

Reply to Yurekli *et al.*

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We thank Yurekli *et al.* [1] for their questions and comments relating to our publication, where we examined how the post-operative pulmonary annular gradient related to pulmonary valve annular size after total correction of tetralogy of Fallot [2]. We examined the patients who did not have significant post-operative right ventricular outflow tract obstruction (RVOTO). We discussed the implications of our findings in the light of current practice and concluded that current recommendations for transannular patch insertion (for pulmonary annular stenosis) may leave a significant number of patients with an undesirable gradient across their pulmonary valve annulus postoperatively.

During repair of tetralogy of Fallot, it is our practice to divide muscular bands that we feel are causing RVOTO (this includes division of the parietal extension of the septomarginal trabecula). As our patients are usually about 6 months of age, we do not routinely resect muscle from the right ventricular outflow tract (RVOT) as is often required in older children (however, we will resect muscle if it is deemed necessary).

We only inserted a transannular patch if we felt that the pulmonary annulus was too small [2]. In the event that a patient had an unacceptable post-repair gradient across the RVOT

(as revealed by intraoperative echocardiography), but had an adequate pulmonary valve annulus, we went back on cardiopulmonary bypass and either resected more muscle from the RVOT or inserted a small RVOT patch.

It has been reported that 'dextroposition' of the aorta is present in all patients with tetralogy of Fallot [3]. We do not use the presence of 'dextroposition' to aid in 'decision making' relating to transannular patch insertion. We thank Dr Yurekli *et al.* once again for their questions and comments.

REFERENCES

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