Abnormal Spirometry in Congenital Heart Disease
Where Do We Go From Here?

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“But the gods, foreknowing that the palpitation of the heart...”

—Timaeus, Plato

The close relationship between the heart and lungs has been appreciated for more than 2000 years, although the functions of each organ and their connection were misunderstood. Although Plato’s assertion that the lungs’ purpose is to support the heart may be considered an early case of cardiac chauvinism, his description of their close interaction aligns with our current understanding. Not only is efficient cardiopulmonary coupling critical to support tissue metabolic demands at rest and with effort, but cardiac and pulmonary development are also intertwined. Cardiac dysfunction produces readily appreciated and dynamic effects on measured pulmonary function; the converse is equally true. Just as the ECG is affected by pulmonary disease, spirometry provides a window on cardiac function. Hutchinson’s description of spirometry and the divisions of thoracic volume in the mid-19th century had been applied to patients with heart disease by the early 20th century, and it was quickly clear that heart disease was associated with abnormal vital capacity.

These relationships have been explored extensively in acquired heart and lung disease, but investigation in congenital heart disease has generally been limited to small series. In this issue of Circulation, Alonso-Gonzalez and colleagues present data on a large number of patients, available pulmonary function data are limited to simple spirometry without information on lung volumes or diffusing capacity, which limits mechanistic inference. Previous reports demonstrated that the pattern of pulmonary function abnormalities and underlying mechanisms may vary between defects and at different stages of disease and repair. With that caveat, potential causes include several variables included in the authors’ analysis, such as scoliosis, prior sternotomy or thoracotomy, and diaphragmatic dysfunction. The strong association between these factors and reduced FVC does not entirely account for the prevalence of low FVC. Data from children and adolescents with unpaired congenital heart disease without scoliosis or apparent lung disease also found a high prevalence of abnormal lung function. This suggests that other, more generally applicable reasons for the considerable prevalence of low FVC exist in this population.

Alveolar size and number continue to increase for several years after birth. Various insults early in life, such as diaphragmatic hernia or pulmonary hypoperfusion, impair normal development. Presumably, early events in patients with congenital heart disease, such as surgical intervention, large chronic pleural effusion, malnutrition, mechanical ventilation, or transient diaphragmatic dysfunction, may have unappreciated effects on pulmonary parenchymal development. Other clinical interventions, such as exercise restriction, also may blunt alveolar growth. Physical activity in early life may translate into differences in FEV1 (forced expiratory volume in the first second of expiration) and FVC.

Contributors to abnormal spirometry include a large number of patients, available pulmonary function data, and preoperative variables such as breastfeeding and early postnatal factors (eg, breastfeeding). This suggests that other, more generally applicable reasons for the considerable prevalence of low FVC exist in this population.

Diverse pulmonary vascular and parenchymal abnormalities, including the presence of low vital capacity, are common among patients with various congenital heart defects and correlate with exercise capacity. Although the present report includes a large number of patients, available pulmonary function data are limited to simple spirometry without information on lung volumes or diffusing capacity, which limits mechanistic inference. Previous reports demonstrated that the pattern of pulmonary function abnormalities and underlying mechanisms may vary between defects and at different stages of disease and repair. With that caveat, potential causes include several variables included in the authors’ analysis, such as scoliosis, prior sternotomy or thoracotomy, and diaphragmatic dysfunction. The strong association between these factors and reduced FVC does not entirely account for the prevalence of low FVC. Data from children and adolescents with unpaired congenital heart disease without scoliosis or apparent lung disease also found a high prevalence of abnormal lung function. This suggests that other, more generally applicable reasons for the considerable prevalence of low FVC exist in this population.

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The reported association between abnormal spirometry and mortality, in conjunction with previous reports relating abnormal FVC to lower aerobic capacity, lends importance to the high prevalence of low FVC in this population. Although this is the first report to specifically highlight this connection among adults with congenital heart disease, numerous studies have reported an association between spirometric variables (eg, slow vital capacity, FEV₁, and FVC) and overall and cardiovascular mortality both in patients with acquired heart disease and in the general population, independent of tobacco use or clinical lung disease.15,16

The existence of an equivalent relationship between abnormal spirometry and mortality in acquired adult heart disease and in the general population makes it more difficult to attribute the relationship described for patients with congenital heart disease to issues specific to an underlying defect or its treatment such as scoliosis, prior thoracic surgery, or gross early pulmonary hypoperfusion. Subclinical pulmonary congestion may explain in part the relationship between low FVC and adverse outcomes in later life.17,18 Although the burden and timing vary by defect type and severity, patients with congenital heart disease have a less favorable fetal and postnatal environment than the average person. In this context, reduced lung size and vital capacity may be an indicator of distant fetal and postnatal events. A second possible cause is that a less physically active childhood (and to a lesser degree adulthood) results in both lower FVC via effects on lung development and increased mortality in the general population and in patients with congenital heart disease because of the many detrimental consequences of low physical activity. Although both hypothetical mechanisms would assign low FVC a noncausal role, they would allow for potential intervention to improve outcomes. In this context, it is plausible that FVC could find a useful function as an intermediate marker to assess the medium-term effects of interventions.

As suggested by the authors, the present findings could allow clinicians to better risk-stratify adults with congenital heart defects. The limited use of spirometry in guiding the clinical care of acquired heart disease provides a less than hopeful example, however. The well-documented relationship between spirometry and mortality in the general population and among patients with acquired heart failure remains little more than an interesting epidemiological observation. Measurements of vital capacity, given its inverse relationship to engorgement of the lungs, were, 70 years ago, “...considered indispensable in cases of heart disease,” but this certainly is no longer the case in clinical practice. The most important obstacle to the application of these findings to patients is that abnormal spirometry is a risk marker that does not suggest any specific intervention. What should a clinician do for an adult with congenital heart disease and low FVC? Until we answer that question, it is difficult to see a meaningful role for spirometry in the clinical care of adults with congenital heart defects.

Translation of the present observations to a clinically useful tool will therefore require 2 related avenues of further investigation. First, the underlying pathophysiology of abnormal spirometry in this population needs to be defined, along with its causal relationship relative to adverse outcomes. FVC has limited specificity for restrictive lung disease, and the contributions of reduced total lung capacity, diaphragmatic weakness, and other contributors, including early developmental factors, remain to be defined. Second, if the underlying mechanisms are potentially modifiable, the efficacy of specific interventions, such as inspiratory muscle training, should be tested prospectively. The present data, considered in the context of prior literature, provide several clinically relevant testable hypotheses. In the current era, congenital heart disease may represent a fortuitous experiment given the enormous heterogeneity in initial anatomy and subsequent care. Although this heterogeneity often frustrates generalizable research, it may alternatively be seen as providing an opportunity to define novel mechanisms and interventions, with implications not only for management of congenital heart disease but also with potential significance for the larger population of patients with acquired heart disease.

Disclosures

None.

References


Key Words: Editorials ■ epidemiology ■ fetal development ■ forced expiratory volume ■ heart defects, congenital ■ physical exertion ■ vital capacity
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