this study demonstrated the feasibility of safely placing a large diameter stent into the fetal atrial septum, which might pave the way for translation into future clinical investigation in humans. In fact, the human anatomy of the junction between the fetal hepatic vein and the IVC being much closer to the RA than in the fetal sheep\(^24\) will probably favor transhepatic access to the RA in humans and guide the perforation and stent delivery system toward the atrial septum. We think that the complete procedure, when translated to a human case of HLHS-IAS, could be performed under ultrasound guidance and would involve transhepatic ultrasound-guided diathermy to perforate the IAS using techniques that we have previously described,\(^11\) followed by predilation of the atrial septum with a coronary balloon if the stent delivery system could not be advanced, then insertion and deployment of the self-expandable stent as described in
this study. The sinus-superflex-DS stent expands with a radial force of 4± to 5 atmospheres, but if that is not sufficient, ballooning of the implanted stent by catheter should be possible.

To our knowledge, there are no published data on the diameter of the human fetal hepatic vein for comparison with the fetal sheep, but limited evidence suggests that the diameters of nearby vessels, namely the ductus venous and intrahepatic umbilical vein, are of similar caliber in the human and sheep fetus.\textsuperscript{25-28} The 14-gauge intravenous catheter that we used in the experiments reported here to access the fetal hepatic vein could be comfortably positioned with some safety margin allowing for the potentially narrower diameter of the hepatic vein in the human fetus. Alternatively, direct access to the intrahepatic section of the IVC could be an option.

To conclude, transhepatic percutaneous delivery of large open-cell stents is a potential treatment for HLHS-IAS and other conditions with an intact or restrictive atrial septum. This approach is a potentially effective alternative to transcatheter manipulations of the atrial septum using balloon-expandable stents. Our experience with this large animal model supports moving forward toward potential clinical application.

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Disclosures

None.

References


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