a research program with the aim of constructing recellularized homografts so that we can offer new alternatives to mechanical prostheses, as other institutes are doing.

The role of the patient is a determining factor in the choice of the prosthesis today. Patients are well informed and their choice is opening a new era in the field of biologic prostheses.

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Is there any difference between surgical outflow reconstruction and transcatheter valvotomy in patients with pulmonary atresia with intact ventricular septum?

To the Editor:

I read with great interest the article by Daubeney and associates¹ for the UK and Ireland Collaborative Study of Pulmonary Atresia with Intact Ventricular Septum. This is an ongoing population study comprising 183 patients. The authors report that independent risk factors for death were low birth weight, unipartite right ventricu-

lar morphology, and the presence of a dilated ventricle.

The primary procedure comprised a systemic-pulmonary shunt in 81 patients, percutaneous transcatheter valvotomy in 40 patients, surgical outflow reconstruction alone in 27 patients, and surgical outflow reconstruction with a concomitant shunt in another 18 patients.

I would like to ask some questions about patients who received surgical outflow reconstruction and the group of subjects who underwent a percutaneous approach:

1. Was there any difference in terms of survival between the two groups?
2. How many subjects treated with a percutaneous approach needed a systemic-pulmonary shunt after the transcatheter procedure?
3. Was there any difference between the two groups in terms of right ventricular morphology and/or tricuspid valvular z score?
4. Was there any difference in terms of the achievement of type of repair (biventricular, univentricular, mixed, or one-and-a-half ventricular)?

In fact, there is no agreement about the best approach to use to open the right ventricular outflow tract in subjects who have the membranous type of pulmonary atresia with intact ventricular septum with a tripartite or bipartite right ventricle. Finally, no comparative studies exist.

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nary Atresia with Intact Ventricular Septum. *J Thorac Cardiovasc Surg.* 2005;130:1071-8.
doi:10.1016/j.jtcvs.2006.02.055

Reply to the Editor:

In the UK and Ireland Collaborative Study of Pulmonary Atresia with Intact Ventricular Septum, 67 of 183 patients underwent a primary procedure on the outflow tract without construction of a shunt: surgical in 27 and transcatheter in 40. Mortality was 26% in the surgical group and 20% in the catheter group. Among the survivors, risk of reintervention within 6 weeks to increase flow of blood to the lungs was significantly higher in those who underwent catheter intervention than in those who underwent surgery. In many cases this was due to failure to cross the atretic pulmonary valve during the initial catheter procedure. When the pulmonary valve was successfully crossed at catheterization, the proportion requiring early reintervention was comparable with that of those treated surgically.

These data represent the earliest experiences in the United Kingdom and Ireland of catheter perforation and dilatation of the atretic pulmonary valve in this condition. In cases in which the atretic pulmonary valve can successfully be crossed, transcatheter intervention can produce good outcomes in the short term comparable with those achieved by surgery. Full details will be published shortly.

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