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Author`s Reply

To the Editor,

We are much pleased with the authors' interest in our article entitled "SYNTAX score predicts postoperative atrial fibrillation in patients undergoing on-pump isolated coronary artery bypass grafting surgery" (1), as published ahead of print for the Anatol J Cardiol 2015 Nov 18, and we would like to thank them for their contributions.

Firstly, definitive diagnosis of postoperative atrial fibrillation (PoAF) is not found in the relevant guidelines. In our study, PoAF was defined as it has been in previous studies (2). In the literature there are many controversial definitions of PoAF (3, 4). In our study, patients were followed with continuous telemetry for between 72 and 96 hours. A 12-lead electrocardiography (ECG) was obtained from the patients every 12 hours or 24 hours at the intensive care and in-patient units, respectively. Rhythm monitoring was continued until patients were discharged from the hospital. If patients had complaints such as dyspnea, palpitation, or angina, 12-lead ECG was taken during hospitalization. Incidence of PoAF could increase beyond the 72 to 96-hour window observed with continuous telemetry. The rate of PoAF may be underestimated in our study.

Drug use, including beta blockers, renin angiotensin aldosterone blockers, and statins before surgery could affect incidence of PoAF. In our study, percentage of beta blocker, angiotensin-converting enzyme inhibitor, and angiotensin receptor blocker use was 100% and 98.9%, respectively. There was no difference in drug use between the 2 groups. Obstructive sleep apnea and obesity were not included in our study as independent parameters because of low number of instances.

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Kounis syndrome presenting with acute inferior wall myocardial infarction and cardiogenic shock secondary to intravenous ampicillin/sulbactam administration

To the Editor,

Kounis syndrome (KS) is induced by allergic and anaphylactic reaction, and is considered a rare cause of coronary artery spasm (1) A 44-year-old male patient was admitted to our center with complaint of severe chest pain lasting for 1 hour. He was administered treatment of 1 g intravenous ampicillin/sulbactam with diagnosis of upper respiratory tract infection. He did not have history of allergy or traditional risk factors for coronary artery disease. Ten minutes after the injection, he felt severe, squeezing retrosternal chest pain. On physical examination, he was pale. He did not have pruritus or rash. His blood pressure (BP) and heart rate were 77/48 mm Hg and 104 bpm, respectively.