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## Author's Reply

The authors of this mentioned article did not send any reply for this Letter to the Editor, despite our insistent requests.

## Homocysteine and masked hypertension

To the Editor,

The recent report "Homocysteine and masked hypertension" in *Anatolian J Cardiol* 2014; 14: 357-62 is very interesting (1). They noted that "in the individuals with no obvious health problems but with MHT, homocysteine levels may not have any significant effect upon high blood pressure levels (1)." In fact, several factors are accepted as contributing factors for "masked hypertension," including "younger age, smoking, alcohol use, contraceptive use in women, sedentary habits, and central obesity (2)". The negative finding on the role of homocysteine level in the present report should be discussed. In fact, homocysteine has been accepted as a good biomarker for identifying risk of cardiovascular disease for a long time (3). However, in addition to hypertension, other vascular pathologies are related to the change of blood homocysteine level. This fact has to be considered in the interpretation of the homocysteine level results. Another important consideration in the determination of homocysteine levels is the false positivity (4). Pre-analytical errors in specimen collection and preparation can significantly result in elevated blood homocysteine levels (4).

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The authors of this article did not send any reply to this Letter to Editor, despite our insistent requests.

## Peripartum cardiomyopathy and triplet pregnancy

To the Editor,

We read with interest the article recently published by Günaydın et al. (1), entitled "Peripartum cardiomyopathy associated with triplet pregnancy," in *Anatolian J Cardiol* 2014; 14: 661-2. However, we have some concerns about the article. First, although the authors claimed the current patient to be the first peripartum cardiomyopathy (PPCM) patient associated with triplet pregnancy in the literature, this may not be true. Rajab et al. (2) described a 26-year-old Bahraini primigravida, at 38 weeks of gestation for elective caesarean section because of pregnancy-induced hypertension and triplets. In this article, at the 39<sup>th</sup> week, she had a cesarean section under general anesthesia but developed PPCM in the early postoperative period. Chapa et al. (3) reported follow-up data of 32 PPCM patients in 2005. They reported 4 women with multifetal gestations; 3 twins and 1 triplet. Golan et al. (4) reported a retrospective review and an analysis of 182 patients with PPCM. Twin or triplet pregnancies were reported in 15% of all patients in this study.

Our second concern is about the acute treatment of PPCM. The management of patients with PPCM is similar to that of other forms of non-ischemic dilated cardiomyopathy but must be individualized based on the patient's clinical presentation (5). In addition to the standard therapeutic options for heart failure, specific targeted agents have been advocated for the treatment of PPCM. In recent years, it has been shown that addition of bromocriptine to standard heart failure therapy in women with PPCM results in significantly greater improvements in