



This Concise Clinical Guidance (CCG) provides practical guidance for outpatient management of isolated common left-to-right shunt lesions in pediatric patients, helping clinicians tailor follow-up, testing, referral, and discharge decisions.

Refer to the full CCG for detailed figures and clinical nuance: *[include QR code here when ready]*

1 Individualize follow-up based on physiology rather than diagnosis alone.
Base visit frequency and testing on symptoms, shunt size, and chamber effects; many children with small, asymptomatic lesions can be followed less often or safely discharged.

2 Avoid routine imaging for small, hemodynamically insignificant lesions.
Small muscular ventricular septal defects (VSD), and trivial or silent patent ductus arteriosus (PDA) often require no routine imaging and may be appropriate for shared decision-making around discharge from cardiology care.

3 Differentiate VSD subtype to guide long-term follow-up.
Muscular VSDs typically have a benign course when small, whereas nonmuscular VSDs warrant continued follow-up due to risks such as aortic valve disease or subaortic obstruction.

4 Increase monitoring during infancy for moderate or large shunts.
Follow infants more closely during periods of transition in pulmonary vascular resistance, using clinical assessment and selective imaging to evaluate evolving physiology.

5 Refer for intervention based on hemodynamic impact, age, symptoms or sequelae.
Consider referral when there is chamber dilation, ratio of pulmonary to systemic blood flow ($Q_p:Q_s$) $\geq 1.5:1$, evidence of physiological progression, symptoms, or associated complications. Shunts with predominant atrial septal defect (ASD) physiology are typically closed at pre-school age, whereas shunts with VSD physiology and PDA are usually repaired during infancy due to symptoms or risk of associated complications.

6 Tailor post-intervention follow-up to residual risk.
Adjust surveillance based on repair type, residual shunting, and ventricular function; stable patients without sequelae may transition to less frequent long-term follow-up.

7 Use echocardiography selectively to support value-based care.
Order imaging for new symptoms, assess for chamber enlargement, or suspected residual lesions, and avoid routine testing in stable, low-risk patients.

8 Counsel families with clear expectations and reassurance.
Explain the natural history, rationale for reduced surveillance, and signs that warrant re-evaluation, emphasizing that less frequent follow-up reflects low risk, rather than reduced care quality.

Scan this QR code to access the full CCG for detailed figures and clinical nuance.

