

## Author`s Reply

To the Editor,

We thank the author(s) for their great interest in our work entitled "Association between platelet-to-lymphocyte ratio and saphenous vein graft disease in patients with stable angina pectoris," which was published in the Anatolian Journal of Cardiology 2015 May 5 (1).

As we mentioned in the limitation section of our paper, we included patients who had CABG surgery >1 year ago to minimize graft failure factors related to the surgery itself. We completely agree with the author(s), but we do not have sufficient data about the mean time from coronary artery bypass grafting to the last coronary angiograms because it was a retrospective study. Also, we do not have the patient's body mass indexes because of the same reason.

We believe that further prospective trials, including data on body mass index measurements and the duration between coronary artery bypass surgery and saphenous vein graft disease, would better clarify the relationship between the platelet-to-lymphocyte ratio with saphenous vein graft disease.

**Harun Kundi**

**Department of Cardiology, Ankara Numune Education and Research Hospital, Ankara-Turkey**

### Reference

1. Kundi H, Balun A, Çiçekcioğlu H, Çetin M, Kızıltunç E, Çetin ZG, et al. Association between platelet to lymphocyte ratio and saphenous vein graft disease in patients with stable angina pectoris. *Anatol J Cardiol* 2015 May 5. Epub ahead of print. [\[CrossRef\]](#)

**Address for Correspondence:** Dr. Harun Kundi  
Ankara Numune Eğitim ve Araştırma Hastanesi,  
Kardiyoloji Kliniği, Ankara-Türkiye  
E-mail: harunkundi@hotmail.com

## Effects of pentoxifylline on blood transfusion

To the Editor,

We congratulate the authors for their study entitled "Preoperative oral pentoxifylline in case of coronary artery bypass grafting with left ventricular dysfunction (ejection fraction equal to/less than 30%)," published in *Anatol J Cardiol* 2015; 15: 1014-9. This study evaluated the feasibility of pentoxifylline when patients with low ejection fraction are considered (1). Systemic inflammatory response is one of the basic parameters that affect the postoperative results of coronary bypass surgery. In this context, pentoxifylline may have posi-

tive effects through the inhibition of some of the inflammatory cytokines (2-4). However, the study of Mansourian et al. (1) reveals another interesting result, i.e., a statistical decrease of blood transfusion in the pentoxifylline group. None of the similar studies have obtained this result. How do the authors explain that?

**Orhan Gökalp, Nihan Karakaş Yeşilkaya<sup>1</sup>, Yüksel Beşir<sup>1</sup>, Ali Gürbüz**  
**Department of Cardiovascular Surgery, Faculty of Medicine, İzmir Katip Çelebi University, İzmir-Turkey**

**<sup>1</sup>Department of Cardiovascular Surgery, İzmir Katip Çelebi University, Atatürk Education and Research Hospital, İzmir-Turkey**

### References

1. Mansourian S, Bina P, Fehri A, Karimi AA, Boroumand MA, Abbasi K. Preoperative oral pentoxifylline in case of coronary artery bypass grafting with left ventricular dysfunction (ejection fraction equal to/less than 30%). *Anatol J Cardiol* 2015; 15: 1014-9.
2. Raja SG, Berg GA. Impact of off-pump coronary artery bypass surgery on systemic inflammation: current best available evidence. *J Card Surg* 2007; 22: 445-55. [\[CrossRef\]](#)
3. Wan IY, Arifi AA, Wan S, Yip JH, Sihoe AD, Thung KH, et al. Beating heart revascularization with or without cardiopulmonary bypass: Evaluation of inflammatory response in a prospective randomized study. *J Thorac Cardiovasc Surg* 2004; 127: 1624-31. [\[CrossRef\]](#)
4. Wehlin L, Vedin J, Vaage J, Lundahl J. Activation of complement and leukocyte receptors during on- and off-pump coronary artery bypass surgery. *Eur J Cardiothorac Surg* 2004; 25: 35-42. [\[CrossRef\]](#)

**Address for Correspondence:** Dr. Orhan Gökalp

Altıncı Cd. No:85 D:10 35320

Narlıdere/İzmir-Türkiye

E-mail: gokalporhan@yahoo.com

©Copyright 2016 by Turkish Society of Cardiology - Available online at [www.anatoljcardiol.com](http://www.anatoljcardiol.com)

DOI:10.14744/AnatolJCardiol.2016.6838



## Author`s Reply

Authors of this mentioned article did not send any reply for this Letter to the Editor despite our persistent request.

## Bonsai-induced coronary artery spasm

To the Editor,

I have read the article by İnci et al. (1) entitled "Bonsai-induced Kounis Syndrome in a young male patient" with great interest, which was published in *Anatol J Cardiol* 2015, 15: 952-3. The authors presented an unusual form of acute coronary syndrome, which developed following the synthetic cannabinoid "Bonsai" use. I would like highlight some points regarding this article.

Although there are no definite diagnostic criteria to differentiate Prinzmetal angina from Kounis syndrome, systemic allergic reactions associated with acute myocardial ischemia in a patient should suggest that the patient has Kounis syndrome (2). Are there any signs and symptoms of systemic allergic reactions such as generalized erythema or urticarial rashes in the patient? Also, after clinical stabilization, additional allergy tests, including skin prick test, may be helpful for diagnosis.

I also would like to highlight a specific point in the treatment of the abovementioned patient. In the cases where type 1 Kounis syndrome progresses to acute myocardial infarction with increased cardiac enzymes and troponins, anti-allergic treatment, including administration of H1 and H2 blockers together with corticosteroids combined with classical treatment of acute coronary syndromes, is recommended (3). Also, in patients with non-ST-elevation acute coronary syndromes, dual antiplatelet therapy with aspirin and clopidogrel has been recommended for 1 year over aspirin alone, irrespective of the revascularization strategy and stent type according to the current guidelines (4). However, the utilization of aspirin is controversial because of the underlying anaphylactic reaction in Kounis syndrome. Acetylsalicylic acid can cause allergic reactions and induce anaphylaxis; therefore, the safety of aspirin use in patients with Kounis syndrome is unknown (5). I would like to kindly ask the authors whether there is any specific reason for the treatment of aspirin in this case?

In conclusion, because the use of synthetic cannabinoid is gradually increasing in our country, rapid diagnosis and appropriate treatment in these patients has great importance because of the complex and complicated course of acute coronary syndromes associated with allergic reactions.

**Can Ramazan Öncel**  
Department of Cardiology, Atatürk State Hospital, Antalya-Turkey

## References

1. İnci S, Aksan G, Doğan A. Bonsai-induced Kounis Syndrome in a young male patient. *Anatol J Cardiol* 2015; 15: 952-3. [\[CrossRef\]](#)
2. Kounis NG. Kounis syndrome (allergic angina and allergic myocardial infarction): a natural paradigm? *Int J Cardiol* 2006; 110: 7-14. [\[CrossRef\]](#)
3. Çevik C, Nugent K, Shome GP, Kounis NG. Treatment of Kounis syndrome. *Int J Cardiol* 2010; 143: 223-6. [\[CrossRef\]](#)
4. Roffi M, Patrono C, Collet JP, Mueller C, Valgimigli M, Andreotti F, et al; ESC Committee for Practice Guidelines. ESC Guidelines for the management of acute coronary syndromes in patients presenting without persistent ST-segment elevation: The Task Force for the management of acute coronary syndromes (ACS) in patients presenting without persistent ST-segment elevation of the European Society of Cardiology (ESC). *Eur Heart J* 2016; 14: 267-315. [\[CrossRef\]](#)
5. Altay S, Çakmak HA, Erer B, Kemaloğlu T, Özpamuk F, Karadağ B. The allergic angina syndrome in naproxen sodium induced type 1 hypersensitivity reaction in an allergic asthmatic young woman: Kounis syndrome. *Acta Cardiol Sin* 2012; 28: 152-6.

**Address for Correspondence:** Dr. Can Ramazan Öncel  
Atatürk Devlet Hastanesi, Kardiyoloji Kliniği  
Anafartalar Cad., 07040, Antalya-Türkiye  
E-mail: r\_öncel@hotmail.com

©Copyright 2016 by Turkish Society of Cardiology - Available online  
at [www.anatoljcardiol.com](http://www.anatoljcardiol.com)  
DOI:10.14744/AnatolJCardiol.2016.6918



## Author's Reply

To the Editor,

We thank you for the interest in and positive reviews for our case report published in the *Anatolian Journal of Cardiology* entitled "Bonsai-induced Kounis Syndrome in a young male patient" (1).

The most important step of the diagnosis of Kounis syndrome is determining the presence of allergic symptoms accompanying chest pain. Systemic allergic reaction is manifest with skin, mucosa, respiratory system, cardiovascular system, or gastrointestinal system signs in minutes/hours after exposure to the allergen. The clinical picture is variable in a wide spectrum from mild skin lesions that might be unnoticed to anaphylactic shock. The course of the allergic reaction occurring in this case was chest pain without skin involvement. No skin lesion was encountered in this patient. However, skin lesions may be absent in majority of the cases (2). The patient was questioned and examined for skin lesions; nevertheless, the mild nature of the skin lesions should be considered so that they may be unnoticeable (3). Leukocytosis, eosinophilia, and increased IgE levels were detected in this case, and other tests could not be performed because of technical unavailability. The skin prick test may be helpful in diagnosis; however, its rate of usage is found to be low in the literature (4).

Primary treatment of Kounis syndrome is AKS management and suppression of the allergic reaction. Because the primary mechanism is coronary vasospasm in young and otherwise healthy patients who have no risk factors for coronary artery disease and are considered to have Type I variant Kounis syndrome, the first-line treatment is nitrates and calcium channel blockers. Suppression of allergy by steroids and antihistamines alone may even alleviate coronary vasospasm. AKS management in those patients, on the other hand, is unclear. Debatable applications have been reported, particularly on the antiaggregants. Because aspirin is a basic building block treatment in the management of AKS, we started aspirin (5). However, as you have mentioned, aspirin has the potential to increase the continuing allergic reaction in patients with Kounis syndrome. It may be more suitable to prefer clopidogrel in patients with hypersensitivity to aspirin.

**Sinan İnci, Gökhan Aksan<sup>1</sup>, Ali Doğan<sup>2</sup>**  
Department of Cardiology, Aksaray State Hospital, Aksaray-Turkey  
<sup>1</sup>Department of Cardiology, Şişli Etfal Education and Training Hospital, İstanbul-Turkey  
<sup>2</sup>Department of Cardiology, Faculty of Medicine, Erciyes University, Kayseri-Turkey