The authors reported no conflicts of interest.

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REPLY: RIGHT VENTRICLE-TO-PULMONARY ARTERY CONDUITS FOR TRUNCUS ARTERIOSUS REPAIR: LET'S SHIFT THE FOCUS

Reply to the Editor:

We thank Buratto and colleagues[1] for their interest in our article.[2] As they mention, in our study right ventricle-to-pulmonary artery (RV-PA) conduit initial size <10 mm was associated with 22% mortality compared with 13% for size 10 to 13 mm conduits and 12% for size ≥14 mm conduits.[2] However, on adjusted analysis using conduit size as a continuous variable, a smaller initial RV-PA conduit size was associated with overall mortality. Therefore, it is incorrect to say that RV-PA conduits >12 mm were associated with better survival in our case series. Instead, we only observed an overall increase in mortality for patients requiring smaller conduits compared with those in whom implantation of a larger conduit was possible.

We agree with Buratto and colleagues[1] that oversizing RV-PA conduits can sometimes reduce conduit performance, leading to graft distortion and a distal anastomosis mismatch.[3] However, our data showed that an RV-PA conduit size ≤11 mm was associated with a higher risk of catheter-based interventions and early reoperation. The risks of oversizing the conduit are therefore somewhat offset by a longer life and an increase in performance, as confirmed by other recently published studies.[4] When a patient's condition permits (eg, absence of prematurity, low birth weight, and no associated anomalies prolonging surgery), a larger conduit (without extreme oversizing) may therefore provide a better investment in the patient's future (Figure 1).

We believe that our data and the new statistical analysis used have demonstrated once again how the focus in the management of patients with congenital heart disease should shift from early or midterm mortality to long-term outcomes. Surgeons must now adapt more and more to the future needs of a patient and abandon personal or institutional beliefs. Hence, when a larger RV-PA conduit can be safely used without adverse anatomical sequelae, it should be considered.

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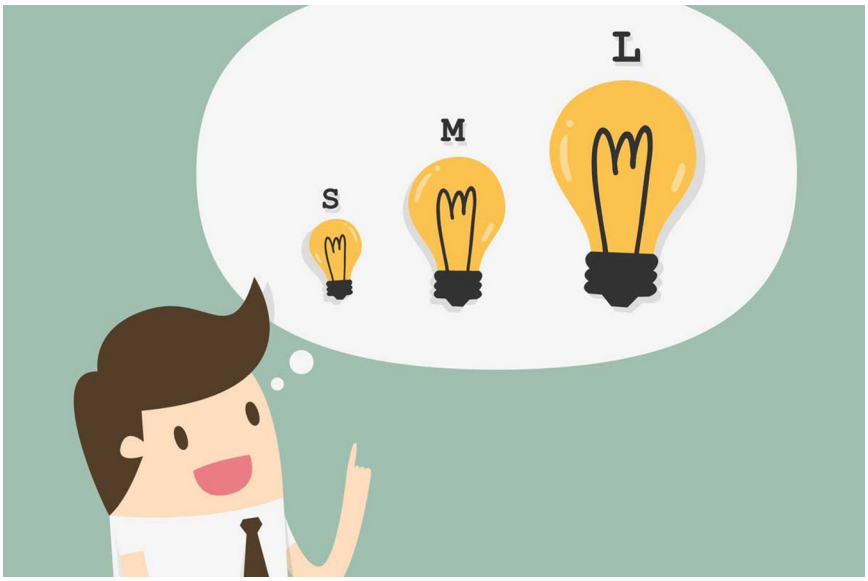

FIGURE 1. Appropriately larger size right ventricle to pulmonary artery conduit may help in survival and delay reintervention after truncus arteriosus repair.

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