Dr Arora has received an unrestricted educational grant from Pfizer Canada Inc and honoraria from Mallinckrodt Pharmaceuticals for work unrelated to this article.

Author has nothing to disclose with regard to commercial support.

We agree that this comprehensive process may be reasonable to consider as a second stage of evaluation for those who have screened positive for features consistent with frailty using a simpler tool.

Contemporary cardiac surgery teams do need tool(s) that assist in shared clinical decision making to make a rational, individualized decisions regarding when we should operate and when we should turn a patient toward other therapies. However, in addition to hard clinical end points, we also need to know the influence on patient-reported outcomes.^{4,5} A scoring system that predicts protracted in-hospital stays, rehospitalization, and thus utilization costs such as the CAF would be of value but will require larger validation with patient-reported outcomes. An ideal score would be fast, simple to perform on the wards or in an outpatient clinic, and would fit on a single screen of a smartphone. We applaud the authors for their initiative. More work is needed to develop a frailty score based on and tested on a large body of patients undergoing cardiac surgery.

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A NEW TOOL TO ASSESS FRAILTY

Reply to the Editor:

Yanagawa and colleagues¹ propose another tool to properly assess frailty before cardiac surgery. The comprehensive assessment of frailty score, based on a group of simple and readily available clinical and laboratory measures, carries the potential not only to predict hospital stay after surgery but also to predict 30-day and 1-year mortality. Further studies should propose the simplest and most effective way to identify frailty and to predict results after surgery. Yanagawa and colleagues¹ conclude that evidence-based scales of frailty should be used not only to guide patient selection for surgery but also to determine how frail patients should be prepared for their procedure.

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ACCURATE REPORTING OF CLINICAL TRIALS

To the Editor:

We were surprised to read Dr Lamy's Editorial Commentary,¹ in which he describes his first reaction ("I was reading fake news") when asked to review our manuscripts reporting the 1-year results of the Aspirin and Tranexamic Acid for Coronary Artery Surgery (ATACAS) trial.^{2,3} We wish to reassure readers of the *Journal* that the content of these articles accurately represents the work undertaken and the observed results. It is disappointing that Dr Lamy does not encourage readers to read the entire article, in which the answers to his queries can be found.

Dr Lamy asks how tranexamic acid, an antifibrinolytic drug, could reduce major adverse cardiovascular events in patients undergoing coronary artery surgery. The answers to this were provided in the Discussion section

Authors have nothing to disclose with regard to commercial support.

of our article.² The well-established reduction in red cell and platelet transfusion requirements seen with tranexamic acid (Table 1)⁴ is one mechanism by which tranexamic acid could reduce the risk of major adverse cardiovascular events after cardiac surgery.⁵ That is, tranexamic acid could have an indirect antithrombotic effect because of the reduction in bleeding and transfusion requirements. This will avoid transfusion-related prothrombotic effects, which may well increase the risk of early coronary graft thrombosis and subsequent late/long-term cardiac events. Our data, both 30-day⁴ and long-term,² provide compelling evidence to reassure readers that tranexamic acid is free of such adverse effects and may well be protective. Furthermore, tranexamic acid has immune modulatory effects that suppress inflammation and immunosuppression⁶; these effects could improve recovery after many types of major surgery.

We reject the assertion that we had made “flashy” or “over-the-top” conclusions. We remind readers to consider the rationale for our trial, the veracity of the trial findings, and our discussion outlining why the findings could be clinically important. As we concluded in our article, we look forward to further mechanistic investigations on the deleterious effects of blood transfusions and

possible beneficial effects of tranexamic acid on late cardiovascular events.

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TABLE 1. Further details of the blood-sparing effects of tranexamic acid in the Aspirin and Tranexamic Acid for Coronary Artery Surgery (ATACAS) trial²

Blood transfusion requirements in the ATACAS trial			
Blood product	Tranexamic acid (N = 2311)	Placebo (N = 2320)	P value
Platelets			
Intraoperative	195 (8.4)	308 (13.3)	<.001
Day 1	174 (7.5)	430 (18.5)	<.001
Fresh-frozen plasma			
Intraoperative	95 (4.1)	168 (7.2)	<.001
Day 1	204 (8.8)	476 (20.5)	<.001
Red cells			
Intraoperative	277 (12.0)	391 (16.9)	<.001
Day 1	406 (17.6)	708 (30.5)	<.001
Any blood transfusion			
Within 24 h of surgery	721 (31.2)	1130 (48.7)	<.001
Total, during hospitalization	875 (37.9)	1269 (54.7)	<.001

Values are n (%).

HACKED BY THE RUSSIANS OR FAKE NEWS

Reply to the Editor:

The issue at stake is the importance of using strict methodology in our articles, especially in the abstract section, the most widely read portion of any article. Personal interpretation of the results should be in the discussion section only.

There are no reasonable explanations that a short-acting and prothrombotic drug such as tranexamic acid “may reduce the risk of late cardiovascular events” as stated in the conclusion of the article of Myles and colleagues,¹ in view of contradictory results from long-term use of antithrombotic medication in the COMPASS trial² and others.