to EuroSCORE. This, in turn, will enable patients to be given more accurate information about the risks they face in undergoing cardiac surgery.

The group assessed the effect that training junior surgeons had on outcomes in 2002 and reported that training did not affect the mortality associated with CABG.² It will be interesting to assess the effect that the publication of individual consultants' outcomes has on the training of future surgeons. The authors have also identified that their work could be strengthened if they could include all patients referred for surgery in the study rather than those who were operated on. They should be encouraged to conduct both these studies.

The drive to publish the outcomes of individual consultants began as a result of the Bristol affair, which, of course, related to outcomes after surgery for congenital heart disease. To date, only detailed outcomes for adult cardiac surgery have been published nationally, although some units do go into much greater detail on their own websites. Should other subspecialties take the same approach? The validity of using coronary surgery as one of the indicators of the performance of a cardiac surgeon relies on two important features of this operation: (1) that it is performed in sufficient numbers by most cardiac surgeons and (2) that a robust risk stratification system be developed to balance out differences in case mix. Percutaneous coronary intervention meets the numbers criteria, but does not have such a well-developed risk stratification system as EuroSCORE. Although major adverse cardiac and cerebral events are well accepted as appropriate measures of performance by the

profession, they do not provide such a well-understood outcome measure as mortality does for CABG.

What about congenital cardiac surgery? Data on the outcomes of surgery for congenital heart disease have already been submitted to the Central Cardiac Audit Database, but should surgeon-specific outcomes be published? I would argue not. The complexities of diagnoses and the variety of valid surgical approaches make this different from the relatively homogeneous group of patients undergoing CABG operations. This would make meaningful comparison between individual surgeons difficult, and the small numbers involved for any one surgeon exacerbates the problem. Does this mean that such data should not be available to the public? No, this would not be appropriate, but I would argue that the outcomes of each unit should be published rather than those of each surgeon—all surgery is a team game, but congenital heart surgery requires a team approach to a much greater extent than most other disciplines. So how can the performance of individual surgeons be evaluated? The answer is by local audit strengthened by the multiunit approach of the North West Quality Improvement Programme.

Competing interests: None declared.

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IMAGES IN CARDIOLOGY

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Post myocardial infarction left ventricular free wall rupture diagnosed by multidetector computed tomography

A 63-year-old man was admitted to an institution with symptoms and electrocardiogram signs consistent (central chest pain and inferior lead ST segment elevation) with inferior myocardial infarction. He had undergone immediate (paramedic administered) thrombolysis after a brief period of third-degree heart block and seemed to be recovering well.

Approximately 24 h after admission (26 h after onset of chest pain) his condition deteriorated, with worsening chest and back pain associated with hypotension. Transthoracic echocardiography showed moderate left ventricular function. A chest x ray showed widened mediastinum. Given a past history of hypertension and plain film findings, non-electrocardiogram-gated multidetector computed tomography of the thorax was performed. The immediate findings were mediastinal blood to the level of the aortic arch, a pericardial effusion and a possible thrombosed aortic dissection flap at the level of the arch.

At this time (48 h after admission), he was transferred to the Department of Clinical Radiology, Plymouth Hospital NHS Trust, Plymouth, UK. On arrival, transthoracic echocardiography showed

moderately impaired left ventricular function (ejection fraction 40–45%), reasonable right ventricular function, normal mitral and aortic valve function, and 1.5 cm pericardial effusion. Sixty-four slice multidetector computed tomography (MDCT) was repeated and showed an inferior left ventricular rupture (panels A, B). Unfortunately, the patient's condition deteriorated and he died after a pulseless electrical activity cardiorespiratory arrest.

A review of the datasets from the original scan showed the extravasations

of contrast from the inferior left ventricular wall. This shows that MDCT has a role in cases such as this: in this instance, proving superior to transthoracic echocardiography. It also serves to remind radiologists that with currently available technology intracardiac pathologies can be visualised only if they are considered.

**R A Crossley, G J Morgan-Hughes,
C A Roobottom**
robacrossley@hotmail.com