Author`s Reply

To the Editor,

We recently demonstrated decreased heart rate variability (HRV) values in patients with irritable bowel disease (IBS) in our study entitled "The effect of irritable bowel syndrome on carotid intima-media thickness, pulse wave velocity, and heart rate variability" published in the September issue of *The Anatolian Journal of Cardiology* 2014; 14: 525-30 (1). We read the letter entitled "Heart rate variability can be affected by gender, blood pressure, and insulin resistance" with great interest. As the authors kindly mentioned, HRV is a valuable tool for assessing autonomic dysfunction. Decreased HRV is associated with coronary artery disease, myocardial infarction, and cardiovascular mortality in patients with diabetes (2). Interestingly, insulin resistance and obesity, the prerequisites of diabetes mellitus, are also related to autonomic dysfunction (3). Our study included 30 women with IBS and 30 healthy control subjects. Although numeric differences existed in the prevalence of hypertension and diabetes mellitus compared with the control subjects, these were not statistically significant. Moreover, body mass index, fasting plasma glucose, and blood pressure values were not different between groups. Therefore, we do not believe that an important difference is present, which would have influenced our results with, regard to insulin resistance and obesity between the control and patient groups.

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Long-term patency of autogenous saphenous veins vs. PTFE interposition graft for prosthetic hemodialysis access

To the Editor,

We appreciate the fluency of the original article by Uzun et al. (1) entitled "Long-term patency of autogenous saphenous veins vs. PTFE interposition graft for prosthetic hemodialysis access," which was recently published in Anatol J Cardiol 2014; 14: 542-6." The authors divided the study population in two groups, those who used autogenous saphenous grafts and those who used PTFE. Although the investigators used saphenous grafts in both the upper arm and forearm, they used PTFE only in the upper arm. It is known that using the same autogenous grafts in different parts of the extremities could cause distinct long term patency. There are considerable peculiarities among the use of autogenously grafts in different regions in terms of infection, steal syndrome, and heart failure (2). In addition, some studies have reported that different autogenous grafts could cause different results even when used in same region (3). In the aforementioned study, although the investigators used autogenous saphenous grafts mostly in the distal part of the upper extremity, they used PTFE mostly in the proximal part of the upper extremity. To our knowledge, this factor could affect the grafts in terms of patency and infection risk. Generally, same regions were used among the studies in the literature; these studies compared different kinds of grafts (4). We want to understand the opinion of the authors regarding this.

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DOI:10.5152/akd.2015.6068

Author`s Reply

To the Editor,

The authors state an important bias about studies comparing different graft types in different regions entitled "Longterm patency of autogenous saphenous veins vs. PTFE interposition graft for prosthetic hemodialysis access." published in Anatol J Cardiol 2014; 14: 542-6. (1). As mentioned in the study, the selection of the anastomosis region was based on the calibration of the arteries and veins (1). Both PTFE and saphenous vein grafts were

used above the wrist in our study because of inadequate calibration of veins and arteries; thus, we did not compare in "very" different regions. Among the complications, infections or other severe complications were not observed in both groups. This issue was described in detail in the study.

The other question of the authors is about the patency that is in close relationship with the localization. PTFEs were used only between the brachial artery and high brachial vein. The reason for this selection was the diameter of the graft. Because thinner PTFEs are more likely to be thrombosed, the selected grafts were at least in 6 mm in diameter. The main finding of our study is the limited patency of the PTFE compared with saphenous veins, although they were used in larger calibers and anastomosed between larger vessels.

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Cardiac enzyme (troponin levels) elevation in cardiac myxomas: Is it real?

To the Editor,

Constituting almost half of the cases of primary cardiac tumors (1), myxomas are frequently detected in adult female patients; moreover, familial patterns have also been identified for these tumors. The left atrium, right atrium, and ventricles are affected in 85%, 10%, and 5% of the cases, respectively. Furthermore, the fossa ovalis of the septum and the posterior atrial wall are common sites for the attachment of atrial myxomas (2). Interestingly, more than one myxoma or a polycentric myxoma can be detected in some patients (1, 2).

Atrial myxomas might be related to varied clinical presentations such as obstructive, constitutional, or embolic scenarios. Because of the blockage of the atrioventricular valves, the obstruction pattern mimics mitral disease or, rarely, tricuspid valvular disease and can cause dyspnea or left heart failure; in such cases, it is sometimes difficult to differentially diagnosis myxomas from mitral or tricuspid valve stenosis (1, 3).

Although myxomas cause systemic embolism in about one-third of the patients, the incidence of coronary artery embolization has been reported to be 0.06-0.1% (3, 4). Although rare, the condition could be fatal. In a case series by Panos et al. (4), inferior, anterior, and posterior myocardial infarctions were diagnosed by electrocardiogram (ECG) in 63.6%, 22.7%, and 9.1% of cases, respectively. Two possible explanations have been suggested for the low incidence rate of coronary artery embolization by myxomas: the vertical position of the coronary ostia to the aortic blood flow and the coverage of the coronary ostia by the opening aortic valve leaflets during cardiac systole. Elevation of cardiac troponin levels has also been reported in atrial myxomas, all of which were secondary to the coronary artery embolization (4, 5).

Interestingly, however, we examined 10 patients (age: 49±13 years; six females) with atrial myxoma and normal coronary arteries by angiography and normal ECG but with elevation of cardiac enzymes. Cardiac troponin and CK-MB levels were measured on admission; these markers were elevated in six patients (four females; normal value of cardiac troponin: I=0.4 ng/mL; increased values in our six patients: 0.70, 1.10, 2.35, 0.86, 1.67, and 1.45 ng/mL, respectively), all of whom had normal coronary arteries, based on angiography findings and normal ECG findings, and had no accompanying chest pain. Patients were further investigated for exclusion of other reasons for elevated cardiac troponin levels, including renal failure, sepsis, pulmonary emboli, tachy, or bradyarrhythmias. These findings suggest that atrial myxoma increases cardiac markers without involvement of coronary arteries. Actually, we think such constitutional symptoms (fever, weight loss, or symptoms resembling connective tissue disease) are due to cytokine (interleukin-6) secretion; cardiac markers could be secreted in cardiac myxomas as well. Moreover, cardiac myxomas could be considered as the differential diagnosis for the diseases with elevated cardiac enzymes. However, further studies are required to reveal this association.

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DOI:10.5152/akd.2015.5871

The preanalytical and analytical factors responsible for false-positive cardiac troponins

To the Editor,

Cardiac troponins (cTn) are the cornerstone of the diagnosis, risk assessment, prognosis, and determination of antithrombotic and revas-