the long term compared with other options for these patients.

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OPTIMAL SURGICAL APPROACH FOR REPAIR OF AORTOPULMONARY WINDOW WITH AORTIC ORIGIN OF THE RIGHT PULMONARY ARTERY To the Editor:

We read with great interest the article titled "Single-Stage Repair of Aortopulmonary Window With Interrupted Aortic Arch by Transection of the Aorta and Direct Reconstruction" by Yoshida and associates.¹

The authors describe a repair technique using autologous arterial wall tissue without artificial material for a patient with aortopulmonary window (APW), right pulmonary artery (RPA) originating from the ascending aorta, and interrupted aortic arch. However, the repair technique for APW and RPA originating from the ascending aorta totally coincides with our previously reported technique.² Inasmuch as APW is a relatively uncommon congenital heart defect, to establish the universality of these kinds of procedures expecting the future growth potential of both the pulmonary artery and the aorta, it is necessary to accumulate widespread data related to the applicability and the late follow-up results.

Taking every step into consideration, the reconstruction of the pulmonary bifurcation is the most critical step in the procedure. Where on the ascending aorta of authors' patients did the RPA arise? As more dorsal and unequal partitioning of the aortopulmonary trunk by the conotruncal ridges is the embryogenesis of the APW associated with origin of the

RPA from the ascending aorta,³ the RPA commonly arises from the right posterolateral aspect of the ascending aorta, and the geometry would be better preserved by our technique with an extensive mobilization of both the aortic arch and the pulmonary arteries. Therefore, our technique seems to be impartially applicable to this combination. Consequently, as the authors noted in the article, we also agree that it can allow not only sufficient enlargement but also growth of the reconstructed arteries (Figure 1).²

We appreciate that our technique using only autologous arterial wall tissue was valid for a large APW extending to the proximal site of the pulmonary artery trunk from the pulmonary bifurcation and with the interrupted aortic arch.¹ However, there are a few useful modifications of our technique: appropriately augmenting one of the reconstructed arteries with autologous pericardium is a good practical alternative to avoid a tense anastomosis of the reconstructed arteries in the individual geometry and associated lesions.^{4,5}

We think that our technique using autologous arterial wall tissue is valid for any APW with aortic origin of the RPA, with some practical modifications, and good late results were also certified by this article.

FIGURE 1. Right ventriculography 15 years after complete repair. These findings show sufficient growth and geometry of the reconstructed right pulmonary artery. Simultaneous cardiac catheterization exhibited that main pulmonary artery pressure is 25/7 (12) mm Hg, and peripheral right pulmonary artery pressure 15/8 (10) mm Hg. A, Anteroposterior view. B, Lateral view.

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Reply to the Editor:

We thank Dr Kitagawa for his thoughtful and informative comments