exceed the blood supply, usually during crying or after feeding. Patients are at risk for emboli, seizures, and loss of consciousness or sudden death after an anoxic spell.

Surgical treatment:

Palliative shunt: In infants who cannot undergo primary repair, a palliative procedure to increase pulmonary blood flow and increase oxygen saturation may be performed. The preferred procedure is a modified Blalock-Taussig shunt operation, which provides blood flow to the pulmonary arteries from the left or right subclavian artery via a tube graft (see Table 23-4). In general, however, shunts are avoided because they may result in pulmonary artery distortion.

Complete repair: Elective repair is usually performed in the first year of life. Indications for repair include increasing cyanosis and the development of hypercyanotic spells. Complete repair involves closure of the VSD and resection of the infundibular stenosis, with placement of a pericardial patch to enlarge the RVOT. In some repairs, the patch may extend across the pulmonary valve annulus (transannular patch), making the pulmonary valve incompetent. The procedure requires a median sternotomy and the use of cardiopulmonary bypass.

Prognosis: The operative mortality for total correction of tetralogy of Fallot is less than 2% to 3% during the first 2 years of life (Park, 2014) Infants younger than 3 months old and children older than 4 years old, as well as those with other CHD or hypoplasia of the pulmonary annulus and trunk have a higher mortality rate. With