patient. A CAC-based reclassification has implications for preventive therapy strategies for patients at intermediate cardiac risk that need to be tested in a prospective, randomized manner (4,5).

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Reply

We agree with the comments of Dr. McEvoy and colleagues regarding our paper (1) that there is an urge to implement coronary artery calcium (CAC) cutoff scores in clinical practice to enhance cardiovascular risk stratification in the individual patient. This especially pertains to persons at intermediate cardiovascular risk, in whom risk management strategies are least clear. Yet, we do not think that reporting the absolute CAC score reclassification cutoffs we would have found by using the classic Framingham Risk Score instead of our Framingham "refitted" model would be helpful. The Framingham Risk Score is designed for a population 30 to 74 years of age (2). Our study focuses on the elderly, of whom a substantial proportion is older than 75 years of age. Previous research within the Rotterdam study has pointed out that the Framingham Risk Score does not fit well in our population (3). Thus, cutoffs derived in our cohort using the Framingham Risk Score would not be meaningful.

Of course, in a utopia we would be able to overcome the inaccuracy of available "general" risk functions. However, we think it would be helpful to create more tailored risk functions for populations with specific demographics and/ or presence of cardiovascular symptoms. Empirically derived cutoffs from these populations are more likely to apply to the individual patient, although they should be tested in comparable study populations before they can be safely used in clinical practice. So, despite the urgent need for CAC cutoffs in cardiovascular risk stratification of the individual patient, we feel that abundant research still has to be performed before CAC cutoff scores can safely be used in clinical practice.

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Nonrandomized Data on Drug-Eluting Stents Compared With Coronary Bypass Surgery

Caution With Interpretation

In a recent issue of the *Journal*, Park et al. (1) presented long-term follow-up results from the Asan-Multivessel Registry in which patients are followed after percutaneous coronary intervention (PCI) with drug-eluting stents (DES) or coronary artery bypass grafting (CABG) for the treatment of multivessel coronary artery disease. After 5 years, similar rates of death or the composite endpoint of death, myocardial infarction, or stroke were found in the DES and CABG groups. This is the first paper to compare these groups after such long follow-up, but it should be highlighted that this is a nonrandomized study. To date, only the SYNTAX (Synergy Between PCI With TAXUS and Cardiac Surgery) trial compared patients randomized to DES or CABG and after 1 year already showed that DES failed to reach noninferiority to CABG (2). A possible explanation for the contradicting results of Park et al. (1) is that apart from baseline characteristics (age, sex, body mass index) and comorbid conditions (hypertension, hyperlipidemia, diabetes requiring insulin, heart failure, prior myocardial infarction), the severity of multivessel disease is less worse than in the SYNTAX trial (Table 1), with an overall SYNTAX coronary score that is much lower in the DES group (SYNTAX trial 28.4% vs. 17.4% in the present study). The SYNTAX trial also included more than twice as many patients with a left main