Letter to the Editor

The EuroSCORE has served us well

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Keywords: EuroSCORE; High-risk; Operative risk

The November 2009 issue of the European Journal of Cardiothoracic Surgery features interesting discussions about the European System for Operative Risk Evaluation (EuroSCORE). The papers by Ranucci and colleagues [1] and Nissinen and colleagues [2] rightly highlight the limitations of EuroSCORE and suggest methods for improvement based on their institutional experiences, and they should be congratulated. More interesting, however, are the erudite accompanying editorial comments by Dewey and Herbert [3] and Nashef [4], which adequately address issues raised in the papers and the poignant editorial by Manasse [5]. There is a consensus that the EuroSCORE needs to be revised or, more appropriately, updated, and the process has been initiated. The EuroSCORE has served us well and proved to be reliable. Rather than re-package an ‘out-of-date’ system to make it appear contemporarily germane, as some of the authors have suggested, the ongoing EuroSCORE project to update the risk stratification model should be enthusiastically supported. Its main advantage, which is the simplicity and bedside applicability, should not be lost in the new form.

While single institutional experiences are important to determine the performance of the risk scoring system, they cannot be reliable as the absolute measure of the precision and currency of the model, because they would be expected to ‘scatter’ about the mean. The use of confidence limits for future comparisons of single-centre mortality rates with the EuroSCORE predicted risk would be more appropriate.

An important consideration for the updated EuroSCORE should be the inclusion of some definitions. Controversies about the ideal definition of ‘high risk’ should perhaps be addressed. To justify the use of alternative therapies, recent reports have variably defined ‘high-risk’ patients using different EuroSCORE cut-offs such that some patients who would otherwise be offered conventional procedures are denied optimal surgical management because they are regarded as too high risk.

References


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Reply to the Letter to the Editor

Reply to Ngaage

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On behalf of the EuroSCORE Project team, we are grateful to Mr Ngaage for his positive comments [1] about our work and for his enthusiastic support of the planned renewal project for this year. His comments on single institutional experiences are apposite. We can assure him that every effort will be made to maintain the model’s simplicity and bedside applicability, and that extreme care has been taken to ensure that the risk factors, definitions and impact will be selected so as to be as relevant as possible to contemporary cardiac surgery.

At the time of writing, nearly 250 centres have registered to participate in data collection for the new model. Of course, the model will be only as good as the data from which it will be built, and, for that reason, we take this opportunity to urge Dr Ngaage and all cardiac surgeons to register their institutions (www.euroscore.org)
for the data collection, which we anticipate will begin within the next 3 months.

Reference


Letter to the Editor

Tricuspid valve replacement is an unfavourable operation* Khaled E. Al-Ebrahim *
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Keywords: Tricuspid; Valve; Replacement

I read with interest the article by Sung and colleagues about tricuspid valve replacement [1]. I agree with the authors that their reported results, although better than others, are still unsatisfactory. I think tricuspid valve replacement is an unfavourable surgery rather than catastrophic. The most important question in these operations is when to replace and not to repair the tricuspid valve. The surgeon has to decide intra-operatively, based on the valve pathology, that the best tricuspid repair technique will produce worse results than replacement. This is applicable in a very small sector of those patients where the tricuspid valve is heavily diseased and the anterior leaflet with its chordae are fibrosed and retracted to the degree that cannot fill an acceptable or adequate valve area. In the old days, severe tricuspid endocarditis with large multiple vegetations were treated with valvectomy, which was well tolerated by patients with mild to moderate pulmonary hypertension. Sung and colleagues clearly demonstrated that cardiopulmonary bypass is a major risk factor in those patients. Most of their procedures were done on an arrested heart and they preferred mechanical prostheses. Cardiac surgeons in the Third World countries are faced with a large number of patients with severe and symptomatic tricuspid regurgitation; most of those patients are usually poor and live in remote areas. Cost containment is now an important issue everywhere and valve replacement implies a major increase in the cost of the procedure and the added cost of complications. Chang and colleagues [2] reported excellent results using autologous pericardial strip repair, which is the most suitable for our patients. The technique is quite feasible and effective in producing excellent intra- and postoperative results. Among its several advantages, it is ready, available without cost, resists infection and is flexible, allowing growth in the paediatric age group. Our surgical technique is different from that of Sung and colleagues in that we perform the repair, or even tricuspid replacements, on a beating heart, which gives us a better assessment of the tricuspid valve before and after the repair as well as early detection of heart block or arrhythmias. This also helps in shortening the aortic cross-clamp and bypass times, which will reflect positively on the morbidity and mortality results of those critical patients as shown by Sung and colleagues and others [1,3]. The choice of the prostheses is of a major concern. Although there is no survival benefit of either type, in general, bioprostheses are more favourable as it has shown good results in freedom from re-operation and structural deterioration [4].

References


Letter to the Editor

Clinical Treatment for Pulmonary Artery Sarcoma

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Pulmonary artery sarcomas (PASs) are extremely rare and the prognosis for patients with PAS is not favourable. Early diagnosis and surgical resection could offer the chance for