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Dear Sir,

I wish to address comments regarding the recent reporting of PHC4. These comments will be directed in two parts: Part one – Regarding my individual cases. Part two- regarding institutional cases.

The first thing I would like to address is the rating that was given to me for CABG/Valve surgery and Total Valve. I do not dispute the reporting of PHC4, but I do question the model under which the determined mortalities are made and I question the logic of re-reporting previously reported data.

This year as with last year, PHC4 is reporting two years at a time. Only one of those years, 2007, has already been previously reported.

For the category Valve/CABG, there were 5 mortalities listed, three of which were previously reported and occurred in 2007. The STS Risk Assessment Calculations for the other four are as follows:

Mitral Valve Replacement, CABG
Aortic Valve Replacement, CABG, Closure of ASD
Aortic Valve Replacement, CABG,
Replacement of Ascending Aorta

Pre-op Mortality: 19.2%
Pre-op Mortality: 25.6%+
Pre-op Mortality: 11.8%+

(Please note that the plus sign is placed after those mortalities that are higher, but because of the limitations of the Risk Calculator, we are unable to include a double valve, ASD or ascending aortic replacement. Calculations were made based on Valve/CABG only.)

The first patient developed massive hemoptosis on the day he was scheduled to be transferred to a rehab center secondary to a bronchial AVM. He recovered from the bleed but developed pneumonia and the family withdrew all support and removed him from the ventilator. He died on post-operative day number 54. The second patient developed renal failure and required dialysis to stay alive but the family refused and made her comfort care. The third patient developed HIT with thrombosis and died on post-operative day number 56. The last patient had an ascending aortic replacement in addition to a Valve/CABG which is far more complicated than a Valve/CABG procedure.

There were two other Valve/CABG mortalities. This occurred in 2008. The STS Risk Assessment Calculations for the other four are as follows:

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Aortic Valve Replacement, CABG, RF Maze
Redo Aortic Valve Replacement, CABG,
Aortic root enlargement, IABP

Pre-op Mortality: 6.8%
Pre-op Mortality: 19.1%

The first patient had severe untreated aortic stenosis, CAD, uncontrolled DM II, HTN and morbid obesity with a BMI >45. She developed a severe systemic reaction to cardiopulmonary bypass and died of multisystem organ failure despite maintaining a cardiac index over 3.0. The second patient had previous cardiac surgery, CAD, previous MI, renal artery stenosis, stage 3 renal failure, severe COPD with asthma and sleep apnea, HTN, and severe aortic stenosis. The patient developed multisystem organ failure and expired.

By including the results from 2007 again, this is greatly affecting the data which is being presented. Without the 2007 results there would only be two mortalities in the Valve with CABG data not five. One of those two patients being extremely high risk with a one in five mortality. This is not reflected in the presented data but is reflected in the STS Database data.

If the data is being accumulated over a two year period so as to have sufficient numbers for reporting, then one of two things must occur: 1) The data is only reported every other year so that results are not duplicated otherwise they will not provide an accurate picture. 2) PHC4 should be using a more accurate predictor of cardiac surgical morbidity and mortality such as the STS Database. This would eliminate the need for Biannual Reporting.

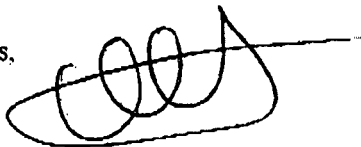
Both my individual and the institution reporting based on the STS Database have been AS EXPECTED for MORTALITY for all aspects of cardiac surgery (CABG only, Valve only, Valve with CABG) from the start of the recording period in 2006 through and including the present.

With regard to the institutional numbers, the Valve with CABG and Total Valve have been explained above since I was the only surgeon performing those procedures at this institution. The institutional CABG only data also includes multiple other surgeons who are no longer at this institution and were transient help during periods of my absence. Measures are being put in place to secure more permanent assistance at the institution to have a more stable presence. We expect that there will be a significant change with the more permanent presence.

Antiquated systems of reporting of cardiac surgery morbidity and mortality data need to step aside for more accurate ways of reporting this data. There is a push by the Society of Thoracic Surgeons to make the STS Database the National Standard for cardiac surgery reporting and to use public reporting. This will eventually make all the other methods of reporting obsolete.

I want to thank you for the opportunity to make comments with regard to the PHC4 reporting.

Sincerely yours,



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