Biventricular Assist Device Utilization for Patients with Morbid Congestive Heart Failure

A Justifiable Strategy

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Background—The rationale for the use of a biventricular assist device (BiVAD) for morbid congestive heart failure (MCHF) has been questioned because of historically unacceptable rates of postimplant and post-transplant mortality as well as perceived barriers to their outpatient management.

Methods and Results—All patients who received a Thoratec BiVAD from January 1990 to December 2003 at the University of Pittsburgh were studied retrospectively. There were a total of 73 patients (32% ischemic, 21% idiopathic, and 47% other) who had a BiVAD implanted. Before implantation, 100% were on inotropic agent, and 77% had an intra-aortic balloon pump. Overall survival was 69%; 42 patients (84%) received cardiac transplantation, 5 patients (10%) were weaned, and 3 (6%) remained supported on BiVAD. If the 14 patients with postcardiotomy failure and acute myocardial infarction with shock are excluded, the overall survival improves to 75%. Five-year actuarial survival after heart transplantation was 58%. Of the 29 patients implanted before 2000, the 4-month actuarial freedom from driveline infections, bloodstream infections, and neurological events was 10%, 54%, and 48%, respectively, whereas the rates of these events for the 44 patients implanted after 2000 improved to 70%, 79%, and 80%, respectively. Since 2000, 21 (48%) patients were discharged from the hospital, of whom 38% went to an outpatient residence, 33% to a skilled nursing facility, and 29% to home. Once discharged, ≥1 readmission occurred in 45% and ≥2 readmissions in 48%.

Conclusions—BiVAD support for MCHF has an acceptable overall mortality and survival to transplantation. Morbidity has been significantly reduced in the past 4 years, and management as an outpatient is achievable. (Circulation. 2005; 112[suppl I]:I-65–I-72.)

Key Words: biventricular assist device ■ cardiomyopathy ■ heart failure

Nearly 300,000 patients die from heart failure each year in the United States despite optimal medical therapy; and although ≈10,000 qualify as transplant candidates, only ≈2000 cardiac transplants are performed each year. As a consequence, left ventricular assist devices (LVADs) are now increasingly used to bridge patients to cardiac transplantation. However, in many patients, their cardiomyopathy can result in substantial right ventricular as well as left ventricular dysfunction. In our early experiences with the Novacor Left Ventricular Assist System (LVAS; World Heart Inc.), we were able to define a population of patients who did poorly with support from an LVAD alone. We found that this group of patients required an extended period of inotropic support for the right ventricle or had a high mortality from multiorgan failure when the strategy for using a right ventricular assist device (RVAD) was delayed until persistent shock occurred on an LVAD. Thus, in patients with severely decompensated heart failure with signs of significant right ventricular failure in whom an LVAD alone may not provide adequate circulatory support, we believed a strategy of planned biventricular assist device (BiVAD) implantation would be more effective. Unfortunately, in most published series, the mortality in patients requiring BiVAD as a bridge to transplantation has been reported to be >40% in contrast to the 25% mortality of patients bridged on an LVAD. This disparity in survival between BiVAD and LVAD, in addition to the perceived technical challenges to placement of a BiVAD, has led some to question the rationale for use of a BiVAD for morbid congestive heart failure (MCHF).

Most reports of using mechanical circulatory support as a bridge to transplantation contain very few patients who receive a BiVAD as an intention to treat, and those that do reflect a substantial number of patients who are at much higher risk, such as patients with postcardiotomy failure.
Although the consequences of prolonged inotropic support for a dysfunctional right ventricle in the setting of an LVAD are not well documented, such a strategy necessitates long-term inpatient management and has implications for rehabilitation and mobility as well as affecting the filling characteristics of the LVAD. In the past 10 years, we have used the Thoratec BiVAD (Thoratec Corp) strategically in patients with significant right ventricular dysfunction as well as in patients in whom we felt the risk for right ventricular failure would be high peroperatively on the basis of our early experience with using a single ventricle strategy. Our hypothesis was that through optimizing right ventricular flow and meticulous postoperative management protocols, we could achieve an acceptable morbidity and mortality in a morbidly ill patient population.

Methods

Data

Demographic and clinical outcome data, including adverse events and information regarding pump performance and device malfunction, were collected prospectively on all VAD recipients at the time of device implantation or on listing for transplantation. Patient data were prospectively collected into the Web-based Transplant Patient Management System (TPMS). This database was designed to function as a clinical database and a research registry and operates under protocols for these purposes that are approved by the University of Pittsburgh institutional review board for the use of patient management, quality assurance reports, and clinical research. It interfaces between multiple electronic databases within the University of Pittsburgh Medical Center and automatically ensures that all laboratory values before implantation of the device. Integrity of the database and quality assurance of the data are maintained by one of the investigators (J.R.B.) who performs the aggregate reports for this study as the honest broker in a deidentified format. Access to the database and quality assurance of the data are maintained by one of the investigators (J.R.B.) who performs the aggregate reports for this study as the honest broker in a deidentified format. Access to the TPMS database is password protected and conforms to Health Insurance Portability and Accountability Act (HIPPA) requirements.

Patients

The prospectively collected data from the TPMS was evaluated retrospectively in patients receiving biventricular support from January 1990 to December 2003. Patients were assigned on the basis of the date of BiVAD implantation into 2 cohorts: group A implanted from 1990 to 1999 (n=29), and group B implanted from 2000 to 2003 (n=44). Patients were included if they were heart transplant candidates and underwent Thoratec BiVAD support as the intention to treat as a bridge to heart transplantation. Patients were excluded from the analysis if the RVAD was placed >24 hours after implantation of the LVAD. Patients were also excluded from the study if they received a different type of RVAD from their LVAD because the anticoagulation protocols for each device were different. Therefore, this report dealt with only those patients for whom a preplanned BiVAD was the method for circulatory support.

Device

The Thoratec VAD system was used for biventricular support in all patients. This device consists of 3 components: (1) a blood pump, which has a 65-mL stroke volume and can deliver pulsatile flows of

\[ \text{1.3 to 7.1 L/min} \]

(2) cannulae, which connect the blood pump to the heart; and (3) a drive console that powers the blood pump pneumatically. The VADs were placed in a paracorporeal position on the anterior abdominal wall. The LVAD cannulation was performed via left ventricular apex (inflow) with return to ascending aorta (outflow). We exclusively used left ventricular apical cannulation even in cases of a fragile left ventricle attributable to acute myocardial infarction. The RVAD was cannulated via the right atrium or, rarely, the right ventricle (inflow) and the pulmonary artery (outflow). Right atrial cannulation was performed in 90% (Figure 1). During implantation, transesophageal echocardiography was used to assess for a patent foramen ovale, which was closed if present. During the group A era of patients, the postoperative anticoagulation protocol consisted of immediate postoperative anticoagulation, with heparin and rapid conversion to Coumadin as soon as the patient was transferred out of the intensive care unit with the aim of removing intravenous lines as soon as possible. The goal was to achieve a target international normalized ratio (INR) of >2.5 as soon as possible. Postoperative anticoagulation in the group B era patients was started with 40% Dextran at 25 mL per hour for 6 hours after admission to the intensive care unit if bleeding was <100 mL per hour. Subsequently, heparin was started when postoperative bleeding from the chest tubes was <50 mL per hour over 3 consecutive hours. The goal for the partial thromboplastin time (PTT) was 40 to 51 seconds for at least the first 72 hours or until the risk of bleeding from more aggressive anticoagulation was felt to be acceptable. Heparin was then increased to maintain a PTT of 42 to 62 seconds. Coumadin was introduced at postoperative day 10 to keep the INR between 2.5 and 3.5. Heparin was discontinued after obtaining an INR of >2.5. The philosophy of anticoagulation in this latter group was to maintain heparin until the patient demonstrated a low risk for bleeding complications and after there had been a period of stable gastrointestinal tract function and diet. This was usually found to occur ~10 to 14 days after implant. A daily dose of 325 mg of aspirin was also started ~48 hours after implant. After discharge, the INR was assessed at a minimum of 2× per week for stable patients. To prevent infection from the exit site and kinking of the conduits, the VADs were restrained with an elastic dressing after implantation.

In the group A patients, driveline dressing changes occurred on a daily basis with the use of antibiotic or betadine rinses. This persisted
73 patients (32%) underwent placement of a biventricular assist device before transplantation, whereas 1 survived after transplantation. All 73 patients who met criteria for this review received the Thoratec VAD system. Patients were then categorized according to the era in which they had their BiVAD implanted, from 1990 to 1999 (group A) or from 2000 to 2003 (group B). The latter time period was one in which standardized postimplant protocols for driveline and anticoagulation were established, the details of which are discussed below. The clinical characteristics and preoperative laboratory values of the entire cohort and each implantation era are shown in Table 1. There were 46 males (63%) and 27 females (37%), with ages ranging from 7 to 66 years (mean 43.5 ± 16.1).

### Analysis

Data were analyzed using the commercially available statistics packages Statview (version 5.0; SAS Institute Inc.) and Statistica (StatSoft Inc.). Survival is expressed in 30-day and actuarial format using Kaplan–Meier statistics, and significance is expressed as P<0.05 with Mantel–Cox statistics or by using parametric or nonparametric comparisons where appropriate. Freedom from driveline and bloodstream infection and freedom from neurological events are expressed actuarially.

### Results

There were 228 patients who received a VAD at University of Pittsburgh Medical Center during the study period. A total of 73 patients (32%) underwent placement of a biventricular assist device as the intention to treat for severe congestive heart failure. This number does not include 3 patients who received an intention-to-treat LVAD followed by an emergency RVAD 24 hours after their LVAD, all of whom died (2 on device before transplant and 1 within 24 hours after transplantation). In addition, it does not include 5 patients who received a hybrid BiVAD: 3 patients received a Novacor LVAS and Thoratec RVAD, and 2 patients received HeartMate LVAS (Thoratec Corp) and Thoratec RVAD. All Novacor-Thoratec hybrid patients died either on device before transplantation (2) or within 30 days after transplantation (1), and 1 HeartMate-Thoratec hybrid patient died on device before transplantation, whereas 1 survived after transplantation. All 73 patients who met criteria for this review received the Thoratec VAD system. Patients were then categorized according to the era in which they had their BiVAD implanted, from 1990 to 1999 (group A) or from 2000 to 2003 (group B). The latter time period was one in which standardized postimplant protocols for driveline and anticoagulation were established, the details of which are discussed below. The clinical characteristics and preoperative laboratory values of the entire cohort and each implantation era are shown in Table 1. There were 46 males (63%) and 27 females (37%), with ages ranging from 7 to 66 years (mean 43.5 ± 16.1).

#### TABLE 1. Demographics

<table>
<thead>
<tr>
<th></th>
<th>Overall (n=73)</th>
<th>Group A (n=29)</th>
<th>Group B (n=44)</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>43.5±16.1</td>
<td>46.2±11.1</td>
<td>42.2±8.2</td>
<td>NS</td>
</tr>
<tr>
<td>Gender (% male)</td>
<td>63.0</td>
<td>58.6</td>
<td>65.9</td>
<td>NS</td>
</tr>
<tr>
<td>BSA (m²)</td>
<td>1.89±0.27</td>
<td>1.80±0.26</td>
<td>1.96±0.26</td>
<td>NS</td>
</tr>
<tr>
<td>Hypertension (%)</td>
<td>52.1</td>
<td>44.8</td>
<td>56.8</td>
<td>NS</td>
</tr>
<tr>
<td>Diabetes (%)</td>
<td>34.2</td>
<td>34.5</td>
<td>34.1</td>
<td>NS</td>
</tr>
<tr>
<td>Dialysis (%)</td>
<td>2.7</td>
<td>3.4</td>
<td>2.3</td>
<td>NS</td>
</tr>
<tr>
<td>Inotropic support (%)</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>NS</td>
</tr>
<tr>
<td>IABP support (%)</td>
<td>76.7</td>
<td>75.9</td>
<td>77.3</td>
<td>NS</td>
</tr>
<tr>
<td>Etiology of CHF</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ischemic (%)</td>
<td>31.5</td>
<td>37.9</td>
<td>27.3</td>
<td>NS</td>
</tr>
<tr>
<td>Idiopathic (%)</td>
<td>19.2</td>
<td>13.8</td>
<td>22.7</td>
<td>NS</td>
</tr>
<tr>
<td>Inflammatory (%)</td>
<td>11.0</td>
<td>10.3</td>
<td>11.4</td>
<td>NS</td>
</tr>
<tr>
<td>Postcardiotomy failure (%)</td>
<td>11.0</td>
<td>10.3</td>
<td>11.4</td>
<td>NS</td>
</tr>
<tr>
<td>Acute myocardial infarction (%)</td>
<td>8.2</td>
<td>3.4</td>
<td>11.4</td>
<td>NS</td>
</tr>
<tr>
<td>Others (%)</td>
<td>19.1</td>
<td>24.3</td>
<td>15.8</td>
<td>NS</td>
</tr>
<tr>
<td>Preoperative laboratory values</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BUN (mg/dL)</td>
<td>33.7±22</td>
<td>35.7±19.8</td>
<td>32.4±24.6</td>
<td>NS</td>
</tr>
<tr>
<td>Creatinine (mg/dL)</td>
<td>1.6±0.8</td>
<td>1.7±0.7</td>
<td>1.5±0.9</td>
<td>NS</td>
</tr>
<tr>
<td>Total bilirubin (mg/dL)</td>
<td>1.5±0.9</td>
<td>1.5±1.0</td>
<td>1.5±0.9</td>
<td>NS</td>
</tr>
</tbody>
</table>

BSA indicates body surface area; CHF, congestive heart failure; IABP, intra-aortic balloon pump.
TABLE 2. Preoperative Hemodynamics

<table>
<thead>
<tr>
<th></th>
<th>Overall Data (n=54)</th>
<th>Group A (n=22)</th>
<th>Group B (n=32)</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>RAP (mm Hg)</td>
<td>16.3±7.0</td>
<td>17.6±7.6</td>
<td>15.4±6.7</td>
<td>NS</td>
</tr>
<tr>
<td>sRVP (mm Hg)</td>
<td>53.2±13.4</td>
<td>53.1±11.6</td>
<td>53.2±14.6</td>
<td>NS</td>
</tr>
<tr>
<td>dRVP (mm Hg)</td>
<td>17.8±6.9</td>
<td>17.0±6.7</td>
<td>18.4±7.2</td>
<td>NS</td>
</tr>
<tr>
<td>sPAP (mm Hg)</td>
<td>51.9±14.6</td>
<td>52.5±12.8</td>
<td>51.4±15.9</td>
<td>NS</td>
</tr>
<tr>
<td>dPAP (mm Hg)</td>
<td>27.3±8.2</td>
<td>27.3±7.9</td>
<td>27.4±8.6</td>
<td>NS</td>
</tr>
<tr>
<td>mPAP (mm Hg)</td>
<td>36.7±9.8</td>
<td>37.9±9.6</td>
<td>35.8±10.0</td>
<td>NS</td>
</tr>
<tr>
<td>PCWP (mm Hg)</td>
<td>27.5±7.9</td>
<td>28.7±7.7</td>
<td>26.6±8.0</td>
<td>NS</td>
</tr>
<tr>
<td>CI (L/min/m²)</td>
<td>1.94±0.61</td>
<td>2.01±0.72</td>
<td>1.89±0.52</td>
<td>NS</td>
</tr>
</tbody>
</table>

CI indicates cardiac index; PAP, pulmonary artery pressure; PCWP, pulmonary capillary wedge pressure; RAP, right atrial pressure; RVP, right ventricular pressure.

Preoperative laboratory values or hemodynamics between groups A and B. Indications for BiVAD implantation are shown in Table 3 but in general included situations in which there was an increased risk for multiorgan dysfunction, right ventricular failure, or perioperative bleeding.

Patient Outcome
Of the 73 patients, 50 (68%) patients, of whom 42 (84%) received a cardiac transplant (after a mean support of 86 days; range 1 to 426 days), 5 patients (10%) were weaned to recovery (mean support of 88 days; range 47 to 191 days), and 3 patients (6%) remained supported with a BiVAD at the end of the study period, mortality after device placement was 32% and occurred after a mean support time of 47 days (range 1 to 170 days). Causes of death included multiorgan failure in 10 (44%), neurological event (embolic, hemorrhagic, ischemic, and cerebrovascular accident) in 5 (22%), sepsis in 3 patients (13%), respiratory failure in 2 (8%), and other causes in 3 (13%).

After BiVAD implantation, 65 patients (89%) were eventually listed for cardiac transplantation. Of those not listed, 5 patients died while supported because of a failure to achieve a level of clinical stability that would allow transplantation to be performed safely or because of unusual circumstances in which major psychosocial or compliance issues were identified that would limit successful survival after transplantation. These patients were, in effect, “destination” BiVAD patients.

TABLE 3. Indications for BiVAD Implantation

<table>
<thead>
<tr>
<th>Indication</th>
<th>Group A (n=22)</th>
<th>Group B (n=32)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute cardiogenic shock with multiorgan dysfunction with coagulopathy</td>
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<tr>
<td>Intractable ventricular arrhythmia or persistent ventricular fibrillation</td>
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<tr>
<td>Severe right ventricular dysfunction—characterized CVP &gt;18 mm Hg or mean PAP &lt;25 mm Hg or diastolic PAP &lt;15 mm Hg on inotropic support and IABP</td>
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<tr>
<td>Giant cell myocarditis</td>
<td></td>
<td></td>
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<tr>
<td>Acute biventricular myocardial infarction with or without ventricular septal defect</td>
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<td></td>
</tr>
<tr>
<td>Acute biventricular postcardiotomy failure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LVAD flow &lt;2.0 L/min/m² and CVP &gt;18 mm Hg after LVAD implantation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CVP indicates central venous pressure; IABP, intra-aortic balloon pump; PAP, pulmonary artery pressure.

Another 3 patients showed significant recovery of biventricular function from peripartum or inflammatory cardiomyopathy to the extent that they could eventually be successfully weaned from support and have the devices explanted. Once listed, 9 (14%) of the 65 patients were subsequently delisted, 7 because of the development of terminal comorbidities, and 2 additional patients were weaned after their initial listing.

Overall 30-day postimplant mortality was 15% (Figure 2A). We examined the mortality in a subset of 59 patients who did not have postcardiotomy failure or acute myocardial infarction with cardiogenic shock because these have been shown previously to be very high-risk populations.4–7 This was confirmed in our study, with our 14 postcardiotomy patients having a 30-day postimplant mortality of 21% and a transplant success rate of only 36%. With these patients excluded, the therapeutic success rate in group A was 72%, and in group B, the success rate improved to 76%.

Mortality 30 days after transplant for those surviving to transplantation was only 4% in the entire cohort, but there was a substantial decrease in the 30-day post-transplant mortality from 6.9% in group A to 2.3% in group B patients (Figure 2B).

Actuarial survival rate after VAD implantation was 53% at 12 months (Figure 3A). Five-year actuarial survival rates after heart transplantation calculated with Kaplan–Meier method was 58% (Figure 3B).

Complications
The need for re-exploration because of bleeding occurred in 25 patients (34%): 17 required only 1 re-exploration, 6 required 2 re-explorations, and 2 required 3 re-explorations. The 4-month
actuarial freedom from driveline infection was 10% in the 29 group A patients, whereas it was 70% in the 44 group B patients (Figure 4). The 4-month actuarial freedom from bloodstream infection in group A was 54% and improved to 79% in group B (Figure 4). The 4-month freedom neurological events improved from 48% in group A to 80% in group B (Figure 4). Although there were no major device malfunctions, 3 patients required elective change-out of the RVAD pump: 2 because of thrombus formation (postoperative days 48 and 321) and 1 patient because of a cracked housing after extended long-term use (postoperative day 584).

Patients Discharged From Hospital
Twenty-one patients (48%) of group B were successfully discharged from the hospital: 8 patients (38%) to an outpatient residence, 7 (33%) to a skilled nursing facility, and 6 (29%) to home, including 1 patient discharged home via a skilled nursing facility. The major barriers to discharging patients directly to home were: a period during which the portable controller of Thoratec VAD system was unavailable, thus requiring discharge to an outpatient skilled nursing facility on console; the requirement for inpatient rehabilitation; and inadequate family support, especially with regard to the inability to provide adequate wound care. Readmission occurred in 20 patients (61%), with approximately half requiring ≥1 admission and half ≥2 admissions. Reasons for readmission included infection in 20%, bleeding in 10%, neurological events in 6%, device malfunction in 6%, arrhythmia in 6%, hepatic dysfunction in 6%, pulmonary dysfunction in 6%, renal dysfunction in 3%, and other causes in the remaining 37%.

Discussion
The rationale for use of a BiVAD for MCHF is still controversial. Patients requiring BiVAD are generally more severely ill in the preoperative period, and the survival of patients through heart transplantation is significantly better in patients who received a LVAD (74%) than in those who had a BiVAD (58%). With twice as many cannulae and pumps, the higher incidences of thrombotic, infectious, cannulation, and mechanical problems with a BiVAD versus an LVAD.
shift. Therefore, in most cases, even with echocardiographically
congestive heart failure, is ultimately more beneficial to the
treatment of an elevated left atrial pressure in patients with chronic
failure even when the preimplant hemodynamics appear to be
factors have been shown to lead to post-LVAD right ventricular
bleeding, particularly in the setting of multiorgan failure. These
severe coagulopathy with risk for substantial perioperative
insertion. We have chosen to place a BiVAD in patients with
right ventricular dysfunction as evidenced by low pulmonary
pressures (\(21\) mm Hg) and high central venous pressure
\(25\) mm Hg mean or a diastolic pressure
\(21\) mm Hg). Data from Farrar et al and our own work has revealed that the
indicators of illness and perioperative factors (lower mixed
venous oxygen saturation, a greater level of inotropic need,
impaired mental status, and a lower ratio of right ventricular
fraction to inotropic need) that result in impairment of pulmo-
nary blood flow or reduced perfusion of right ventricle after
LVAD implantation were considered to be more predictive of
the need for additional right ventricular assist than preimplanta-
tion measures of right ventricular function or hemodynamic
variables.\(^8\) Farrar demonstrated patients requiring BiVAD were
more severely ill, as demonstrated by a higher serum creatinine,
a greater proportion of ventilator dependence before VAD, and
emergent implantation.\(^8\) Other authors concluded the need for
circulatory support, female gender, nonischemic etiology,\(^12\) low
pulmonary artery pressure, and low right ventricular stroke work
index\(^13\) were significant predictors for RVAD use after LVAD
insertion. We have chosen to place a BiVAD in patients with
right ventricular dysfunction as evidenced by low pulmonary
pressures (<\(25\) mm Hg mean or a diastolic pressure
<\(15\) mm Hg) and high central venous pressure (>\(18\) mm Hg).
In addition, we placed a BiVAD in patients with severe biven-
tricular dysfunction in the setting of myocardial infarction, in
the presence of severe pulmonary edema, or in whom there is a
severe coagulopathy with risk for substantial perioperative
bleeding, particularly in the setting of multiorgan failure. These
factors have been shown to lead to post-LVAD right ventricular
failure even when the preimplant hemodynamics appear to be
satisfactory for LVAD alone support.

Data from Farrar et al and our own work has revealed that the
septal shift, which accompanies the implantation of an LVAD,
results in mild to moderate right ventricular dysfunction in most
patients receiving an LVAD. However, the profound right
ventricular afterload reduction, which accompanies the reduc-
tion of an elevated left atrial pressure in patients with chronic
congestive heart failure, is ultimately more beneficial to the
function of the right ventricle than the negative impact of septal
shift. Therefore, in most cases, even with echocardiographically
documented severe right ventricular dysfunction, an RVAD is
not required. On the other hand, if complications occur that raise
the parenchymal or vascular pulmonary pressure, such as with
pre-existing pulmonary edema or microvascular obstruction that
accompanies severe bleeding and subsequent massive blood
product transfusion, then there is little afterload reduction for the
right ventricle, the negative effects of septal shift will predom-
ninate, and right ventricular failure becomes pronounced.
Therefore, it appears that the most important factor in avoiding right
ventricular failure after LVAD implantation is protection of the
lungs. It was our prejudice to implant a BiVAD in those
instances in which we expected pulmonary insults including
bleeding requiring massive blood product transfusion and ongo-
ing severe preimplant pulmonary edema. This was in addition to
the indications outlined previously that included factors affecting
right ventricular coronary perfusion, severe preoperative right
ventricular dysfunction, or severe intractable ventricular arrhyth-
mas. It is our belief that the morbidity of delayed placement of an
RVAD or attempting to support a patient on an LVAD with
high doses of inotropic support leads ultimately to multiorgan
failure. For these reasons, when presented with a high-risk
patient population as outlined in Table 2, it is our preference to
implant a BiVAD strategically as the first device.

The 1- and 5-year survival rates after heart transplantation in
patients after BiVAD implantation were \(76\)% and \(58\)%,
respectively. This compares favorably to data from the registry of the
International Society for Heart and Lung Transplantation (ISHLT)
21st Official Adult Heart Transplant Report—2004, in which 1- and
5-year survival rates were ~\(80\)% and \(65\)% respectively.\(^2\) Although
our 5-year survival rate was inferior to that of ISHLT, our 15
patients who died after heart transplantation had more risk factors
than the patients in the ISHLT report (Table 4).
The most common complications after VAD implantation are
bleeding, infection, and thromboembolic events. With the increase
of the mean support duration because of the shortage of donor
organs, patients are exposed to an increasing probability of infec-
tious and thromboembolic complications during VAD support.
Bleeding is the most common perioperative complication and is
especially important in those with pre-existing hepatic dysfunction
secondary to cardiogenic shock combined with preimplant antico-
agulation with Coumadin. The reported prevalence of bleeding in
patients with Thoratec VAD is \(31\)% to \(60\).\(^{14}\) We developed
strategies to decrease intraoperative bleeding by using aprotonin or
Amicar before surgery. We also used meticulous preclotting of the
outflow grafts with blood- and calcium-activated thrombin spray
and apply calcium product bio-glue to the apex cannulation site. The
safety provided by the device allows us to withhold anticoagulation
for \(8\) to \(12\) hours after device implantation, thereby reducing the
risk of perioperative bleeding.

Driveline infection is still a continuing problem for VAD
patients, especially with extended periods of use. Ankersmit et al
pointed out that VAD implantation causes an aberrant state of
T-cell activation, heightened susceptibility of CD4 T cells to
activation-induced cell death, progressive defects in cellular
immunity, and increased risk of opportunistic infection.\(^13\) In the
REMATCH trial, the probability of infection of the LVAD was
\(28\)% within 3 months after implantation.\(^16\) Although these
infections occur primarily in the VAD driveline and pocket, it is
nevertheless common to develop to fatal sepsis. Because driv-
elined infection rates are high even in an intracorporeal LVAD with only the 1 driveline passing through the skin, it would be expected that the Thoratec BiVAD would have a higher infectious risk because it has 4 percutaneous cannulae. McBride et al demonstrated driveline infection prevalence was 15% in bridge to transplant patients with a mean support duration of 40.7 days. To address the issue of driveline infections, we changed to transplant patients with a mean support duration of 40.7 days. To address the issue of driveline infections, we changed to a strategy of decreasing the frequency of wound exposure and thus have decreased the frequency of dressing changes from daily to weekly as long as there is no significant drainage present. Wound care was done with betadine (povidone–iodine 10%) solution initially but switched to Technicare because of an increase in the rate of infection. However, after we switched to Technicare, we experienced an outbreak of pseudomonas infection, and now diluted Hibiscens is the preferred agent during dressing changes. We also asked the patients to not shower as frequently. With the institution of these changes to the dressing protocol, we improved the 4-month actuarial freedom from driveline infection rate from 10% in group A to 70% in group B. Bloodstream infection is also a devastating problem. Prevalence rates in various series are reported to be 22% to 55%, and this complication strongly affects mortality. Intraoperative care with sufficient irrigation and appropriate antibiotics administration made it possible to increase the 4-month actuarial freedom from bloodstream infection rate from 54% in group A to 79% in group B.

The rate of thromboembolic events in bridge to recovery and bridge to transplantation patients is 9% and 19%, respectively. The 4-month actuarial freedom from neurological complications in our series improved from 48% in group A to 80% in group B. This result parallels the reduction in infection rates and also reflects careful patient and family training on how to manage drivelines. We recently introduced use of the thromboelastogram (TEG) to monitor platelet function. We anticipate the precise platelet function control based on TEG will further prevent long-term thromboembolic complications.

From the beginning of introduction of the Thoratec VAD, we initiated a program of discharge from hospital with VAD support. The benefits of discharging patients to home couples quality of life improvements and economic advantages for patients on VAD. DeRose et al were able to discharge 19 of 32 patients (59%) on LVAD from the hospital on mean postoperative day 41±4 (range 17 to 68) for an outpatient support time of 108±30 days (range 2 to 466). In group B, 21 of 44 patients (48%) were discharged after the patients and families received education for proper VAD maintenance. Use of the newer implantable configurations of system (Thoratec implantable VAD [IVAD]) will likely further increase the proportion of patients who can be discharged directly to home because of the simplicity of its wound care compared with the BiVAD. However, the readmission rate is still high (61%).

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This was not meant to be a study of the differences in characteristics between patients who had LVAD and BiVAD but rather an assessment of the outcomes of our particular strategy of placing a BiVAD and our subsequent improvements in the care of these patients. Our efforts at outpatient management benefit from a robust support system of physicians, nurses, engineers, and other support personnel experienced with the care of patients on ventricular support. It also acknowledged that there is the potential that many of our reasons for placing patients on biventricular support are related to perioperative right ventricular dysfunction, and that if a low-cost removable alternative for temporary right heart support existed, we may have been able to place a traditional implantable LVAD. The temporary RVAD could then be removed at a later date. We did not systematically try to wean patients form the RVAD once the BiVAD had been implanted.

Conclusion
Support with BiVAD offers an acceptable rate of survival to cardiac transplantation. Furthermore, the use of a BiVAD itself does not confer an increased morbidity or mortality, and overall outcomes with this device are comparable to that of implantable LVADs if used strategically in severe congestive heart failure. With the institution of meticulous wound care, morbidity has been significantly reduced, and management as an outpatient is achievable; however, readmissions are still frequent. The precise factors that determine the need for biventricular versus univentricular support are still ill defined but remain a major focus for future research.

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References


Biventricular Assist Device Utilization for Patients with Morbid Congestive Heart Failure: A Justifiable Strategy

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