

## Author's Reply

To the Editor,

We thank the author for their interest in our studies and results and for bringing up this point. As the author has mentioned, shunt operations are challenging procedures in congenital patients because it is difficult, if not impossible, to predict short- and long-term performance in specific patients (1-3). Thus, patient-specific surgical planning and decision making for shunt configuration (location, diameter, and type) are crucial for the success of surgery (3-6). In our study (7), we have investigated in detail the performance of shunt configurations in terms of pulmonary flow rates, energy (pressure) loss, and blood damage (hemolysis). Moreover, we have studied the effect of pulmonary artery diameter and pulmonary vascular resistance on pulmonary flow rates. Tables 2 and 6 present the right, left, and total pulmonary artery perfusion calculations. In the "Flow splits" subsection of the Results section, flow preference has been discussed on the basis of shunt configuration, pulmonary artery diameters, and pulmonary vascular resistance.

In the Discussion section, flow preferences have been discussed on the basis of pulmonary resistance, shunt anastomosis angle, and pulmonary artery sizes.

Furthermore, in the Conclusion section, we have suggested that the anastomosis angle between the shunt and pulmonary artery has a crucial effect on flow splits directed to the pulmonary arteries. The shunt angle should not be directed toward the narrow pulmonary artery (right or left) since total pulmonary flow rates decrease. Furthermore, vertical anastomosis configurations increase total pulmonary perfusion; thus, these configurations are preferable compared with leaned anastomosis shunt configurations.

We, hereby, thank again the author for their fruitful discussions. They have summarized shunt surgery planning based on previous literature and our current paper. They have also emphasized the importance of the topic and remarked the place of our current paper among the surgical planning literature.

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## Value of ATRIA risk score and gender in predicting adverse events in patients with myocardial infarction

To the Editor,

I have read the article by Çetinkal et al. (1) entitled "Comparative performance of Anticoagulation and Risk factors In Atrial fibrillation and Global Registry of Acute Coronary Events risk scores in predicting long-term adverse events in patients with acute myocardial infarction" with great interest, which was published in *Anatol J Cardiol* 2018; 20: 77-84. In their study, the authors divided 1627 patients with acute myocardial infarction into three risk groups according to ATRIA risk score: ATRIA 0, ATRIA 1-2, and ATRIA >3. They reported that ATRIA risk score >3 was found to be an independent predictor of major adverse cardiac events in this group. This is a well-written study, and I would like to draw attention to the gender-related differences that can affect the results of the present study.