The burgeoning literature on coronary artery bypass surgery is at best confusing and more likely uninterpretable. Incomplete description of patient cohorts, variability of follow-up, and lack of standard definitions have created a morass of data which is impossible to compare. The major thrust of emerging literature on this subject appears to be in the direction of identifying subgroups of patients who are more or less likely to benefit from surgical intervention. The true importance of these subgroups is being clouded by our inability to compare their experience with the general experience.

These problems are not the fault of the individual investigators who have been reporting data. Rather, they reflect a lack of generally accepted definitions.

As an ultimate goal, we should strive for uniform data collection and reporting throughout the literature. Until we realize this goal, the least we can do is establish common definitions for commonly reported data. While awaiting the formation of ad hoc committees, working parties, international councils, etc., perhaps editors of major cardiovascular journals could insist on some standard definitions for the data they publish.

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References


Conditions Simulating the Tetralogy of Fallot

To the Editor:

In the January issue (Circulation 49: 173, 1974) Drs. Rao and Edwards commented on a variety of conditions simulating the Tetralogy of Fallot. I was very much surprised not to see in the references two papers of Coelho et al. where the same subject was discussed more than ten years ago. In fact, under the title "Tetralogy of Fallot — Angiographic, electrocardiographic, vectorcardiographic and hemodynamic studies of the Fallot-type complex” (Am J Cardiol 7: 538, 1961) they extended the old concept of tetralogy of Fallot into the idea of the ”Fallot-type complex” which included any malformation with the clinical picture of tetralogy of Fallot and the same common anatomic denominator, differing only in the functional relationship between the two main morphologic elements of the complex. They stated that of the four elements comprising the tetralogy of Fallot, pulmonary or infundibular stenosis and ventricular septal defect dominate its pathologic physiology; right ventricular hypertrophy is secondary and dextroposition of the aorta is functional rather than anatomic.

To the first six groups: (1) classic tetralogy of Fallot; (2) extreme tetralogy of Fallot (with pulmonary atresia or pseudotruncus arteriosus); (3) so-called acyanotic or slight tetralogy of Fallot; (4) stenosis of the outflow tract of the right ventricle or pulmonary stenosis with ventricular septal defect and no overriding of the aorta; (5) partial transposition of the great vessels (or transposition of the ventricular chambers) with stenosis of the outflow tract of the right ventricle or pulmonary stenosis and ventricular septal defect; and (6) single ventricle with pulmonary stenosis, they added later a seventh, origin of both great vessels from the right ventricle with pulmonary stenosis (Am Heart J 65: 766, 1963), and finally the eighth group, pulmonary stenosis with atrioventricular septal defect (J Soc Med Lisboa 131: 656, 1967).

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