Letters to the Editor

Rastelli repair for transposition of the great arteries

To the Editor:

I read with interest the letter from Lecompte¹ regarding the article "Twenty-five-year experience with Rastelli repair for transposition of the great arteries."² Although the letter was elegantly answered by my mentor in the Rastelli project, I believe there are a few points that need further clarification.

Lecompte claims that I am confused regarding the differences between a Lecompte maneuver and a Lecompte procedure. I consider that the concept that Rastelli brought into our field was a breakthrough discovery. The ventricular septal defect baffling from the left ventricle to the aorta is the main concept in the correction of transposition, ventricular septal defect, and pulmonary stenosis or atresia. I do not believe that resection of the conal septum or of the anterosuperior margin of the defect is of such importance to merit a new name of a procedure. Likewise, the way in which right ventricular-pulmonary arterial continuity is established can be another modification of the original Rastelli procedure. These are really accessories of the main concept: ventricular septal defect baffling from the left ventricle to the aorta and establishment of right ventricular-pulmonary artery continuity.

Like Lecompte, I believe that modifications or even more reappraisals of the original Rastelli technique for correction of tetralogy of Fallot and pulmonary atresia with autologous fresh pericardium³ can be and should be taken into consideration for repair of transposition, ventricular septal defect, and pulmonary stenosis or atresia. For example, our experience with Rastelli procedures with autologous fresh pericardial valved conduits was presented in several meetings and articles.^{4,5} The late results are spectacular, with a freedom from reoperation and a survival of more than 80% at 15 years.

This is another alternative to the "classic" Rastelli operation. I believe that the

operation proposed by Gian Carlo Rastelli is here to stay, with all the modifications that will allow improvements in survival and reoperation rates.

Christian Kreutzer, MD

Instructor in Cardiovascular Surgery

Ricardo Gutierrez Children's Hospital

Buenos Aires, Argentina

References

1. Lecompte Y. Rastelli repair for transposition of the great arteries: still the best choice [letter]? *J Thorac Cardiovasc Surg.* 2002; 123:192-3.
2. Kreutzer C, Gauvreau K, de Vivie J, Oppido G, Kreutzer J, Freed MF, et al. Twenty-five-year experience with Rastelli repair for transposition of the great arteries. *J Thorac Cardiovasc Surg.* 2000;120:211-23.
3. Rastelli GC, Ongley PA, Davis GD, Kirklin JW. Surgical repair for pulmonary valve atresia with coronary pulmonary fistula: report of a case. *Mayo Clin Proc.* 1965;40: 521-7.
4. Schlichter AJ, Kreutzer C, Mayorquim R, Simon JL, Vazquez H, Roman MI, et al. Long term follow up of autologous pericardial valved conduits. *Ann Thorac Surg.* 1996;62:155-60.
5. Schlichter AJ, Kreutzer C, Mayorquim R, Simon JL, Roman MI, Vazquez H, et al. Five to fifteen year follow-up of autologous pericardial valved conduits. *J Thorac Cardiovasc Surg.* 2000;119:869-79.
doi:10.1067/mtc.2003.336

Quinaprilat during cardioplegic arrest

To the Editor:

I read with interest the recent article by Korn and his coworkers¹ concerning quinaprilat during cardioplegic arrest to prevent ischemia-reperfusion injury. They have demonstrated that quinaprilat enhances recovery of the ischemic myocardium and suggests that its protective mechanism may be due to the increased coronary blood flow during the early reperfusion period. My group at the Boston Medical Center has recently published a study that helps to identify the mechanisms for the beneficial effects of quinaprilat.²

In an intact porcine model involving ischemia and reperfusion with cardioplegic arrest on cardiopulmonary bypass, hearts

The Editor welcomes submissions for possible publication in the Letters to the Editor section that consist of commentary on an article published in the Journal or other relevant issues. Authors should:

- Include no more than 500 words of text, three authors, and five references
- Type with double-spacing
- See <http://jtcs.ctsnetjournals.org/misc/ifora.shtml> for detailed submission instructions.
- Submit the letter electronically via jtcvs.editorialmanager.com.

Letters commenting on an article published in the JTCVS will be considered if they are received within 6 weeks of the time the article was published. Authors of the article being commented on will be given an opportunity to offer a timely response (2 weeks) to the letter. Authors of letters will be notified that the letter has been received. Unpublished letters cannot be returned.