

Author's Reply [ARTICLE IN PRESS]

To the Editor,

I thank the authors for their interest. The first title of the case report was "Concomitant left main coronary artery and prosthetic mitral valve thrombosis treatment: Improvisation is a must!" to emphasize the uncertainty and need for versatility while treating these patients. There were two patients treated by percutaneous coronary intervention in Yesin et al.'s (1) paper, but there is no detail about the amount and quality of coronary thrombotic material. I think that there are two kinds of thrombotic coronary materials in these patients: easily dispersible and lysable and denser, bulkier coronary thrombotic material. I am not aware of any autopsy or thrombus aspiration study in such patients characterizing thrombus qualities, and Yesin et al. (1) study cannot be accepted as the last verdict in these patients due to limitation in describing coronary thrombus quality and amount. Our case fundamentally differs from their patient group by left main coronary artery occlusion and urgent need for terminating coronary ischemia. In Yesin's study, only 19% of the patients were receiving aspirin, and none were on clopidogrel on admission that reduced the bleeding rate in their protocol. I retrospectively think that low-dose and ultra-slow fibrinolytic therapy (25 mg/25 h) was safer in our patient due to aspirin and clopidogrel treatment necessitated by stent implantation and suggested 25 mg/6 h protocol would increase bleeding risk. Heparin infusion was necessitated due to intra-aortic balloon pump (IABP) use in the follow-up. Our patient is also different from the TROIA and PROMETEE patient groups

that did not include any patient with IABP (2, 3). As a result, it is very difficult for authors to say "total disagreement on heparin use" by referencing the TROIA and PROMETEE trials because both were not enrolling any patient on IABP. Necessary precautions were taken for tPA stability during a 24-hour infusion. We do not know the thrombus size before the 2nd episode of tPA infusion because TEE was not performed again due to the general condition of the patient and good transthoracic image quality showing stuck mitral leaflet.

In conclusion, it is very difficult for authors to claim low-dose and slow infusion TT to be a better treatment strategy in our patient because their referenced studies did not include any patient on IABP.

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References

1. Yesin M, Karakoyun S, Kalçık M, Gürsoy MO, Gündüz S, Astarcioglu MA, et al. Status of the Epicardial Coronary Arteries in Non-ST Elevation Acute Coronary Syndrome in Patients with Mechanical Prosthetic Heart Valves (from the TROIA-ACS Trial). *Am J Cardiol* 2018; 122: 638-44.
2. Özkan M, Gündüz S, Gürsoy OM, Karakoyun S, Astarcioglu MA, Kalçık M, et al. Ultraslow thrombolytic therapy: A novel strategy in the management of PROsthetic MEchanical valve Thrombosis and the prEdictors of outcomE: The Ultra-slow PROMETEE trial. *Am Heart J* 2015; 170: 409-18.
3. Özkan M, Gündüz S, Biteker M, Astarcioglu MA, Çevik C, Kaynak E, et al. Comparison of different TEE-guided thrombolytic regimens for prosthetic valve thrombosis: the TROIA trial. *JACC Cardiovasc Imaging* 2013; 6: 206-16.

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