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Author`s Reply

To the Editor,

We would like to thank the authors for their comments on our article entitled "An increase in epicardial adipose tissue is strongly associated with carotid intima-media thickness and atherosclerotic plaque, but LDL only with the plaque." published in Anatol J Cardiol 2017; 17: 56-63(1) in their letter entitled "Inflammatory activity of adipose tissue." Visceral obesity is strongly associated with atherosclerosis. Even though waist circumference and body mass index (BMI) are the most common assessment methods of total visceral adipose tissue and cardiometabolic risk, these methods lack direct measurement of adipose tissue and seem to have better correlation to subcutaneous fat, rather than visceral fat. This may explain why BMI was related to carotid intima-media thickness (CIMT) in univariate analysis, but not an independent variable in multivariate analyses in our study.

The metabolically healthy obese phenotype and the metabolically unhealthy non-obese phenotype may possibly blunt the predictive power of BMI for CIMT. Perivascular adiposity is primarily related to visceral adipose tissue, which is not necessarily related to increased BMI.

In our personal opinion, the liver may have a central role in determining visceral or subcutaneous adiposity. Genetic determinants, diet, and physical activity may have some role in some specific liver functions, which determine lipid influx from the bloodstream, lipid synthesis in liver, and efflux to subcutaneous tissue or visceral organs. Healthy and unhealthy obese and non-obese phenotypes that have isolated increase in EAT may help us to understand precise roles of EAT in vascular disease.

Additional data would be required in order to clarify the diagnostic role of EAT in managing obese and non-obese patients, and to decrease cardiometabolic risk.

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Predictors of postoperative atrial fibrillation after coronary artery bypass grafting surgery

To the Editor,

We read the article written by Geçmen et al. (1) titled "SYNTAX score predicts postoperative atrial fibrillation in patients undergoing on-pump isolated coronary artery bypass grafting surgery" published in Anatol J Cardiol 2016;16:655-61 with great interest. In their study, the authors reported that there was an independent association between age, chronic obstructive pulmonary disease, and SYNTAX score in predicting postoperative atrial fibrillation. We would like to emphasize some important points about this well-written study.

It has been demonstrated that volume overload could increase postoperative atrial fibrillation incidence by elevating intraatrial pressure (2). It has also been reported that increased cross-clamp and cardiopulmonary bypass time could increase risk for postoperative atrial fibrillation (3). We think that intraoperative factors should be taken into consideration when evaluating these patients.

Another important point is that body mass index, presence of metabolic syndrome, and waist-to-hip ratio are important markers for coronary artery disease, and moreover, obesity is associated with higher levels of inflammatory cytokines in circulation (4). As inflammation has been shown to cause deterioration in atrial conduction and predispose patients to develop atrial fibrillation postoperatively, authors should state these factors for each group (5).

In our opinion, to verify whether SYNTAX score is an important predictor of postoperative atrial fibrillation development, the