

Author's Reply

To the Editor,

We would like to thank the authors of this letter for their interest in our recently published paper (1). We agree that antithrombotic management of patients with atrial fibrillation (AF) undergoing percutaneous coronary intervention (PCI) can be challenging, especially in the elderly population, due to the attendant bleeding risk. International guidelines have previously recommended triple therapy, including oral anticoagulation (OAC) and dual antiplatelet treatment, for one up to six months after PCI as the preferred strategy to prevent both coronary events and AF-related thromboembolic complications (2, 3). With the aim to reduce the risk of bleeding events, recent studies have investigated in this setting the use of dual antithrombotic therapy with a single antiplatelet agent, mainly a P2Y12 inhibitor, in combination with OAC (4-6). We have recently published a study-level meta-analysis of randomized trials on this topic, including approximately 6,000 patients with indication to chronic OAC, mostly because of AF; this meta-analysis showed that, compared to triple therapy, dual antithrombotic treatment with a single antiplatelet agent (essentially clopidogrel) plus OAC [warfarin or non-vitamin K antagonist anticoagulant (NOAC)] prevented 15 major bleeding and 39 minor bleeding events per 1,000 patients at one year, without any increase in the risk of myocardial infarction, definite stent thrombosis or stroke (7). Interestingly, our data might suggest a potential survival benefit with dual antithrombotic regimen that needs confirmation by larger studies. These data reinforce the concept that dual therapy may represent the preferable therapeutic option in patients with AF undergoing PCI, especially in the elderly and in presence of a high bleeding risk. Available evidence and logical considerations derived from the better safety profile of NOACs compared to warfarin, indicate that the optimal combination for dual therapy may be a P2Y12 inhibitor plus a NOAC.

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High anthracycline cumulative dose without cardiac toxicity: A possible protective role of morphine

To the Editor,

Improvements in global anticancer strategy have resulted in better outcomes for a large proportion of cancer patients. Anthracyclines (A) are the best studied anticancer drugs with an established clinically significant dose-dependent cardiotoxicity. One of the strategies developed to reduce their well-known dose-dependent toxicity is dose limitation to 400-450 mg/m² for doxorubicin (DOX) and 900 mg/m² for epirubicin (E) (1). Preclinical evidences have pointed out a possible role for morphine as a cardioprotective agent (2, 3). On the basis of these, we conducted a retrospective database search to determine patients receiving a higher E dose without cardiotoxicity so as to look for clinical or pharmacological protective factors while focusing on concomitant opioid use.

We collected data of patients who were receiving a cumulative dose of E >900 mg/m² (representing the threshold warning dose) and who had undergone regular appropriate cardiac monitoring (1) without any evidence of cardiotoxicity. All available clinical/pathological characteristics were recorded focusing on concomitant medication with known cardioprotective effects as well as concomitant opioid use. We identified 10 such patients [median age, 58 (range, 49-71) years, F/M=9/1]. Their cumulative epirubicin dose was 1600 (range, 1350-2220) mg. None of the clinical parameters (age, sex, body mass index, comorbidities,