

Author's Reply

To the Editor,

First of all, we would like to thank the authors of the letter for contributing valuable comments to our article "Nebivolol compared with metoprolol for erectile function in males undergoing coronary artery bypass graft" published in the February issue of the Anatol J Cardiol 2016; 16: 131-6. (1). Erectile dysfunction is defined as the persistent inability to attain and maintain an erection sufficient to permit satisfactory sexual performance (2). Massachusetts Male Aging Study reported an overall prevalence of 52% ED in men aged 40–70 years (3). The prevalence of ED increases with age. Wagle et al. (4) reported that ED in the ≥ 70 year age group was 77% and 61% in the 40 to 69 years. Until recently, ED has been accepted as psychology-based and to be a 75% organic-based disease (5). Organic-based ED may be vasculogenic, neurogenic, anatomical, and hormonal (2).

We agree with the comment that some laboratory tests should be performed as mentioned by the authors of the letter. According to the European Association of Urology Guidelines on male sexual dysfunction routine laboratory tests, glucose-lipid profile and total testosterone are required to identify and treat any reversible risk factors and modifiable lifestyle factors. Additional hormonal tests such as the estimation of prolactin and luteinizing hormone levels should be performed if low testosterone levels are detected (2). In our study we searched the lipid profile of the patients and no difference was observed between the groups. Hb and glucose levels of all patients were recorded but not compared between the groups and were not mentioned in the study. Testosterone levels were not evaluated.

The authors of the letter have proposed the exclusion of patients over the age of 70 years. In our study, mean age of the patients were 60.6 ± 10.6 and 58.8 ± 11.6 , respectively, and there were no statistically significant differences between the two groups ($p=0.61$). Thus, we believe that the exclusion of patients over the age of 70 years is not essential.

The authors of the letter have questioned about the adjustment of the beta-blocker doses. Unfortunately, we did not adjust beta-blocker doses according to the blood pressure and heart rates. We used the routine doses of 5 mg/day oral nebivolol and 50 mg/day metoprolol succinate.

These valid issues noticed by the authors of the letter could be mentioned as our study limitations. We hope that our study can be a modest model for new comprehensive ones.

We thank the authors of the letter again for their great contribution to our work.

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Cardiac problem because of Zika virus infection: a possibility

To the Editor,

Zika virus infection is the present global concern. The infection can cause acute febrile hemorrhagic fever and congenital defect (1, 2). In cardiology, the interesting question is whether there can be any cardiac problem because of Zika virus infection (3). Based on the recent autopsy report in death fetus, no heart involvement has been observed. However, based on the nanostructural consideration, the viral particle is approximately 40 nm, slightly smaller than dengue virus. Based on the previously published concepts in nanopathology (4), the direct invasion to the cardiac tissue to cause cardiac involvement is possible because the virus is so small that it can pass into the heart. The good evidence is seen in animal model study in the previous reports since 1958 (5). If the cardiac pathology exists, the problems should be similar to those seen in dengue.

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