Diaphragmatic palsy after cardiac surgical procedures in patients with congenital heart

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ABSTRACT

Paralysis of diaphragm on one or, exceptionally, both sides is a common cause of delayed recovery and excessive morbidity following pediatric cardiac surgery. The consequences of this complication after all forms of congenital heart surgery in newborns and young infants can be potentially serious. The impact of diaphragmatic palsy on the physiology after single ventricle palliations is particularly significant. It is necessary for all professionals taking care of children with heart disease to be familiar with the etiology, diagnosis, and management of this condition. Early recognition and prompt management of diaphragmatic palsy can potentially reduce the duration of mechanical ventilation and intensive care in those who develop this complication. This review summarizes the anatomy of the phrenic nerves, reasons behind the occurrence of diaphragmatic palsy, and suggests practical guidelines for management.

Keywords: Diaphragm, paralysis, phrenic nerve

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INTRODUCTION

Diaphragm is a musculofibrous sheet that separates the abdominal and thoracic cavities. It has two components: peripheral muscular arising from chest wall and the upper lumbar vertebrae and a central fibrous body. It has an important respiratory function and acts as a main muscle for inspiration. It is innervated by the phrenic nerve that may be injured during various cardiac surgical procedures leading to unilateral or bilateral diaphragmatic paralysis. In this review, we briefly review the anatomy of the phrenic nerve and discuss the incidence, pathophysiology, clinical presentation, and management of this common problem.

RELATED ANATOMY

The diaphragm is innervated by the phrenic nerve that arises chiefly from the fourth cervical ventral ramus, but also has contributions from the third and fifth rami. It is formed at the upper part of the lateral border of scalenus anterior and descends vertically across its anterior surface behind prevertebral fascia. It descends posterior to sternocleidomastoid, inferior belly of omohyoid, the internal jugular vein, transverse cervical and suprascapular arteries and on the left, the thoracic duct [Figures 1 and 2]. The phrenic nerve enters the thorax by crossing medially in front of the internal mammary artery.[1] Within the thorax, the phrenic nerve descends anteriorly to pulmonary hilum, between the fibrous pericardium and mediastinal pleura, to the diaphragm accompanied by pericardiophrenic vessels. The right phrenic nerve is shorter and more vertical. It descends lateral to the right brachiocephalic vein, the superior vena cava [Figure 1], and the fibrous pericardium that covers the right surface of the right atrium and inferior vena cava. The left phrenic nerve crosses anterior to the left internal thoracic artery, descending across the medial aspect of the apex of the left lung and its pleura to the first part of subclavian artery, where it crosses obliquely to reach the groove between the left common carotid and subclavian arteries. It passes anteromedially, superficial to the left vagus nerve just above the aortic arch and behind the left brachiocephalic vein, and then passes superficial to the aortic arch and the left superior intercostal vein, anterior to the left pulmonary hilum, to lie between the fibrous pericardium covering the surface of the left ventricle and the mediastinal pleura [Figure 2].[2]

INJURY TO PHRENIC NERVE

The phrenic nerve may be injured by the ice cold slush used for myocardial protection. Because of its course on
the left side, ice slush injury is more likely on the left, although there may be bilateral involvement. Dissecting near the area of internal thoracic artery pedicle in adults can cause its damage. The left phrenic nerve may get damaged while removing thymus on the left side or during the dissection of the vertical vein in patients undergoing repair of total anomalous pulmonary venous return. The phrenic nerve may be severed while dissecting or it may be injured due to conducted heat while dissecting in area near to its course. This is particularly likely to happen on the right side when the superior vena cava is being dissected and mobilized. At re-operations, the lung is often adherent to the cardiac chambers, and during dissection, to separate the heart and lungs, the phrenic nerve may get accidentally damaged. Rarely, it may be injured during placement of a subclavian or jugular vein catheter or a pacing lead. During pericardiectomy for constrictive pericarditis, it is common to accidentally sever the phrenic nerve on one or both the sides.

**INCIDENCE**

Cardiovascular surgery is the most common cause of
acquired diaphragmatic palsy (DP) and accounts for about 64% of phrenic nerve injuries.[3] Various studies of the etiology of DP in children have addressed the incidence of this complication following heart surgery and have reported it to range from 0.28 to 5.6%.[4-14] Table 1. The incidence is particularly high after the bidirectional Glenn or Fontan operation, systemic to pulmonary artery shunts particularly the classic or modified Blalock-Taussig (BT) shunt, ventricular septal defect closure, surgery for tetralogy of Fallot, and arterial switch operation. Akay[6] reported a high incidence of DP following correction of tetralogy of Fallot (31.5%), BT shunt (11.1%), and VSD closure with pulmonary artery patch plasty (11.1%). The incidence of DP requiring diaphragmatic plication was higher following BT shunt (23.8%), arterial switch operation (19%), and correction of tetralogy of Fallot (11.9%).[6] Joahe-areola et al.[7] also reported a higher incidence of DP after arterial switch operation (10.8%), Fontan procedure (17.6%), and BT Shunt (12.8%). Watanabe et al.[11] found the incidence of DP to be 6.7% after the Mustard procedure, 5.6% after right ventricular outflow tract reconstruction, and 2.7% following repair of tetralogy of Fallot; in patients undergoing closed heart procedures, it was 6.2% following the Glenn anastomosis, 5.9% following Blalock-Hanlon atrial septectomy, and 5.1% following the right BT shunt.

**CLINICAL FEATURES AND DIAGNOSIS**

Unilateral DP reduces pulmonary function by about 25% in older children and is usually well tolerated; however, it causes severe respiratory embarrassment in infants and young children.[15,16] This is because neonates and infants are diaphragmatic breathers with intercostal muscles playing a little or no role in respiration. Bilateral DP is more sinister as it can reduce the respiratory function by up to 60% resulting in failure to wean from ventilator support. Even if the patient is extubated, it increases chances of atelectasis, pneumonia, and lung collapse.[17]

**EFFECTS OF DP IN PATIENTS UNDERGOING UNIVENTRICULAR REPAIR**

Diaphragmatic palsy has a significantly unfavorable impact on the early and late post-operative course of patients undergoing univentricular repair and this has prompted us to discuss this issue separately. After univentricular repair, the systemic venous return enters the pulmonary arteries without the aid of a right-sided pump. Therefore, the flow in the pulmonary circulation is non-pulsatile. In normal biventricular circulation, the normal pulsatile flow is responsible for keeping the distal pulmonary vasculature patent. Loss of this pulsatility following univentricular repair effectively increases the afterload because of elevation of pulmonary arterial impedance. In addition after univentricular repair, the systemic and pulmonary venous circulations are in series and this adds further resistance to the systemic venous return. These problems are further compounded by the transient ventricular dysfunction that is common in these patients and the heightened gravitational variation. All these factors put together impede the systemic venous return. In such a situation, the negative intrathoracic pressure generated by a normally functioning diaphragm assumes significance in ensuring optimal systemic venous and pulmonary arterial circulation. In the presence of DP, these patients have higher Fontan pressures, resulting in a significant increase in morbidity, including pleural effusions, ascites, duration of hospital stay, and need for readmission [Figure 3a]. These are likely to improve with early diaphragmatic plication as has been demonstrated in previous studies [Figure 3b].[18,19]

The diagnosis of DP should be considered whenever there is persistent atelectasis, paradoxical breathing, or inability to wean from ventilation. The clinical diagnosis is nearly impossible because of the presence of intercostal drainage tubes particularly in patients on positive pressure mechanical ventilation. In patients who are not on positive pressure ventilation, simple inspection may reveal paradoxical breathing and optical markers can be used to amplify this paradoxical movement. Inspiratory

**Table 1: Studies on the incidence of diaphragmatic palsy**

<table>
<thead>
<tr>
<th>Author</th>
<th>Year</th>
<th>Total number</th>
<th>No. with DP</th>
<th>Incidence (%)</th>
<th>Study period (Years)</th>
<th>Time to plication (days)</th>
<th>Time to extubation (days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dagan[4]</td>
<td>2006</td>
<td>3214</td>
<td>9</td>
<td>0.28</td>
<td>10</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Lemmer[5]</td>
<td>2006</td>
<td>5128</td>
<td>74</td>
<td>1.4</td>
<td>14</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Akay[6]</td>
<td>2006</td>
<td>3071</td>
<td>152</td>
<td>4.9</td>
<td>10</td>
<td>12</td>
<td>*</td>
</tr>
<tr>
<td>Van Omna[8]</td>
<td>1998</td>
<td>867</td>
<td>17</td>
<td>1.9</td>
<td>5</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Vazquez[9]</td>
<td>1996</td>
<td>556</td>
<td>13</td>
<td>2.3</td>
<td>5</td>
<td>5</td>
<td>*</td>
</tr>
<tr>
<td>Picard[11]</td>
<td>1996</td>
<td>3400</td>
<td>25</td>
<td>0.73</td>
<td>-</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Watanabe[13]</td>
<td>1986</td>
<td>7670</td>
<td>125</td>
<td>1.6</td>
<td>12</td>
<td>14</td>
<td>2</td>
</tr>
<tr>
<td>Mickell[14]</td>
<td>1978</td>
<td>1891</td>
<td>32</td>
<td>1.7</td>
<td>8</td>
<td>*</td>
<td>*</td>
</tr>
</tbody>
</table>

*Data not available, DP: Diaphragmatic palsy*
indrawing of the lateral chest (Hoover’s sign) is typical of infants with diaphragmatic paralysis.

DP should be suspected with progressive elevation of a hemidiaphragm on serial chest radiographs [Figure 4], but this sign can be inconsistent on mechanical ventilation. Diagnosis is confirmed in suspected cases by the use of bedside echocardiography (ultrasonography) or fluoroscopy while the patient is breathing spontaneously without any positive pressure ventilatory support (Kienbock’s sign). On echocardiography, DP may be identified as paradoxical movement of the diaphragm with respiration [Figures 5 and 6]. A paralyzed diaphragm may appear atrophic, with less contraction and shortening on inspiration than occurs in the normal diaphragm. On fluoroscopy, the diagnosis is established by the “sniff test” in a spontaneously breathing patient; when a patient is observed fluoroscopically while sniffing, the affected diaphragm will move paradoxically upward due to negative intra-thoracic pressure. Both the modalities have been shown to be equally useful with sensitivity of 100% and specificity of 74% and 81% for fluoroscopy and echocardiography, respectively.[16] However, the gold standard for assessment of the phrenic nerve/diaphragm unit is electrical or magnetic stimulation of the phrenic nerve with recordings of the compound muscle action potential [Figure 7] and/or the transdiaphragmatic pressure.[20] Transdiaphragmatic pressure is measured by placing an esophageal catheter with an esophageal balloon and a gastric balloon. The difference between the pressures measured at the two balloons is the transdiaphragmatic pressure. Patients with diaphragmatic dysfunction and paralysis have a decrease in transdiaphragmatic pressures.

MANAGEMENT

The management of the phrenic nerve injury leading to diaphragmatic paralysis mainly harbors around preservation of respiratory function. Optimal management of phrenic nerve palsy (PNP) in children who have undergone cardiac surgery remains controversial and consists of prolonged ventilation or diaphragmatic...
plication. A guideline is suggested in Figure 8. The patients are kept on mechanical ventilatory support and tracheostomy may be required. Haller et al. suggested a trial of continuous positive airway pressure (CPAP) for 4–6 weeks during which the diaphragmatic function is presumed to improve with conservative management.\textsuperscript{[21]} A major difficulty with this approach is that the natural history of PNP following cardiac surgery is unknown. With the conservative approach, Watanabe et al.\textsuperscript{[13]} reported recovery of the affected diaphragm between 5 and 51 days indicating that recovery is an unpredictable phenomenon. Further follow-up suggested that 16% never recovered. Iverson\textsuperscript{[22]} showed that in many cases of traumatic injury to the phrenic nerve, normal diaphragmatic function could be expected to return after 6–12 months. Mickell\textsuperscript{[14]} noted radiographic or fluoroscopic resolution of PNP in 95% of children up to 3.5 years after operation. Our institutional policy is to follow the guidelines suggested in [Figure 8]. However, in patients undergoing univentricular repair, we would elect to perform early diaphragmatic plication to prevent significant morbidity as discussed above.

The definitive surgical option in patients with DP is plication of diaphragm. The decision of plication should be based on the respiratory status of the patient.\textsuperscript{[23]} In earlier years, the use of mechanical ventilation was the favored option. However, in the current era, surgical plication is the widely accepted treatment of diaphragmatic palsy (DP) especially in children under 1 year of age. Controversy still persists on when this procedure should be undertaken. Some authors recommend that diaphragmatic plication should be performed as soon as the diagnosis of DP has been confirmed\textsuperscript{[24]} while others recommend a waiting period of 1–6 weeks in anticipation of potential spontaneous
Suspected diaphragmatic paralysis

Chest X-ray
Ultrasound
Flouroscopy

Pathologic function

Normal function

No further studies

< 6 months

> 6 months

Waiting period (2 weeks)

Plication

X-ray after surgery and before discharge

Not weanable
Symptomatic

X-ray and Ultrasound after 6-12 months

Plication

X-ray and Surgery and before discharge

Weanable
not Symptomatic

X-ray and Ultrasound before discharge

Pathologic

Normal

X-ray and Ultrasound after 6-12 months

No further studies

Table 2: Indications for diaphragmatic plication in children with diaphragmatic palsy after open-heart surgery

<table>
<thead>
<tr>
<th>Age under 6 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory distress</td>
</tr>
<tr>
<td>Tachypnea</td>
</tr>
<tr>
<td>Oxygen dependency</td>
</tr>
<tr>
<td>CO₂ retention</td>
</tr>
<tr>
<td>Inability to wean from ventilator</td>
</tr>
<tr>
<td>Children with cavopulmonary shunts with the intention to prevent increase in pulmonary vascular resistance</td>
</tr>
</tbody>
</table>

Figure 8: Algorithm of patients with diaphragmatic paralysis. (Reproduced with permission from [31].)
demonstrated.[25] As is well known, the downward movement of the healthy side of the diaphragm during inspiration produces negative intrathoracic pressure and the abdominal contents are drawn into the paralyzed side of the thorax due to the paradoxical upward movement of the paralyzed side. This paradoxical motion does not let the lung expand on this side and results in poor gas exchange. After plication, the paralyzed side is more resistant to these pressure changes and over a period of time, the adjacent lung segments expand.[28]

CONCLUSIONS

DP is not uncommon following open-heart surgery in children and can be a cause of significant morbidity and mortality. A high-index of suspicion is required for timely diagnosis and the management has to be individualized depending on the overall clinical scenario. Patients undergoing univentricular repair should have early diaphragmatic plication.

REFERENCES


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