



Challenges of Managing Complex Cardiac ECMO Patients

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A close-up photograph of an ECMO (Extracorporeal Membrane Oxygenation) circuit. The central component is a blue pump housing with a transparent window revealing internal rollers and a red blood-filled circuit. Various clear plastic tubes and connectors are attached to the pump. In the background, a blurred medical monitor displays yellow digital readouts, including the number '870'.

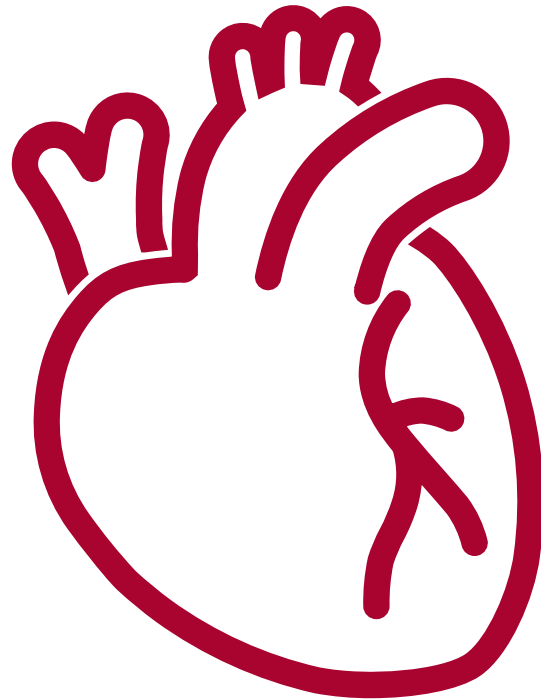
ECMO is life saving...
And morbid, complicated,
and challenging ...

Overview: Challenging ECMO patients

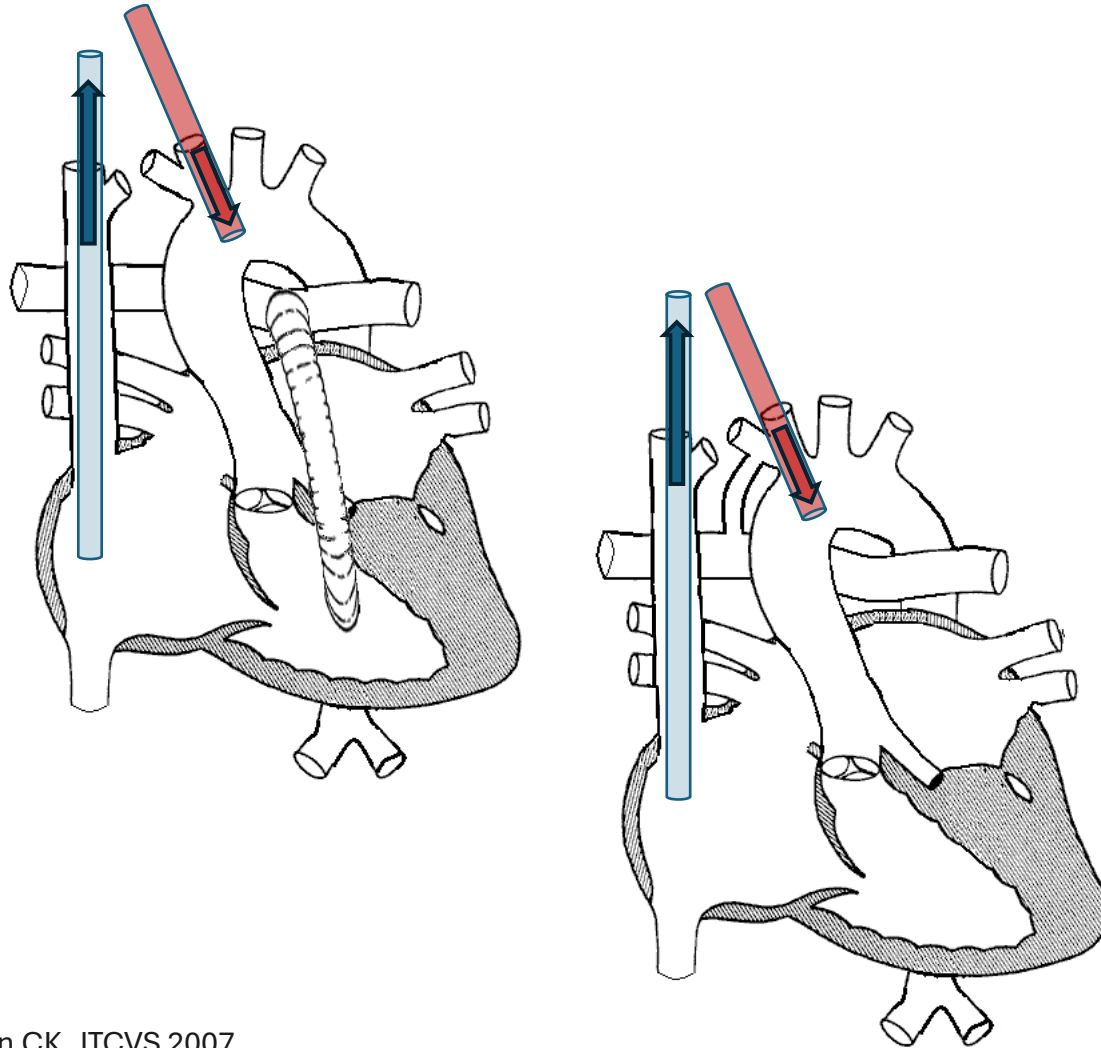
Challenges providing adequate cardiac output and cardiac rest:

- Single ventricle heart disease
 - Norwood circulation
 - Glenn / Hemi-Fontan circulation
 - Fontan circulation
- Left atrial decompression
- Other anatomic & physiologic considerations

ECMO support with single ventricle heart disease



ECMO + Stage I Norwood circulation

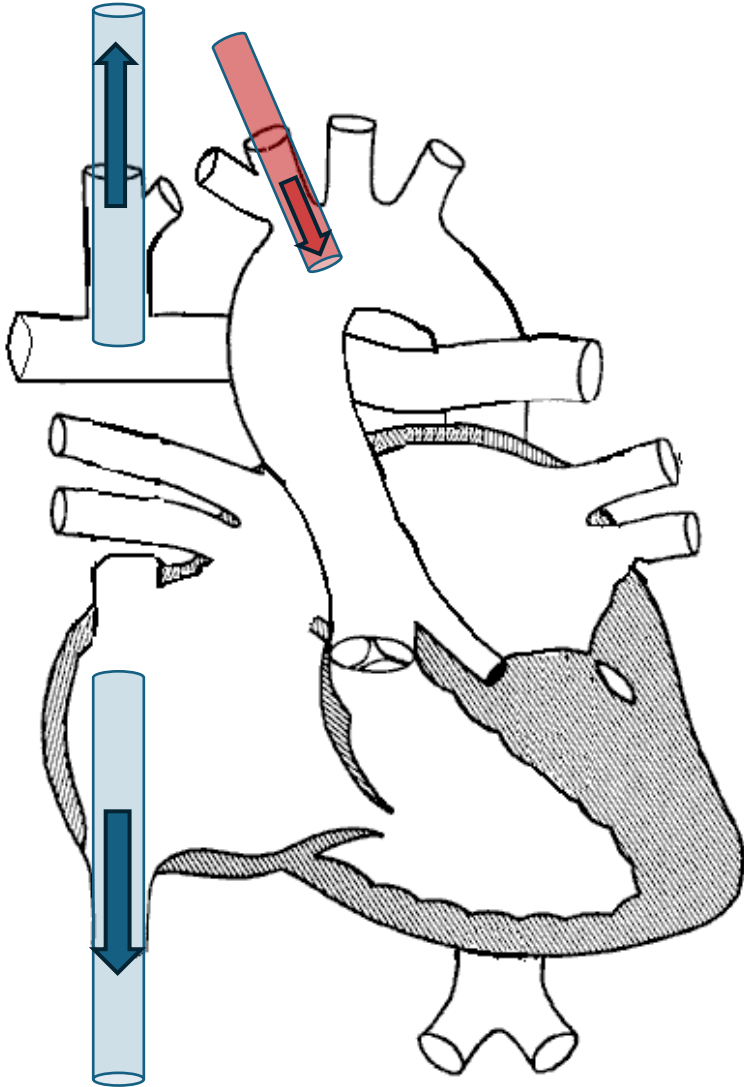


- Supporting 2 circulations, frequently need higher flows ($>120\text{-}150\text{ mL/kg/min}$)
- Preferential flow to BTT shunt, causing systemic steal
 - May require BTT shunt banding
 - Will require de-banding prior to decannulation

ECMO + Stage I Norwood circulation

- Frequently ECMO utilized in Norwood operation:
 - Failure to separate from bypass
 - E-CPR (ECMO canulation to achieve ROC in cardiac arrest)
- Survival higher than other SV ECMO
 - Reversible or transient causes
- Survival rates 30-40%

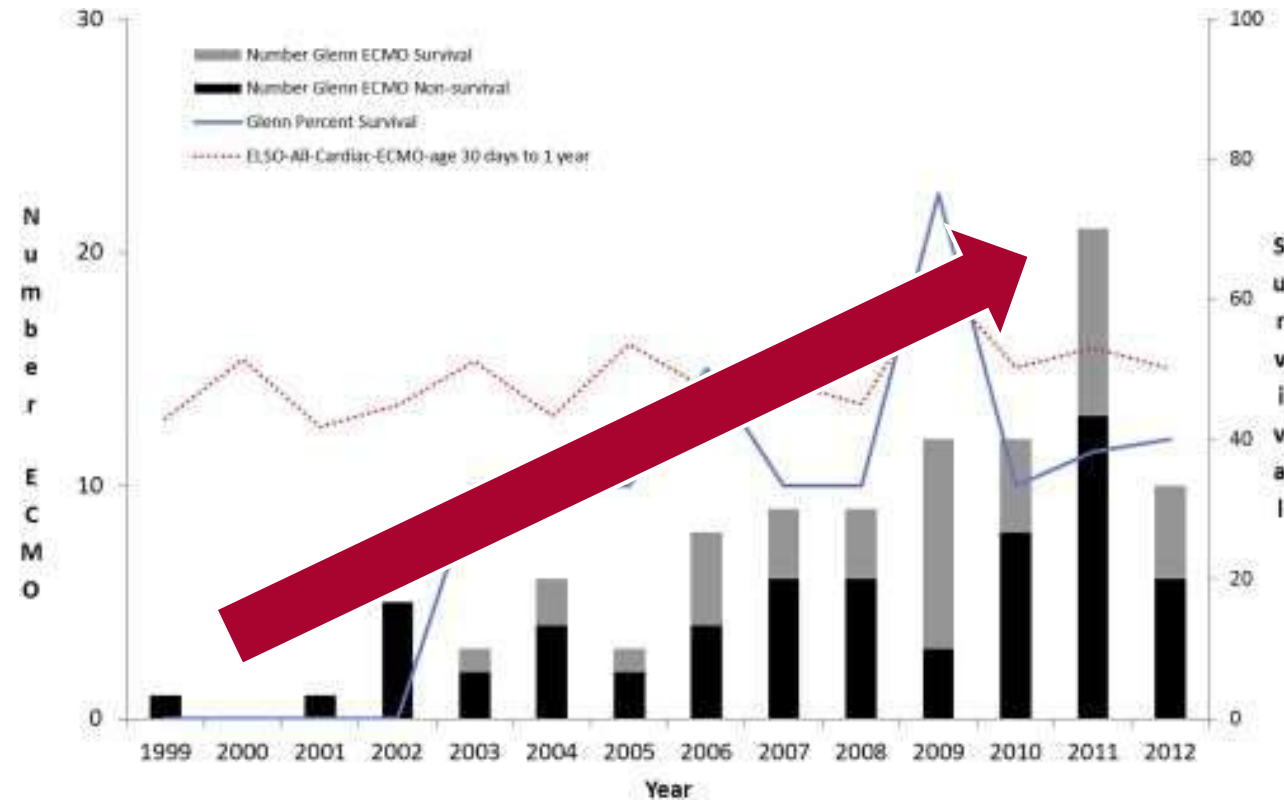
ECMO + Glenn/Hemi-Fontan circulation



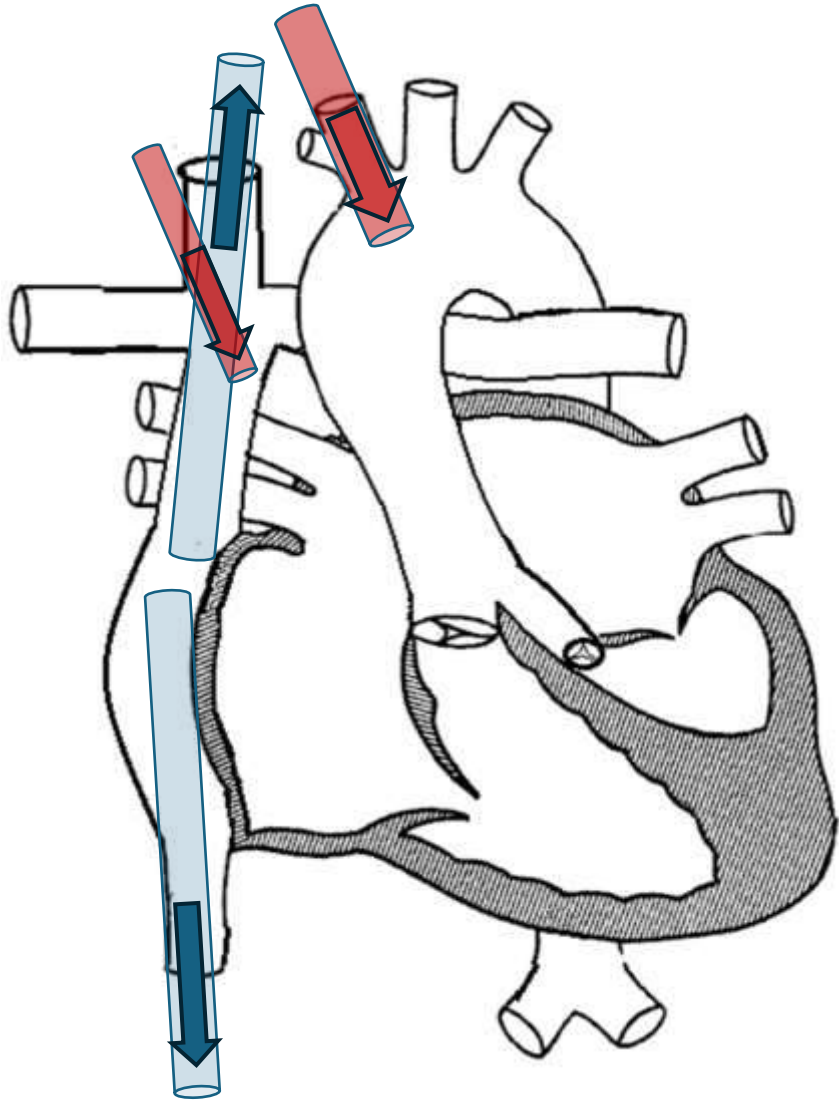
- Circulation with SVC separated from heart
- Cannulation strategies can include:
 - Upper body primarily drained passively
 - May require second cannula in SVC for appropriate decompression
- Risk of brain injury with low cerebral perfusion pressure
 - Secondary to high Glenn pressure

ECMO + Glenn/Hemi-Fontan circulation

- Previously reported low rates of successful decannulation (50%) and 30% survival
- ECMO support with superior cavopulmonary connection has been increased in ELSO registry
- Increasing survival (42%) but with higher rates of neurologic injury
 - Seizures
 - Hemorrhage
 - Embolic stroke



ECMO + Fontan circulation



- Venous cannulation can be via 1 (or 2) cannula
- Still dependent on functioning Fontan circulation
 - Open lung strategy
 - iNO to optimize PVR
- Sometimes V-A-A strategy utilized for some oxygenated blood to flow through Fontan

ECMO + Fontan circulation

- Largest cohort of 230 subjects:
 - 35% survival of Fontan patients on ECMO (compared to ~50% of all cardiac ECMO)
- Single-center experience: 13 cases over 35 years (@ CHOP)
 - When ECMO used shortly after Fontan, higher survival and high rates of ECMO takedown
 - When ECMO utilized later after Fontan, high rate of mortality

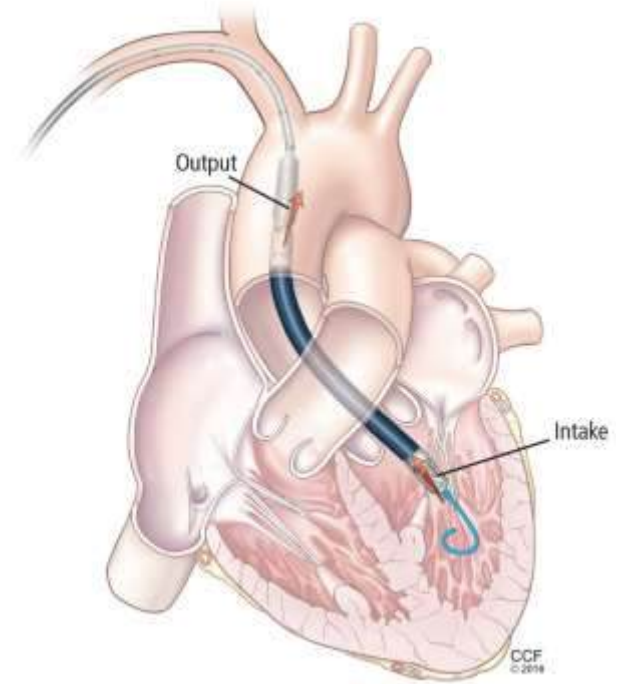


Atrial Decompression Strategies



Atrial decompression

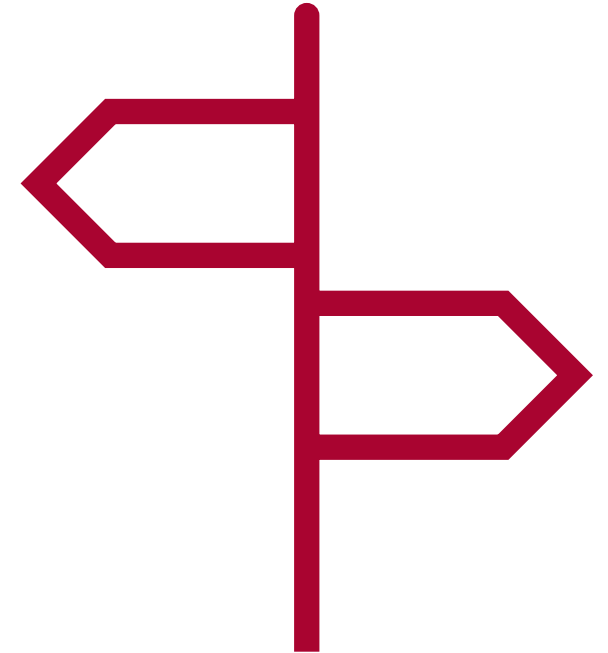
- Goals of atrial decompression:
 - Lower wall tension of LV
 - Lower left (common) atrial pressure to minimize LA pulmonary edema




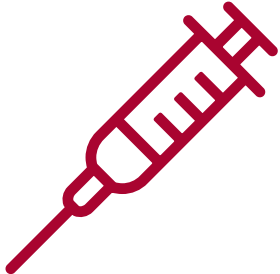
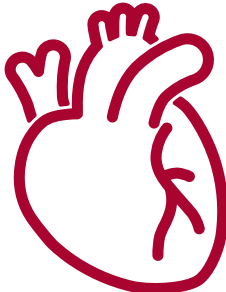
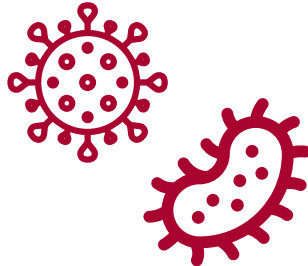

| Method | Benefits | Challenges |
|----------------------------------|---|--|
| Balloon atrial septostomy | <ul style="list-style-type: none"> • Transcatheter approach | <ul style="list-style-type: none"> • Sometimes technically difficult • May be insufficient (atrial stent, septostomy) • Requires repair later |
| Left atrial venting | <ul style="list-style-type: none"> • Direct decompression • Able to adjust flow | <ul style="list-style-type: none"> • Difficult in smaller children; open chest considerations |
| IMPELLA | <ul style="list-style-type: none"> • Transcatheter/hybrid approach | <ul style="list-style-type: none"> • Limited to larger patients |

Is there a better strategy?

- Difficult to compare strategies given different patient characteristics
- Atrial decompression seems to provide more benefit to myocarditis and cardiomyopathy ECMO cases
 - Survival benefit not seen in as strongly in CHD population
- Earlier decompression (<18 hours) may reduce ECMO duration and mechanical ventilation
 - No survival benefit demonstrated



Other challenges...

| ECMO support in large children | Anticoagulation strategies | Aortic insufficiency | Distributive shock | Withdrawal of ECMO support |
|--|--|--|--|--|
| <ul style="list-style-type: none">Femoral cannulation strategiesRetrograde aortic flowLeg perfusion strategies | <ul style="list-style-type: none">Predominantly heparin-basedConsiderations for bivalirudin | <ul style="list-style-type: none">Aortic cannula flow preferentially goes back in (left) ventricle | <ul style="list-style-type: none">Venous return decreasedCutting out (venous cannula pressures)Peripheral vasoconstrictors | <ul style="list-style-type: none">Brain death or non-survivable end organ injury |
|  |  |  |  |  |

Thank You!

