Table 3: The frequency of in-hospital mortality, right-ventricular failure and the 1- and 5-year actuarial survival and survival on condition of hospital discharge

	Lower tertile	Middle tertile	Upper tertile	*p* Value
In-hospital mortality % (no. available)	5.6 (53)	0 (53)	5.7 (52)	0.20
In-hospital RV failure % (no. available)	18.9 (53)	24.5 (53)	28.8 (52)	0.48
1-year actuarial survival %	92.5	100	100	See Fig. 1
5-year actuarial survival %	75.2	91.2	89.2	See Fig. 1
1-year actuarial survival on condition of hospital discharge %	97.9	100	100	See Fig. 2
5-year actuarial survival on condition of hospital discharge %	84.4	91.2	94.6	See Fig. 2

The figures are given as the percentage of the denominator available.
RV: right ventricle.

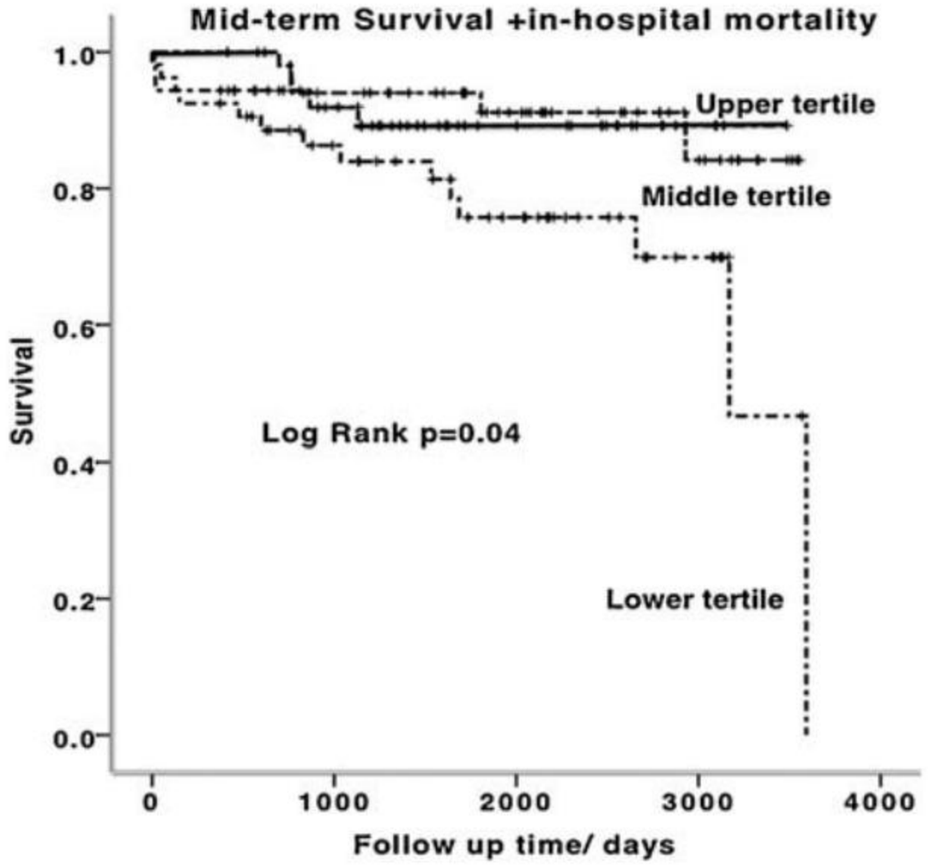

Figure 1: Kaplan-Meier survival plots of the overall actuarial survival according to the weight mismatch tertile group, from the time of operation to final follow-up. There was reduced survival among those in the lowest tertile group, log-rank $p = 0.04$.

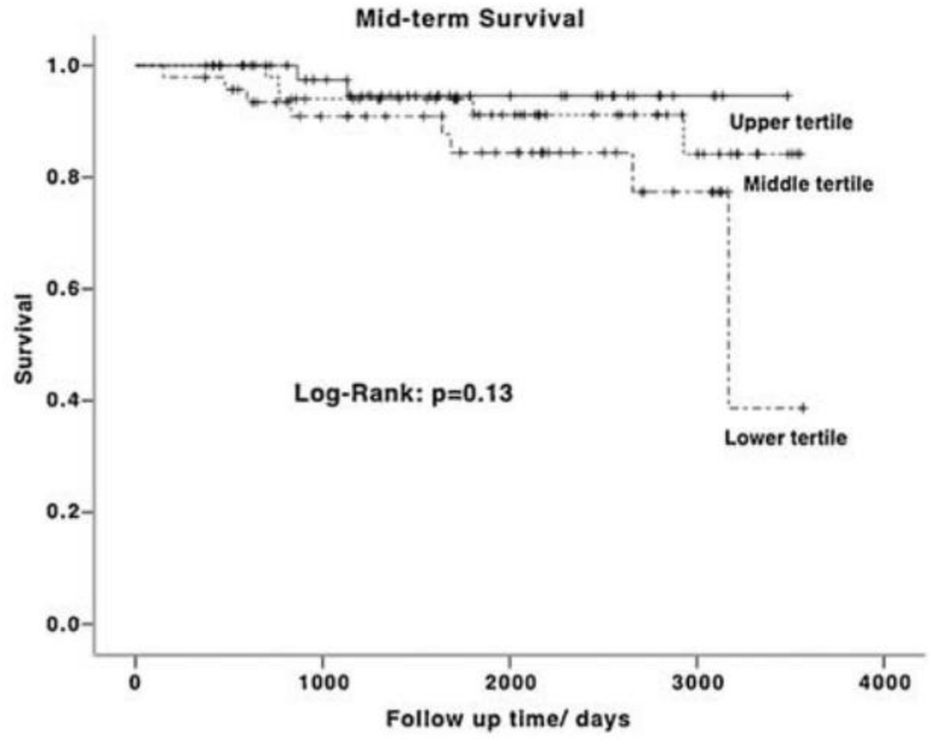

Figure 2: Kaplan-Meier survival plots of the midterm survival according to the weight mismatch tertile group, on the condition of discharge from hospital. The plots were not significantly different, log-rank $p = 0.136$.

tertile groups. Plotting survival to the end of the follow-up period (Fig. 2 and Table 3) showed that there was no statistically significant difference in long-term survival between the three tertile groups (log-rank $p = 0.13$).

Of the 104 patients who had received an ambulatory blood-pressure analysis during their follow-up period, 25 (18.4%) were hypertensive and receiving treatment for it. On Kaplan–Meier analysis of freedom from hypertension from the time of hospital discharge to date of last ambulatory blood-pressure measurement, there was no difference between the three weight groups (log-rank$p = 0.39$) (Fig. 3).

Secondary outcome measures

Data on postoperative RV function was available in 158 out of 161 patients. Thirty-eight patients (24%) developed RV failure. In the lower tertile group, 18.9% developed postoperative RV failure, in the middle group 24.5% and in the upper tertile group 28.8%; this was not statistically different ($p = 0.48$) (Table 3).

The mean period of ventilation post transplant was 302.7 h (SD 617.8), median 102 h (IQR298). On Spearman's rank correlation, this was not associated with the donor/recipient weight ratio (Fig. 3) ($p = -0.12$, $p = 0.14$). Even when excluding the 11 patients who had been intubated for more than 100 h, there was no association ($p = -0.10$, $p = 0.38$) (Fig. 4).

The mean period of ITU stay was 448 h (SD 749.2), median 184 h (IQR374). On Spearman's rank correlation, this was also not related to the weight ratio ($p = -0.04$, $p = 0.58$) (Fig. 5). Again, if the six patients who were in the ITU for more than 2000 h were excluded, there was still no association ($p < 0.01$, $p = 0.98$).

Extreme mismatch subgroup

There were nine patients in whom the donor-recipient weight mismatch was 3 or greater (5.5%). By the end of the follow-up period, there was only 11% (1/9) mortality, compared with 18.2% (23/126) for those with a ratio of <3 ($p = 0.76$).

At the end of the follow-up period, of the six patients with 'extreme' mismatch who had been investigated with ambulatory blood-pressure measurement, only one was being treated for