The MCC model is an impressive solution, but the inclusion of single-ventricle patients and their local follow-up may be ambitious beyond practicality. The resources committed to 1 single-ventricle patient might take care of several tetralogy of Fallot patients. As always, careful patient selection may be the path to optimal outcomes and optimal resource distribution.

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Commentary: Caring for those often left behind

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In this issue of the *Journal*, Lacour-Gayet and colleagues¹ report on the amazing work of the Mecenat Chirurgie Cardiaque Foundation in France, whose mission is to “Operate in the best conditions on children from disadvantaged countries suffering from heart malformations.”² The foundation has treated more than 3000 children since 1996. The purpose of their current article is to report on the 531 patients with “severe” congenital heart disease from among the 3000 who have undergone repair. Although the word “severe” is not commonly used in current classifications of congenital heart disease, the authors chose this designation to convey the increased risk and intensity of care associated with performing palliative and reparative operations in children with advanced disease. The authors note that “severity” reflects “the intensity of resources needed to diagnose and treat a patient with a given diagnosis.”³ This

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CENTRAL MESSAGE

Children from developing nations with advanced, complex congenital heart disease including single ventricles can be successfully treated.

definition captures this high-risk group of patients cared for by the Foundation who would typically be excluded from care rendered on surgical mission trips due to the preference for one-stage, straightforward corrective procedures or possibly undergo staged palliation at local centers not equipped with the facilities, training, or human capital to render similar results that are achieved at established centers in developed nations.⁴ They are caring for those who are often left behind.

Despite the complexity and severity of the patients and disease, the Foundation has achieved remarkable results. Care of the single-ventricle population deserves special recognition. Lacour-Gayet and colleagues report a mean unadjusted perioperative mortality of 6.3% from a combination of bidirectional cavopulmonary connections (3.9%),

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total cavopulmonary connections (5.1%), systemic to pulmonary shunts (12.5%), and pulmonary artery banding (9%). The Society of Thoracic Surgeons Spring 2019 Harvest lists unadjusted mortality rates of 1.8%, 1.3%, 7.4%, and 7.1%, respectively.⁵ Although the Foundations outcomes are slightly better, this likely reflects the risks in caring for these patients who have potentially accumulated greater morbidities secondary to untreated congenital heart disease. Given that no benchmark exists for treating imported, advanced congenital heart disease in high-income countries, the results from the Mecenat Chirurgie Cardiaque Foundation may serve as a good target. In addition, the Foundation's favorable long-term survival results with single-ventricle tricuspid atresia (97% at 15 years) may influence other charitable care organizations to consider interventions in this surgically neglected

collection of patients. Congratulations to the Foundation for their amazing work!

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