**SUPPLEMENTAL METHODS**

**TTE Methodology**

Systolic time intervals (STI) were measured using on-board ECG, which was only performed when the infants were on routine ECG monitoring. From the start of the QRS complex until opening of the Aortic valve (Ao) in a long axis M-mode was used to estimate LV pre-ejection period (LV-PEPTTE). Time of open Ao was estimated as the LV ejection time (LV-ETTTE) in the same view. LV-velocity time integral (VTI) was measured in an apical 5-chamber view just below Ao level and the Ao diameter in the long axis 2D view (hinge point measurement at end-systole) was used to estimate SVTTE from VTI measurement as recommended.[8] RV outflow tract diameter was measured in a short axis 2D- view (hinge to hinge) and RV-VTI was measured in the same view. All diameters were averaged over three cardiac cycles and reference values were used to check diameter measurements for outliers.[9] To minimize the influence of respiration on SV measurements, we averaged VTI and STI measurements over 4 cardiac cycles as recommended.[10] HR was estimated using R-R intervals for each parameter separately. All sonographers (EMD and CES) are trained in functional echocardiography with experience over 15 and 10 years, respectively. All measures were performed post-hoc and all images were critically evaluated for accuracy (i.e. angle of insoniation) by EMD, while he was blinded to EC measures.