LETTERS TO THE EDITOR

Scope
Heart welcomes letters commenting on papers published in the journal in the previous six months. Topics not related to papers published earlier in the journal may be introduced as a letter: letters reporting original data may be sent for peer review.

Presentation
Letters should be:

- not more than 600 words and six references in length
- typed in double spacing (fax copies and paper copy only)
- signed by all authors.

They may contain short tables or a small figure. Please send a copy of your letter on disk. Full instructions to authors appear in the July 1997 issue of Heart (page 97).

Bidirectional superior cavopulmonary anastomosis: how young is too young?

Sir,—The paper by Slavik et al1 has a curi- ous objective. It attempts "to define the low- est age at which the bidirectional superior cavopulmonary anastomosis can safely be used in infants with complex congenital heart defects". It is difficult to achieve this objective without a properly conducted clinical protocol. This does not seem to be the case in this study. So how have the authors achieved their objective? They have presumably performed bidirectional cavopulmonary anastomosis on younger and younger infants, and when young babies stopped at an age when the mortality would have become prohibitive.

Slavik et al1 have in fact described the experimental use in a younger group of patients of what is a standard operation in an older age group.2 Their patients were between three and seven weeks old and, in one, the pulmonary artery pressure was at systemic level. These would conventionally be contraindications to this operation. The authors are to be congratulated for their results, but their paper raises some important ethical issues.

If we accept that this was an experimental operation, was ethical committee permission obtained prior to embarking on this approach and was fully informed consent obtained from the parents? If so, were the parents informed that this was an experimental approach? The alternative conventional treatment in three out of four patients was the use of "a straightforward non-bypass surgical procedure with proven low morbidity and mortality".3 Does this small series represent all the patients in this age group who have undergone this experimental approach analysed on the basis of intention-to-treat, or is this paper a description of their experience after "the learning curve"?

We fully endorse attempts at improving the patients' outcome for congenital heart disease and advancing medical knowledge as a result of properly conducted studies. These advances have almost invariably been dependent on innovation and avoidance of inflexible attitudes on the part of clinicians. Any "new" treatment will be critically compared with the current standards of treatment by everyone. Some, but not all, of the authors of this paper may have been disdainful of "complicated interventional techniques being applied to complex forms of congenital heart disease on an experimental basis".4 We find it illogical that some of the authors of the current paper judge that new surgical experimental interventions are easily acceptable but have major difficulties in accepting transcatheter interventional methods.

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Outcomes of isolated congenital heart block diagnosed in utero

Sir,—I read with great interest the report by Groves et al5 about perinatal outcome of iso- lated congenital heart block. They have been able to diagnose prenatally a very large series of patients, especially considering the accepted low incidence of the condition (1 in 15 000). They have given a wider perspective of the disease than previous neonatal series because they focused on perinatal outcome for a group of fetuses diagnosed and managed at a single institution.

They reported that heart block was related to anti-Ro or anti-La antibodies in most of their patients. They remarked that two patients in their series, Weiss DL, Jones RA, et al. Early bidirectional cavopulmonary shunt in young infants. Postnatally, they have been followed up to the age of 11 years. Circulation 1993;88:140–51.


As emphasised in our discussion, despite a zero mortality in these four children, we remain cautious in making firm recommendations regarding the safe lower age limit for the cavopulmonary anastomosis.

Z SLAVIK
R K LAMB
A M WEBBER
J A DDEVLIN
B R KEETON
J M M EDTOR
A P SALMON
Westmead Cardiotoracic Centre, Southamptom Children's Hospital, Tremona Road, Southamptom SO16 6DY


