Challenges Faced in Managing an Adult Uncorrected Tetralogy of Fallot Patient with Pneumonia and Septic Shock in the Intensive Care Unit

Surya Y Prakash¹, Munta Kartik², Manimala Rao³, Yogesh R Harde⁴

ABSTRACT

Tetralogy of Fallot (TOF) is the most common form of cyanotic congenital heart disease. We present a 61-year-old uncorrected TOF patient who presented with sepsis and acute respiratory failure. At presentation, the patient had tachypnea, tachycardia, and oxygen saturation (SpO₂) 64%. Chest X-ray (CXR) showed bilateral basal opacities. 2D echo revealed left ventricular dysfunction, infundibulum stenosis, pulmonary atresia, overriding of the aorta, and ventricular septal defect. A provisional diagnosis of community-acquired pneumonia with septic shock with uncorrected TOF was made. He received empirical antibiotics, ventilatory support, and supportive care. Ventilator weaning was done accepting an arbitrary baseline SpO₂ of 70–75% and lactate-guided volume resuscitation led to a successful outcome. Coronary angiogram showed collaterals. This case report illustrates the dilemmas faced in treating a critically ill uncorrected TOF. To the best of our knowledge, this case could be the oldest surviving uncorrected TOF patient in the Indian population.

Keywords: Cyanotic congenital heart disease, Fluid resuscitation, Sepsis, Uncorrected adult tetralogy of Fallot, Ventilation.

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INTRODUCTION

The average life expectancy of a newborn with uncorrected tetralogy of Fallot (TOF) is only 12 years. Ten percent of TOF patients reach their 30s and it is only 3% for the age group above 40s.¹ Tetralogy of Fallot comprises ventricular outflow tract obstruction, overriding of the aorta, interventricular septal defect, and right ventricular hypertrophy.² Pulmonary infections in patients with cyanotic heart disease are rare as compared to acyanotic heart disease. Tetralogy of Fallot patients have high hematocrit and polycythemia with low oxygen saturations. We present an uncorrected TOF with pneumonia, septic shock, and the dilemmas in ventilation and volume resuscitation.

CASE DESCRIPTION

A 61-year-old male uncorrected TOF patient presented with a history of dry cough and shortness of breath (NYHA grade III) for 2 days. At a presentation in the emergency room (ER), he was conscious, coherent with a respiratory rate of 45/minute, heart rate (HR) 110/minute, and blood pressure (BP) 180/110 mm Hg. Room air SpO₂ was 64 and 72% with 6 L/minute O₂. On examination, central cyanosis was seen with bilateral digital clubbing and leukocytosis. The patient received vasopressor and inotropic support to reduce shunt and treat septic shock. We could not use a hemodynamic monitor to guide volume resuscitation because of his financial constraint.

During the intensive care unit (ICU) stay, he was ventilated with pressure control of 16 cm H₂O, rate of 28/minute, 10 positive end expiratory pressure (PEEP), and 100% FiO₂. Chest X-ray (CXR) showed bilateral basal opacities and cardiomegaly. Lung ultrasound revealed bilateral basal dynamic air bronchogram suggestive of consolidation. Electrocardiogram showed right axis deviation, right ventricular hypertrophy, and incomplete right bundle branch block. 2D echo revealed severe left ventricular dysfunction, severe infundibulum stenosis, pulmonary atresia, overriding of the aorta, and ventricular septal defect (VSD). Lab parameters revealed hemoglobin 18.8 g/dL, hematocrit 66.8, creatinine 1.2 mg/dL, normal electrolytes, and 17,700 cells/mm³ leukocytes. The patient received vasopressor and inotropic support to reduce shunt and treat septic shock. We could not use a hemodynamic monitor to guide volume resuscitation because of his financial constraint.

Post-resuscitation ABG showed pH 7.17, PCO₂ 61.2 mm Hg, PaO₂ 57.2 mm Hg, and bicarbonate 18.3 mmol/L with a decrease in both lactates and hematocrit. Based on his SpO₂, which was targeted between 70 and 75% ventilator was weaned.

Endotracheal (ET) culture grew multi drug resistant (MDR) Klebsiella and appropriate antibiotics were continued. On the 4th day of minimal ventilatory support, ABG showed pH 7.41, PCO₂ 31 mm Hg, PaO₂ 43.9 mm Hg, bicarbonate of 19.5 mmol/L, lactates 1.91 mmol/L, and hematocrit 54%. So, the patient was extubated and received non invasive ventilation (NIV) support to avoid reintubation. The next day, he was weaned off NIV support.

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Table 1: Factors varying from pulmonary vascular resistance (PVR) and systemic vascular resistance (SVR)

<table>
<thead>
<tr>
<th>Increase in PVR</th>
<th>Decrease in SVR</th>
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</thead>
<tbody>
<tr>
<td>Hypercarbia</td>
<td>Vasodilatation—sepsis, anaphylaxis</td>
</tr>
<tr>
<td>Acidosis</td>
<td>Anemia</td>
</tr>
<tr>
<td>Hypoxia</td>
<td>Cirrhosis</td>
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<tr>
<td>Hypothermia</td>
<td>Hyperthermia</td>
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</tbody>
</table>

The goals of management in such a patient are preventing hypoxia, preventing falls in systemic vascular resistance (SVR), avoiding an increase in pulmonary vascular resistance (PVR), prevention acidosis, hypothermia, tachycardia, and hypovolemia.

In TOF with septic shock, SVR is decreased leading to an increase in right to left (R→L) shunt and worsening hypoxia. Vasopressor supports help in the prevention of SVR fall, thereby preventing worsening of the shunt. Factors varying from PVR and SVR are to be avoided (Table 1). Acidosis in septic shock with TOF results in increased pulmonary vascular resistance and increasing R→L shunt. Henceforth, lactate clearance by volume resuscitation and respiratory acidosis by ventilator management is essential. Tachycardia causes increased myocardial oxygen demand. Sedation and paralysis prevent any stress or anxiety-related tachycardia. Hypovolemia not only causes cyanois by decreasing preload which results in narrowing RVOT but also causes increase R→L shunt because of low systemic pressure. Hypothermia causes PVR to increase and worsening of R→L shunt.

The challenges faced in managing uncorrected adult TOF patients with pneumonia and sepsis are the prevention of hypoxia, determining the adequate PaO2 levels for ventilating and weaning. The patient’s PaO2 never reached an acceptable range seven to increase and worsening of R→L shunt. Which results in narrowing RVOT but also causes increase R→L shunt. Hypovolemia not only causes cyanois by decreasing preload which results in narrowing RVOT but also causes increase R→L shunt because of low systemic pressure. Hypothermia causes PVR to increase and worsening of R→L shunt.

Volume resuscitation plays an important role in septic shock patients. As the patient had severe left ventricular dysfunction, volume resuscitation was challenging. Hematocrit could not be of much help as the patient had elevated values due to cyanotic heart disease. Arterial blood gas lactate levels at presentation were 5.2 mmol/L. We continued volume resuscitation basing on lactate clearance. Post-resuscitation ABG showed a fall in lactate to 4 mmol/L and was 1.91 mmol/L at the time of extubation. Vasopressor and inotropic supports were also weaned off.

A coronary angiogram revealed extensive collaterals. This could explain the underlying reason for the survival of our patients until this age.

**CONCLUSION**

A good interpretation of altered physiology in TOF along with management of septic shock is essential for resuscitation. Such cases of uncorrected TOF with sepsis and acute respiratory failure pose a challenge for intensivist in determining parameters to guide ventilatory weaning and adequate volume resuscitation. In this case, lactate clearance as a fluid guidance parameter, and in ventilator management acceptance of target SpO2, prevent variations in SVR and PVR helped us for a successful outcome.

**REFERENCES**


