Cardiol Young 2004; 14 (Suppl. 1): 114
© Greenwich Medical Media Ltd.
ISSN 1047-9511

Debates

Rebuttal

Leonard L. Bailey

Department of Surgery, Loma Linda University, Loma Linda, California, USA

THE PORTRAYAL OF A BEAUTIFUL YOUNGSTER performing uninhibited acrobatics based on Fontan physiology, as presented by Marshall Jacobs, is a brilliant and beautiful thing for us to see. It is, perhaps, all about will over physiology. But it is, nevertheless, happening for that child. Marshall mentioned the need for re-transplantation, whether the beginning strategy was transplantation or reconstructive surgery. Indeed, a relatively small percentage of children transplanted will require re-transplantation because of severe graft coronary disease. Remarkably, in the Loma Linda experience, 10-year actuarial survival for 26 patients following elective re-transplantation is over 85%, exceeding overall actuarial survival at 10 years for children following primary transplantation. Many of the transplanted infants, however, seem to be realistically hopeful that one heart will last their entire lifetime. Of course, the hope is that their's will be a long and healthy lifetime. The requirement for late transplantation following Fontan procedures, however, seems almost inevitable. We'll simply have to keep these children with Fontan circulation under surveillance to see when, in the course of their lives, transplantation will become necessary. Unfortunately, operative and long-term survival among children who are transplanted for failing Fontan physiology have, as yet, been somewhat suboptimal.

So that you understand the trends, only 11 babies with hypoplastic left heart syndrome have had transplantation for that diagnosis at our center in the past 5 years. There never have been, and there never will be, enough donors for this entire cohort of infants. Hence, the vital role of Norwood reconstructive surgery. We currently employ transplantation on a selective basis for the diagnosis of hypoplastic left heart syndrome. We attempt to identify and select those patients who are at a significantly higher risk for staged palliative reconstruction, and then we do our very best to transplant those infants. Of course, we continue to honor the parents' wishes with regard to choice of intervention. The ratio of transplantation versus palliation on a nationwide basis would, in my mind, be around 1 to 10.

Correspondence to: Leonard Bailey MD, Professor and Chair, Department of Surgery, Loma Linda University, 11175 Campus Street, Suite 21120, Loma Linda, CA 92354, USA. Tel: 909 558 8744; Fax: 909 558 4116; E-mail: lbailey@som.llu.edu

https://doi.org/10.1017/S1047951104006432 Published online by Cambridge University Press