Inotropic support during cardiac surgery

Editor—We read with interest the article on the incidence, and risk calculation for utilisation, of inotropic support in patients undergoing cardiac surgery.¹ The findings of the independent predictors of ventricular dysfunction (presence of chronic obstructive pulmonary disease, age >65 yr, aortic cross clamp time >90 min), would be of no surprise to any cardiac anaesthetist.

More importantly from a scientific point of view, these are essentially the predictors of ventricular dysfunction which have been known for 10 yr or more, as reported in two of the references quoted in the paper.²,³ A further limitation of this report is one common to all scoring systems in medicine. Although such a calculated score is a guide for an individual patient’s likely treatment needs, it is only a guide and not an absolute predictor.⁴ Therefore in predicting the need for inotropic support after cardiopulmonary bypass, such a scoring system, using well-known and previously described clinical determinants, is very unlikely to be any better than an average specialist clinician’s usual clinical practice.

‘Timely therapeutic intervention’ in this context¹ is at the time of first attempting to separate the patient from cardiopulmonary bypass. Knowledge of likely need for inotropic support in individual patients is not increased by such a scoring system, and is best managed by a clinician judging the constellation of pre- and intraoperative factors that will determine such, if any, need.

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Editor—we are grateful for the opportunity to comment on the interesting letter from Drs Weidmann and Herbertson. We fully agree with their opinion that no scoring system can replace clinical experience. However, as we pointed out,¹ knowledge of


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