described four patients who were managed conservatively though they were operated subsequently; however, the criteria for considering conservative management for these four patients is not clear. Also it has been shown that the fibrin tissue patch reinforcement of the primary repair yields better results than primary repair alone.² The principle of surgery remains the same, *i.e.* aggressive management with adequate mediastinal and pleural drainage and nutritional support.⁵ Use of stents is another option described but the indications for it are not clear. Whether a transhiatal approach should be considered when the re-operation rate was quite high as stated by the authors, is another debatable question.

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AUTHOR'S RESPONSE

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The authors mention a very recent publication on the management of Boerhaave's syndrome. They ask about the indications for conservative management of the four late-presenting Boerhaave patients as well as stenting. Our paper makes it clear that it was our policy before 2003 to treat late-presenting Boerhaave patients conservatively; however, since then, we have changed our policy and now treat all Boerhaave patients surgically.

The authors also ask about the re-operation rate for transhiatal repair. We have found the transhiatal approach safe for the majority of patients. All Boerhaave patients are at risk of further interventions, be that interventional radiology or re-operation.

Predicting operative mortality in patients undergoing coronary artery bypass surgery

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COMMENT ON

Lawrence DR, Somaskanthan R, Barnard MJ, Curtis M, Keogh BE.

Are coronary angiograms of value in the risk stratification of patients undergoing coronary artery bypass surgery?

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Lawrence and colleagues have highlighted the inadequacies and pitfalls of risk scores in predicting operative mortality in patients undergoing coronary artery bypass surgery. The dominance of coronary artery system, the degree of luminal obstruction, the number of diseased coronary vessels and calcification of coronaries and the aorta should be taken into consideration in the risk stratification of patients undergoing coronary artery bypass grafting (CABG). The above points are addressed in the SYNTAX scoring system (developed in May 2009),^{1–5} which is a unique scoring system to assess the severity and the anatomical complexity of coronary artery disease and provides a guide to revascularisation options to the cardiologists. Incorporating the SYNTAX score into the Euroscore will provide an additive value in predicting outcome after CABG.

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The timing of our article and the release of the SYNTAX score were entirely coincidental. The issues highlighted in