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numbers crackTo the Editor, We would like to
thank the authors for their interest in our case
report and for the valuable contributions to the
understanding of this rare condition. It is
important to highlight that atrial flutter (AFL) is a
very common arrhythmia in clinical practice, with
an incidence rate estimated at around 0.07--0.5%
in the general population \[\[@bb0005]\]. The most
common origin is the AV node, whereas it is less

common (1%) in the setting of a bigeminal conduction \[\[\@bb0005\]\]. AFL has been previously reported in a 3-year-old female patient \[\[\@bb0010\]\]. In this case, the unusual features were the association with right ventricular outflow tract (RVOT) hypoplasia in the anatomical substrate and the early onset of the disease, which is rare in this setting. Another interesting feature was the complete effective treatment of AFL with oral amiodarone, an antiarrhythmic drug that is a well-known class I agent, and which has now become the gold standard for the pharmacological treatment of AFI \[\[\@bb0005\]\]. Here, we would like to discuss these findings. The presence of conduction block in the left side is less common in AF than in AFL and is usually related to an intrinsic right bundle branch block or a left anterior fascicular block \[\[\@bb0005\]\]. We also hypothesise a possibility of early onset of the disease in our patient: the first symptom was a generalised palpitations that led to the diagnosis of AFL. However, the clinical features, rhythm on the electrocardiogram, and the diagnostic flowchart based on the international recommendations did not point to a diagnosis of AFL \[\[\@bb0005\]\]. Another possible explanation is that the right AV node was already in an

abnormal conduction condition when the tachyarrhythmia developed. Indeed, a recent study reported that abnormal conduction in the right bundle branch \[[@bb0015]\] and in the junctional area \[[@bb0020]\] may predispose to the development of AFL. In conclusion, we would

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