Letters and comments

Contributors to this section are asked to make their comments brief and to the point. Letters should comply with the instructions to authors at <http://www.rcseng.ac.uk/publications/annals/authorinstructions.html>. Tables and figures should only be included if absolutely essential and no more than five references should be given. The editor reserves the right to shorten letters and subedit contributions to ensure clarity.

Changes required to improve CEA outcomes

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COMMENT ON

Brown C, Naylor R. Improving the provision of carotid endarterectomy in line with UK Government targets requires more than just motivated surgeons.

Ann R Coll Surg Engl 2009; **91**: 326–9

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We read with interest this article regarding improving the provision of carotid endarterectomy (CEA). As noted, achieving a 2-week target requires a change in practice as well as ‘motivated’ surgeons. Historically, CEA was performed more frequently by some surgeons in our unit (7 in total) than others, reflecting referral practices and ‘special’ interests. In order to meet the 2-week target, we developed a policy that all symptomatic patients requiring CEA would be accommodated on the next available consultant operating list. Over the last 6 months, we have achieved 97% compliance with the 2-week target.

With increasing centralisation, many centres now have ‘vascular’ lists most days. We would, therefore, recommend our unit’s policy to others particularly since a recent national audit suggests little improvement in CEA provision since the 2-week time limit was published.¹ In addition, the greatest risk of stroke is within the first few days following the index

neurological event² and awareness amongst the public and GPs regarding the significance of transient ischaemic attacks is poor;³ greater steps are required to identify ‘brain attacks’ early through public awareness campaigns and physician education. We believe that this and the suggested changes in service provision are required to improve overall outcomes.

References

1. Halliday AW, Lees T, Kamugasha D, Grant R, Hoffman A, Rothwell PM *et al.*, Carotid Endarterectomy Steering Group; Clinical Effectiveness and Evaluation Unit, Royal College of Physicians; Vascular Society of Great Britain and Ireland *et al.* Waiting times for carotid endarterectomy in UK: observational study. *BMJ* 2009; **338**: b1847.
2. Rothwell PM, Warlow CP. Timing of TIAs preceding stroke: time window for prevention is very short. *Neurology* 2005; **64**: 817–20.
3. Jagadeham VP, Aparajita R, Gough MJ. Can the UK guidelines for stroke be effective? Attitudes to the symptoms of a transient ischaemic attack among the general public and doctors. *Clin Med* 2008; **8**: 366–70.

Surgical management of Boerhaave’s syndrome in a tertiary oesophagogastric centre

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COMMENT ON:

Sutcliffe RP, Forshaw MJ, Datta G, Rohatgi A, Strauss DC, Mason RC, Botha AJ. Surgical management of Boerhaave’s syndrome in a tertiary oesophagogastric centre. *Ann R Coll Surg Engl* 2009; **91**: 374–80.

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Sutcliffe *et al.* have produced a well-structured study which describes the surgical management of Boerhaave’s syndrome which is quite a challenging job. Various studies have been performed to propose the best management for the patients who present late. The review by Wang *et al.*¹ describes the surgical management to achieve the best outcome and may lead to reduced mortality. The authors have

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.

References

1. Wang Y, Zhang R, Zhou Y, Li X, Cheng Q, Wang Y *et al.* Our experience on management of Boerhaave's syndrome with late presentation. *Dis Esophagus* 2009; **22**: 62–7.
2. Erdogan A, Gurses G, Keskin H, Demircan A. The sealing effect of a fibrin tissue patch on the esophageal perforation area in primary repair. *World J Surg* 2007; **31**: 2199–203.
3. Teh E, Edwards J, Duffy J, Beggs D. Boerhaave's syndrome: a review of management and outcome. *Interact Cardiovasc Thorac Surg* 2007; **6**: 640–3.

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.

References

1. SYNTAX score calculator <www.syntaxscore.com>.
2. Serruys PW, Mohr FW, for the SYNTAX Investigators. Percutaneous coronary intervention versus coronary artery bypass grafting for severe coronary artery disease. *N Engl J Med* 2009; **360**: 961–72.
3. Kappetein AP, Dawkins KD, Mohr FW, Morice MC, Mack MJ, Russell ME *et al.* Current percutaneous coronary intervention and coronary artery bypass grafting practices for three-vessel and left main coronary artery disease. *Eur J Cardiothorac Surg* 2006; **29**: 486–91.

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