body radiation. We are grateful for the opportunity to discuss these important issues with you and look forward to further advances in the postoperative surveillance and treatment of lung cancer.

Andrew Pierre, MD, MSc
Wael C. Hanna, MDCM,
MBA, FRCSC
Toronto General Hospital
Toronto, Ontario, Canada

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DOES THE SOCIETY OF THORACIC SURGEONS RISK SCORE ACCURATELY PREDICT OPERATIVE MORTALITY FOR PATIENTS WITH PULMONARY HYPERTENSION?

To the Editor:

We read with interest the article by Kennedy and colleagues,¹ "Does the Society of Thoracic Surgeons Risk Score Accurately Predict Operative Mortality for Patients With Pulmonary Hypertension?" We concur with Kennedy and colleagues¹ that the current Society of Thoracic Surgeons system² poorly models patients with elevated pulmonary arterial pressure (PAP) or associated right heart dysfunction. In our experience and that of others, patients undergoing cardiac surgery with PAP hypertension have worse outcomes than patients without PAP elevation. An important question is why is PAP hypertension an important prognostic marker? To complement the work by Kennedy and colleagues,¹ we would like to emphasize that although

elevated PAP is a good marker for increased morbidity and mortality, the potential underlying reason for worse outcomes in these patients is right heart dysfunction.

For better independent quantification of right heart function, we have begun implementing cardiac magnetic resonance imaging (cMRI) on a routine basis for patients deemed to be at increased risk for right heart dysfunction arising from elevated PAP. Use of cMRI allows accurate interpretation of right ventricular ejection fraction as well as chamber volumes or right ventricular end-diastolic and end-systolic volumes, which serve as the criterion standard for establishment of right heart function in patients with elevated PAP.³ We perform cMRI selectively during our preoperative workup in patients with suspected elevated PAP and in those deemed to be at risk for possible right heart dysfunction, such as patients with valvular heart disease and those with ischemic cardiomyopathy.⁴⁻⁶ Patients who are not found to have any associated right heart dysfunction are then reevaluated to establish whether there are interventions available for medical optimization, because increased PAP is often due to other reversible cardiac causes or noncardiogenic causes in this subset (sleep apnea, volume overload, interstitial lung disease, etc).⁴ Those who demonstrate severe right heart dysfunction are also reevaluated for medical optimization, as well as for appropriateness of surgical intervention, especially in patients with apparent advanced biventricular disease. Within our population, this method has allowed us to improve preoperative risk stratification and our ability to select appropriate surgical candidates, improving our outcomes.^{5,6}

We believe that cMRI should be used in patients with elevated PAP (mean PAP >35 mm Hg) to help define right ventricular function and better select patients for cardiac

surgical procedures. Consideration should be also given to adding right heart function to existing risk models to accurately risk stratify this population.

Gregory Trachiotis, MD
Dominic Emerson, MD
Michael Greenberg, MD
Divisions of Cardiothoracic Surgery
and Cardiology
Veterans Affairs Medical Center/
George Washington
Washington, DC

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Reply to the Editor:

We appreciate the comments by Trachiotis and colleagues on the importance of right ventricular (RV) function in perioperative morbidity and mortality. We agree that a comprehensive assessment of RV function