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Author`s Reply

To the Editor,

We are very well aware of the fact that the changing current malpractice system in Turkey will be very hard and exhausting when current political, legal, and sociological perspectives are considered. Not assuming any responsibility is a tradition in the Turkish bureaucracy, and this carelessness can only be overcome by interdisciplinary work and education. Fear of penal, administrative, and pecuniary (moral/material) punishment adds a heavy psychological burden on physicians and prevents them from practicing sound clinical medicine. A physician who is held back by the multilayered punishment threat cannot normally function. When an upper respiratory tract infection treatment is in question, a multilayered punishment structure is tolerable by physicians; however, every critically ill patient deserves a fearless doctor's treatment. According to our study, which investigated the defensive medicine practice in 250 Turkish cardiologists, 11.6% were sued for malpractice claims, 6.9% of the sued cardiologists were given financial compensation fines, and 3.4% of the sued cardiologists were given an imprisonment sentence because of negligence. From the surveyed cardiologists, 132 (52.8%) reported that they had revised their practice patterns because of the fear of litigation and 232 (92.8%) reported that they would like to see implementation of our new proposed PCS instead of the current malpractice system (*author's unpublished data*). Legal claims of citizens are universal constitutional rights; however, preliminary results of our study show that a significant percentage of cardiologists unnecessarily appear in courts and change their practice patterns. Current malpractice laws are undermining many citizens with severe diseases from obtaining effective medical treatments.

Because of limited space and need for a larger body of experts to implement PCS, we had just discussed the main frame and purpose of PCS in our previous letter. Implementation of our proposed PCS requires an interdisciplinary study between doctors and lawyers and a thorough legal structure that provides patient safety and safeguards physician from unnecessary stress and exaggerated punishments. The authors' suggestions are important to avoid previous mistakes and to design a strong and functional PCS, which will be under the title of "alternative dispute resolution methods." Compared to the developed and most developing countries, it can be reported that it is too late for Turkey to have such functioning bodies to provide alternative dispute resolutions and arbitration services that are alternatives to the court system. We envisage PCS as an "compulsory arbitration board," which is a stronger body than the previously abrogated "conciliation board." A stronger PCS board would regulate penal, administrative/disciplinary, and pecuniary responsibility areas. Moral and material damages will also be resolved under a single entity in PCS. Regarding the patients' right to recourse to judicial review, a strong legal foundation can be established, and jurists who are expert in health law will be required to be part of PCS to provide an independent, impartial, and compulsory arbitration board. The foundation of PCS can be laid from similar compulsory arbitration boards in Turkey, and jurists who are experts in health law need to be educated in the medical law division of law faculties. Patients can leave compulsory arbitration board and follow ordinary court procedures as a basic constitutional right but courts generally accept aoutnomous arbitration court's decisions.

We believe that PCS is a stronger body than the previously abrogated "conciliation procedure" and its mainframe structure and purpose should not be changed by auxiliary regulations. Although the PCS system includes legal and structural deficits, we believe that discussing this subject will increase awareness, which might be a good start for preventing physicians from discontinuing traditional and solution-targeted medical practice. As distinct from comments of lawyers, the involvement of physicians similar to us who experience this problem in person would help in the development of new systems. We thank the authors for their suggestions, which can help the implementation of our proposed PCS.

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Electrical storm might be the initial presentation of arrhythmogenic right ventricular cardiomyopathy

To the Editor,

We read with great interest the paper by Özcan et al. (1) entitled "Catheter ablation of drug refractory electrical storm in patients with ischemic cardiomyopathy: A single center experience," published as Epub ahead of print in The Anatolian Journal of Cardiology 2015. They aimed to evaluate the safety and efficacy of catheter ablation in a relatively large cohort with the electrical storm. We congratulate the authors for the successful clinical management of these patients.

The electrical storm can be defined as ≥3 life-threatening ventricular arrhythmia within a 24-h period and may cause implantable cardioverter defibrillator discharges, resulting in morbidity and mortality. The electrical storm in adults with ischemic heart failure is common. However, the electrical storm might be the initial presentation of arrhythmogenic right ventricular cardiomyopathy (ARVC), although ARVC usually presents with sustained ventricular tachycardia or sudden cardiac death (2). Moreover, some patients with ARVC may have unusual presentations such as acute coronary syndrome or heart failure (3). In clinical practice, if ARVC is not considered as a possible cause of ventricular arrhythmias, the diagnosis might be overlooked because of the requirement of a different diagnostic approach for the diagnosis of ARVC according to the modified criteria (4). In the study by Özcan et al. (1), it would be better to evaluate the patients for cardiomyopathies, including ARVC, in terms of diagnostic and therapeutic management.

Although ventricular tachycardia frequency is reduced after catheter ablation, the incidence of rapid ventricular arrhythmia during long-term follow-up is still common in patients with ARVC. In addition, catheter ablation may not be able to cure ventricular arrhythmia in ARVC, and cardiac transplantation can be the only choice for the treatment of the electrical storm in a patient with ARVC (5). In this large cohort with the electrical storm reported by Özcan et al. (1), it will be valuable to determine whether some patients have undergone cardiac transplantation because of the electrical storm.

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Author`s Reply

To the Editor,

We would like to thank the authors of the paper entitled "Electrical storm might be the initial presentation of arrhythmogenic right ventricular cardiomyopathy" for their interest in our article published in Anatol J Cardiol 2015 (1). The authors suggested arrhythmogenic right ventricular cardiomyopathy (ARVC) among possible diagnoses for patients who presented with incessant ventricular tachycardia (VT). Firstly, the VT ECG's presented by us highlighted the left ventricule (LV) as the source of arrhythmia and not consistent with epicardial VT. Sinus ECG's did not show the features of ARVC. None of the patients had family history for sudden death. Our patient group was defined as ischemic cardiomyopathy after we performed coronary angiograms at our center or if they had undergone the same at another hospital and was documented to us. If they underwent CABG surgery, they were also included in that group. We also conducted nuclear imaging studies for some patients. Prior to ablation, all of the patients underwent echocardiography, which was performed by experienced physicians, and none of the patients were reported as having abnormalities recalling ARVD. During the electrophysiological study, mapping demonstrated that an abnormal electrogram and scar regions were present in the LV. As known, ARVD-related VT's generally have substrates at the epicardium, and our unipolar recording above 8.27 mV endocardially. We defined LAVA's, late potentials, and diastolic potentials in LV, and all these locations checked with pacing to delineate long stimulus to QRS to define slow conduction zones. Our pace mapping inside LV were also matched with clinical VTs. Procedures that were performed during VT were entrained with concealed fusion, and post-pacing intervals showed that re-entry circuits were present in LV. During follow up, none of our patients underwent cardiac transplantation for incessant VT. However, the issue raised by the authors is important, and one should keep in mind the differential diagnoses for patients presented with the electrical storm.

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