approach to sternal infection risk modeling and the observance of orthodox epidemiology maneuvers. Our work was clearly planned to intentionally occupy the second category, and subsequent workers in other centers have cited it without attacking its focus, conclusions, or methods.

The authors have produced what can only be called a blockbuster study; it is going to be widely quoted in the future. Simultaneously, I would plead for more vigorous bibliographic scrutiny when writing in a subject area that is receiving increasing attention during the current enthusiasm for "medical error reduction." Sophisticated studies will continue to appear at a steady pace and contradictory reports will probably emerge. We have an incomplete grasp of the detailed phenomenology of this puzzling, expensive, and potentially lethal outcome flaw.

REFERENCES

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James T. Lee, MD, PhD, FACS
Department of Veterans Affairs Medical Center
Minneapolis, Minnesota

The authors reply.

We would like to thank Dr. Lee for bringing his study to our attention. We highlighted several studies that have also identified diabetes as a risk factor, but neglected to cite the study by Slaughter et al.[1] The study was based on a sample of more than 2,000 patients who underwent coronary artery bypass procedures and coronary artery bypass plus valve replacement procedures at the Minneapolis Veterans Affairs Hospital. Of the 14 variables tested in their analysis, only diabetes and steroid use emerged as statistically significantly associated with sternal wound infection. Reoperation, an important risk factor in our study, was not statistically significant in their analysis. A comparison of the two studies provides an example of how risk factors may vary in different institutions due to case mix, hospital practices, and the number of procedures used in the denominator. Their study highlights the importance of wound infection surveillance systems and it was an oversight that we did not reference it in our article.

REFERENCE

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Michele Kohli, MSc
Lilian Yuan, MSc, MD
Michael Escobar, PhD
Department of Public Health Sciences
Tirone David, MD
Division of Cardiovascular Surgery
Toronto General Hospital
University Health Network
Grant Gillis, BSc, BComm
Marta Garcia, BSN, MEd
John Conly, MD
Infection Prevention and Control Unit
Toronto General Hospital
University Health Network
University of Toronto
Toronto, Ontario, Canada