not investigate the relationship between cardiovascular events and clopidogrel resistance. So, for our study group it is not known whether clopidogrel resistant patients have worse clinical outcomes compared to the clopidogrel responder patients. This was actually one of the limitations of our study which was already mentioned in our article. The authors mainly emphasized the results of a recent trial called ARCTIC study in which clinical outcomes of 2440 patients undergoing percutaneous coronary intervention (PCI) had no significant differences with platelet function monitoring and without monitoring (5). In the past decade, compelling evidence from numerous observational studies has emerged demonstrating a strong association between high platelet reactivity to adenosine diphosphate (HPR) and post-percutaneous interventions (PCI) ischemic events, especially stent thrombosis. Since then, updated ACC and ESC guidelines issued a Class IIb recommendation for platelet function testing (PFT) to facilitate the choice of P2Y12 inhibitor in selected, high-risk patients undergoing PCI, although routine PFT is not recommended (Class III, no benefit) (6-8). Recent prospective randomized trials evaluating personalized antiplatelet therapy based on PFT did not demonstrate clinical benefit, thus questioning whether treatment modification based on the results of PFT can actually influence outcomes (5, 9, 10). Concerning these controversies in literature a consensus and update document was published in JACC in December 2013 about the definition and clinical use of platelet reactivity (PR) to adenosine diphosphate (11). This document included the results of the mentioned ARCTIC study as well as many other studies focusing on PR during antiplatelet regimens. They presented a therapeutic window for PR cut-offs associated with ischemic and bleeding events for all PFT's used in routine clinical setting. This document concluded that HPR can be considered as a risk factor for post-PCI stent thrombosis (ST) and myocardial infarction. They also stated that relation of PR to clinical outcome occurrence in the PCI setting is stronger during the initial period (up to 30 to 60 days), when intensive P2Y12 inhibition may be more effective. The relationship between PR and clinical outcomes in medically-managed patients recovering from acute coronary syndrome may be less robust. This document concluded that PFT is helpful in identifying high-risk patients, but its usefulness in influencing therapeutic management deserves further evaluation in large-scale trials. They pointed that the overall low event rates observed in prospective trials would require enrollment of a large number of patients to definitively evaluate the utility of PFT for personalized therapy in those patient populations. So instead of totally ignoring the clinical utility of these PFT, it would be more appropriate to use them in high-risk patients (clopidogrel-treated patients with current or prior ACS or a history of ST, patients treated with clopidogrel who have poor left ventricular function, complex anatomy, high body mass index, and diabetes mellitus) The present recommendation for clinical use of these tests is putting them as a part of risk algorithm that includes PFT along with biomarker testing and clinical factors (11).

Concerning the above clinical evidence we think that the association of MPV and clopidogrel resistance is an important finding as the PFT still have limited availability in routine clinical practice.

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Should obese people be allowed to rise to high altitude?

To the Editor,

We read the article "Obesity is a risk factor for acute mountain sickness: a prospective study in Tibet railway construction workers on Tibetan plateau" written by Yang et al. (1) published in 2013 December issue of The Anatolian Journal of Cardiology with great interest. They aimed to investigate and compare the acute effects of high-altitude on obese and non-obese railway workers. They concluded that the obese people should not be allowed to rise to high altitude due to the develop-

ment of acute mountain sickness (AMS). Thanks to the authors for their contribution.

We know that high altitude leads to some negative effects without acclimatizing on pulmonary and cardiovascular systems. AMS is a syndrome due to the rapid ascending to high-altitude in aviators and mountaineers. It is a serious health problem especially in obese subjects. In present study, we want to learn that the subjects were taken to high altitude as volunteers or part of their duties. In our country, we perform like these researches in hypobaric chamber with simulating hypoxia because of legal issues. At hypobaric chamber, we can monitor oxygen saturation, blood pressure and heart rhythm of the subjects so we can easily stop the hypoxia and give oxygen to the subjects. We have some questions about the design of this article. Did the subjects take oxygen when the oxygen saturation was below the threshold value? It could be emphasized that the subjects stayed at high altitude for 24 hours or not and individuals were taken at what speed and which vehicle to high altitude.

In relation to these, we also know that there are some recent studies about the effects of high altitude on cardiac parameters (2). For example we reported a case of cardiac decompression sickness on an aviator (3) and an asystolia during hypobaric chamber training 30.000 feet (4). In another study, we investigated the acute effects of hypoxia on noninvasive electrocardiographic parameters in aviators (5).

In conclusion, although the obese and non-obese subjects had same conditions before high altitude, what happened there and how high altitude was caused problems for the obese. The subject is very important and we believe that these findings will act as a guide for further studies.

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Author`s Reply

Authors of this mentioned article did not send any reply for this Letter to Editor, in spite of our insistently requests.

Shisha versus cigarette smoking and endothelial function

To the Editor,

The recent report on "Shisha versus cigarette smoking and endothelial function" is very interesting. Selim et al. (1) published, reported in 2013 December issue of The Anatolian Journal of Cardiology that "Shisha smoking has a more hazardous effect on brachial artery endothelial-dependent flow mediated vasodilation compared to cigarette." This conclusion is very interesting and should be discussed. In fact, the recent report showed that there was no difference in aerosol produced by cigarette and shisha (2). There are many factors that affected the final measured outcome. The dosage has to be mentioned. Poredos et al. (3) demonstrated that "smoking is associated with dose-related increase of intima-media thickness and endothelial dysfunction." The genetic underlying of each subject is also important factor to be considered.

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Author`s Reply

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Mortal suicidal acetazolamide intoxication in a young female

To the Editor,

Acetazolamide is a carbonic anhydrase inhibitor used in the treatment of glaucoma, epilepsy, benign intracranial hypertension, metabolic alkalosis and is also used as a diuretic. Hyperchloremic metabolic acidosis, renal stones, renal potassium wasting are some toxicities of chronic acetazolamide usage. In elderly or diabetic patients and