branching technique for the stent graft placement still carries some morbidity and mortality risk. The optimal use of endovascular stent graft for mycotic aortic aneurysm needs to be clarified in further studies.

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Grey zone area for Glenn and future Fontan candidates

To the Editor:

We enjoyed the very good article by Scheurer and colleagues.¹ We have a few comments.

Inhaled nitric oxide produces significant reduction in Glenn pressures and improvement in systemic perfusion and pulmonary gas exchange in patients with marked increases of Glenn pressures after bidirectional Glenn anastomosis. Patients who do not respond should be investigated for an anatomic lesion.²

Glenn shunt mortality was higher with surgical intervention before age 120 days but was not affected by surgical intervention during the respiratory virus season. Operations in the youngest age groups might adversely affect mortality.³

There were no differences in morbidity and mortality outcomes after the bidirectional Glenn operation between the Norwood-Right ventricle to pulmonary artery and Norwood-Blalock-Taussig Shunt groups. Despite younger age at presentation, the Norwood-Right ventricle to pulmonary artery patients had better growth rate, which might have contributed to the similar postoperative outcomes.⁴

Atrial septal defects should be left open for all patients with severe right heart hypoplasia and in patients with postbypass right atrial pressures of more than 12 mm Hg.⁵

The advantages of incorporating a hypoplastic ventricle to partly support the pulmonary circulation are the following: (1) ability to increase the cardiac output; (2) adaptation to exercise; (3) maintenance of pulsatile flow in the pulmonary circulation; (4) flexibility to increased pulmonary vascular resistance; (5) circulation at low venous pressure in the Inferior Vena Cava system; and (6) capability of a hypoplastic right heart to adequately handle the reduced preload.⁶

There is a major debate for the gray-zone high-risk patients who do not fulfill the Choussat commandments. The current protocol in those patients is first to review all the data in detail. Full consideration is given as to whether there are any surgically (or interventional) correctable lesions, such as atrioventricular valve regurgitation amenable to repair or isolated stenoses or hypoplasia within the central pulmonary arteries. Ventricular function, if impaired, might be optimized by altering medical management (vasodilators, diuretic therapy, and trial of oral enoximone, if appropriate). Evidence of increased pulmonary vascular resistance is treated with a course of pulmonary vasodilator therapy (sildenafil or bosentan). The patients are then reassessed for suitability for Fontan completion. The evidence would suggest that only 2 of the original 10 commandments of Choussat carry significant weight for both early and late outcome over the Fontan procedure and that they are preoperative ventricular function and preoperative pulmonary artery pressures of greater than 15 mm Hg.⁷

We found that right ventricular morphology; single ventricle; intact septum; semilunar valve abnormalities; diastolic dysfunction; myocardial hypertrophy, dilatation, or both; older age; bilateral superior vena cavae; pulmonary airway disease; and hypotonia all carry a worse prognosis and a tough postoperative course.

To be right ventricular morphology; single ventricle; intact septum; semilunar valve abnormalities; diastolic dysfunction; myocardial hypertrophy, dilatation, or both; older age; bilateral superior vena cavae; Interrupted IVC; pulmonary airway disease; and hypotonia all carry a worse prognosis and a tough postoperative course.

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Hypertension in coarctation

To the Editor:

I read with great interest the article by Hager and associates¹ on coarctation repair. The authors note that the majority of patients remained hypertensive in the long term, even after coarctation repair. This very interesting phenomena, however, has to be examined in the mirror of the little known fact that most patients are often hypertensive *below the level of the coarctation even before the coarctation is repaired!* While pressure measurements indeed show significantly higher pressures above the coarctation, the mean arterial pressure below the coarctation is also higher than that of an average normal subject. Thus, arterial hypertension