that ligation of a single pulmonary vein, either superior or inferior, may be accompanied by dilation of collateral veins to the azygous system, which may be compatible with life.⁴ This area requires further study, and conclusions should not be based on a single case.

In surgical emergencies, a transected main pulmonary artery does not preclude abrupt abortion of the intended surgical procedure. However, this should be used as a last resort. In elective cancer cases, a thorough inspection of all structures including artery, veins, and bronchus should be undertaken to ensure resectability before transection of any individual major structure.

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TO FENESTRATE OR NOT TO FENESTRATE

To the Editor:

In their recent article, Salazar and colleagues¹ have rightly addressed a pertinent topic. We agree that under usual circumstances a fenestration at the time of a total cavopulmonary connection should be avoided. Between June 2000 and June 2006, a total of 132 consecutive patients were treated at our institution without any fenestrations. At the time of total cavopulmonary connection, 93 patients (70%) were younger than 48 months. We continue to complete at a young

age and to avoid fenestrations. We have since opted for fenestration in only 2 patients, both of whom underwent single-lung palliation.

Salazar and colleagues¹ state that they opted for fenestration only in "highly selected patients." They mention patients with elevated pulmonary vascular resistance or transpulmonary gradient, significant atrioventricular regurgitation, and single-lung physiology. We would appreciate further guidance on their selection criteria, because we would like to know their cut-off for elevated pulmonary vascular resistance and why they deem patients with atrioventricular regurgitation to be candidates for fenestration. In addition, why should any intracardiac anatomy not be amenable to an extracardiac completion? In our view, the extracardiac completion does in fact help to overcome many complex morphologic obstacles and helps make it quite easy to reroute central venous blood flow to the pulmonary vascular bed.

Salazar and colleagues¹ might also elucidate their experience with fenestration patency. Ruiz and colleagues² have published an intriguing concept in which the lower atrial orifice toward the divided inferior vena cava is sutured in an end-to-side fashion to the leftward aspect of the punched conduit.

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A RISK FACTOR FOR HYPERLACTATEMIA AFTER SURGICAL REPAIR OF SECUNDUM ATRIAL SEPTAL DEFECT IN CHILDREN: WHAT IS THE PROBLEM?

To the Editor:

We read with great interest the article by Abraham and colleagues.¹ They report their results of a retrospective study on the intraoperative risk factors for early postoperative hyperlactatemia in patients undergoing atrial septal defect repair. Multivariate logistic regression analysis showed that lower cardiopulmonary bypass (CPB) flow rate is an independent risk factor for early postoperative hyperlactatemia in children after atrial septal defect repair. It has instructive significance for the perfusionist to maintain higher mixed venous saturations and use vasodilators during CPB to improve overall tissue perfusion.

The study includes 68 patients with atrial septal defect, Risk Adjustment for Congenital Heart Surgery category I, who had good cardiac output in the postoperative period. This effectively avoids the influence of confounding factors on blood lactate, such as the CPB temperature, hemodilution, duration of CPB, cardiac function, drugs used perioperatively, liver and kidney function, and so forth. The design is a benefit for the study of the correlation simply between intraoperative factors and postoperative hyperlactatemia. However, several other factors that influence the blood lactate should be considered.

The subjects have atrial septal defect and are aged less than 21 years (range, 5–201 months). The age span is comparatively large because there is a big difference in the CPB prime and management between those aged 5 months and those aged 201 months. Generally, children aged less than 1 year would be primed with banked red blood cells and have comparatively more banked blood perioperatively. Banked blood itself, which