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Author's Reply

To the Editor,

We would like to thank the authors for their comments on our article in their letter entitled "Epicardial adipose tissue and atrial fibrillation: the other side of the coin." published in *Anatol J Cardiol* 2017; 17: 56-63. (1) epicardial adipose tissue (EAT), a special fat depot that is related to visceral fat rather than total adiposity, shares the same microcirculation with the myocardial tissue and coronary vessels. Recent studies have identified EAT as an active organ, which secretes several mediators, called adipokines, affecting the vascular system. In a prior study, we determined that EAT is associated with diastolic dysfunction and left atrial dilatation because of local or systemic effects in untreated hypertensive patients (2). We also revealed that EAT is an independent factor for adverse changes in the carotid intima-media thickness, flow-mediated dilation, and pulse wave velocity (3). Vascular structure and functions were mainly related to EAT, possibly with perivascular adiposity.

In our opinion, EAT has two main causative roles in atrial fibrillation (AF) development. The first role is the direct local interactions, which predispose the myocardial tissue to arrhythmic genesis due to abnormal atrial architecture, adipocyte infiltration, and atrial fibrosis (4). The second role is the indirect effects on left atrium reflecting from vasculature, which is mainly related to increased blood pressure because of increase in the peripheral vascular resistance after structural and functional impairment in the vascular endothelium (3). The latter mechanism is also a possible driver of the diastolic heart failure and diastolic dysfunction (2) as well as AF. Therefore, as a phrase, "peripheral resistive" may be more reason-oriented than "diastolic" in heart failure with preserved ejection fraction. These roles may be important in the prevention/management of cardiovascular diseases.

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P2Y12 inhibition after thrombotic thrombocytopenic purpura remission

To the Editor,

We read the article entitled "Ticagrelor-associated thrombotic thrombocytopenic purpura" by Doğan et al. (1), which was recently published in the *Anatolian Journal of Cardiology*, with great interest. It is well known that patients with acute coronary syndrome (ACS) who visit the emergency department have increased rates of recurrent ischemic events. Dual antiplatelet therapy (DAPT) is of importance to reduce these rates; further, DAPT duration after drug-eluting stent (DES) implantation is one the most significant determinant for reducing recurrent ischemic events, including stent thrombosis (2). In your case, DAPT was discontinued 5 weeks after ACS because of ticagrelor-associated thrombotic thrombocytopenic purpura (TTP), and aspirin was used as the only antiplatelet therapy for 6 months. According to the guidelines, DAPT should be administered for at least 12 months after ACS is treated with DES implantation (2). Further, retreatment with P2Y12 after TTP complete remission in ACS can be considered necessary. Reportedly, it is possible to encounter rechallenge with the same P2Y12 inhibitors, leading to TTP after remission. It was indicated that this approach does not induce relapse (3). In addition, in one case, ticlopidine was used instead of clopidogrel because of clopidogrel-linked TTP after TTP complete remission, and no relapse occurred after ticlopidine usage (4). Considering the foregoing data, a group of P2Y12 inhibitors different from ticagrelor could have been used with aspirin after TTP remission in your patient. Thienopyridines have action mechanisms different from those of ticagrelor and can be administered after ticagrelor-linked TTP.