to discontinue them, and if the patient is not yet prescribed these medications, once their acute decompensation is treated, an attempt should be made to prescribe these medications prior to discharge.

**Q:** Did any of the study’s results surprise you?

**A:** I don’t think that they are that surprising. If you ask many clinicians who take care of a lot of these patients what types of things might predict outcome, they would predict things like blood pressure, kidney function and age.

The unique contribution of this particular paper is that it puts it into a model that allows a risk prediction. Rather than just having some impression that a patient with bad kidney function or advanced age or low blood pressure is likely to be at higher risk, we can put all of that together, and we can come up with a relatively precise risk assessment.

The way that patients have been assessed previously is based on bedside gestalt, but that is probably an extremely crude way of determining who is at high mortality risk and who is not. This nomogram has tremendous power to allow a better risk assessment. The good news is that it does not require the assessment of anything that is not routinely done in practice at the time of presentation or admission of these patients.

**Q:** Are you planning any future studies based on these results?

**A:** We are interested in doing some prospective work in using the risk assessment to make these triage and treatment decisions, and evaluating the impact on outcome. If you make better triage decisions, appreciating the mortality risk, getting patients into the right setting, and moderating the aggressiveness of treatment based on mortality risk, do you improve outcome? That would require a prospective interventional study. It takes quite a bit to organize, so we have not quite gotten there yet.

Sarah Pressman Lovinger, ACP Member, is a freelance medical reporter based in Evanston, Ill., and a general internist who practices part-time in Chicago.