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Commentary: The Everest of pediatric cardiac surgery: Unifocalization of aortopulmonary collateral arteries

Osman O. Al-Radi, FRCSC

In a recent article about climbing Mount Everest, Huey and colleagues¹ noted that the success rate has improved over time from <20% in the 1970s to about 70% in the current decade. The rate of death, which most of time occurs during the descent phase of the climb, has remained low at 1%.¹ There is no question that climbing Mount Everest is not everyone's cup of tea. The drive, dedication, training, and innate and acquired endurance required for the climb are rare among mortals. Huey and colleagues¹ show that even such tasks are reproducible and can improve over time and with more people doing them. If an operation in pediatric cardiac surgery could be compared with climbing Mount Everest, unifocalization of major aortopulmonary collateral arteries would be it.

As reported in previous publications² and by Mainwaring and colleagues,³ single-stage unifocalization can require cardiopulmonary bypass times averaging 6 hours and extending up to 10 or more hours. The operative times would surely be a few hours longer than that, especially with the need for intraoperative flow studies and challenging hemostasis. The authors show that not only is that achievable in hundreds of patients, but also that it produces excellent short- and long-term outcomes.³ One can only admire the endurance, determination, and resolve of the surgical team. Surely not every cardiac surgeon's cup of tea.

Climbing Mount Everest might be thought of as a luxury challenge or a fanatical endeavor. If no one did it, little or no

Osman O. Al-Radi, FRCSC

CENTRAL MESSAGE

Surgery for pulmonary atresia/ MAPCAs is a burden that only a few can carry.

harm will be done. On the other hand, the surgical care of patients with pulmonary atresia/unifocalization of major aortopulmonary collateral arteries is far from that. It is an obligation of the community of congenital cardiac surgery teams in each country or region. If done by some, the rest would be relieved from the burden, but if no one does it, the conscience of all should be bothered.

Who should be the chosen one(s) to take on the challenge? One might think of a socialist deterministic approach and assign a surgeon/group in each area, which in my view is doomed to fail. However, like all other human endeavors, once something is invented or discovered—and if it continues to be needed—the competitive spirit and need to achieve that is at the core of human nature will spur the self-selected few to take the burden off the shoulders of the rest of us. The Mainwaring and colleagues group is living proof of that. The next question is: Who will carry the baton next?

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From the Faculty of Medicine, Department of Surgery, King Abdulaziz University, Jeddah, Saudi Arabia.

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Address for reprints: Osman O. Al-Radi, FRCSC, Faculty of Medicine, Department of Surgery, King Abdulaziz University, PO Box 80215, Building 10, Room 1027, Jeddah 21589, Saudi Arabia (E-mail: oradi@kau.edu.sa).

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