relevant with AF recurrence in the present study. In addition, we aimed to predict AF recurrence using parameters that easily applied in daily clinical practice. We therefore preferred AP-Lad that is routinely used in daily electrocardiographic evaluations and more practical than LAVI.

Interatrial conduction delays have been implicated in initiating and maintaining AF (6). P-wave dispersion (PWD) shows the prolonged interatrial conduction and can be used to predict the recurrence of AF. We agree with the opinion that PWD can be used as a practical predictor of AF. It could be exciting and interesting study in which NLR and PWD are evaluated together and these parameters are compared.

We are in absolutely agreement with authors about the improving effects of antiarrhythmic drug therapy on prognosis in AF. Therefore, amiodarone was given to all patients before cardioversion (CV) and was continued for 1 month following CV in this study. Antihypertensive agents such as angiotensin converting enzyme inhibitors and angiotensin receptor blockers have antiarrhythmic and antifibrotic actions via inhibition of angiotensin II. Also, statins have anti-inflammatory and antioxidant action. However, according to the ESC 2012 AF guideline, there is only little reason to consider the use of such therapy for the prevention of AF recurrence in patients with little or no underlying heart disease (7).

We agree with authors that bacterial or viral infections, chronic inflammatory disease and drug treatments might affect neutrophil and lymphocyte counts and so the ratio of these parameters might be changed. Therefore, we excluded the patients with chronic obstructive pulmonary disease, malignity and acute infectious disease. It could be considered to evaluate together with other serum inflammatory markers. However, these inflammation markers are not used in daily practice and are only assayed with commercially available kits. Another limitation of commercial kits is those shelf lives are generally short after first use. However, our aim was to find a basic parameter analysis of which is quick, economical and labor free for predicting AF following electrical cardioversion (ECV). For this reason, other serum inflammatory markers were not evaluated.

Finally, we support the comments of authors that future large-scale prospective clinical studies are needed to clarify the essential pathophysiological mechanisms in the recurrence of AF after ECV in patients with non-valvular AF.

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Importance of multislice computed tomography angiography for the diagnosis and evaluation of silent coronary ischemia and asymptomatic acute myocardial infarction: long-term follow-up of three cases

Sessiz koroner iskemisinin ve sempombsuz akut miyokart enfarktisinin taminda ve degerecearlimesinde çok kesitli bilgisayararl koroner kalp tomografisinin önemi: Uzun dönem takip edilmiş tıc oltu

Multislice computed tomography angiography (MSCTA) is a very useful and an important tool for the noninvasive evaluation, intervention and cure of coronary arterial pathology (1-12). We present the assessment of three patients with coronary artery disease (a 88-year old man, 62-year old man and 66-year old man, using a MSCTA coronary angiography (64-320 slice technology), that was firstly described by Leschka S (5).

Figure 1. This figure shows first patient’s ECG (a), MSCTA (b), and angiography and stent implantation (c)

ECG - electrocardiogram, MSCTA - multislice computed tomography angiography
First patient was admitted to the Cardiology Department with trivial exercise dyspnea, and palpitation from time to time lasting for about one month in 2007. Electrocardiogram (ECG) and exercise ECG were normal (Fig. 1). The patient denied coronary angiography, and 64-slice MSCTA was performed. The left anterior descending coronary artery (LAD) with vulnerable soft plaque leading to severe coronary artery stenosis (%95) at the middle segment was detected by coronary angiography and the result was completely parallel to MSCTA. Percutaneous coronary intervention (PCI) was performed for LAD lesion and drug-eluting stent was implanted after predilatation. The patient was examined routinely and is completely asymptomatic for more than six years.

Second diabetic patient was admitted with trivial swelling after routine insulin injection. His cardiac enzymes were elevated which were taken routinely before admittance to our clinic. His ECG (Fig. 2) showed that the slightly prominent and non-significant T waves on V2-3 leads. On MSCTA (320-slice), a completely total occlusion of the left circumflex artery proximal segment and critical stenosis (98%) at the middle segment of LAD were detected and invasive coronary angiography was performed on the same day. The result was in agreement with MSCTA findings. This patient has had an acute asymptomatic posterior myocardial infarction. PCI with predilatation was performed firstly for totally occluded circumflex artery, which was opened successfully, and drug-eluting stent was implanted. Again predilatation was performed to the critical LAD lesion and drug-eluting stent was implanted. The patient is followed up routinely. He is asymptomatic for more than three years after the procedure.

The third patient, a 66-year-old man, was examined routinely without any complaints. His resting ECG was normal, however during 4th stage of exercise ECG an atypical chest pain occurred without ST-T changes. His MSCTA (320-slice) surprisingly showed 95% narrowing LAD lesion with adventitial calcifications (Fig. 3). This lesion was similar to his coronary angiography and at the same time metal bare stent implantation was performed. Since then, he has been working very hard without any complaints and symptoms.

We conclude that the MSCTA is a very important tool for diagnosis and evaluation of coronary lesions. In addition, it is an important guide for cure of silent ischemia and myocardial infarction, particularly to persuade denying patients for invasive coronary angiography.

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Life-long oral anticoagulant therapy and rupture of corpus luteum

Yaşam boyu oral antikoagülan tedavisi ve korpus luteum rüptürü

Mechanical heart valve prostheses have a high thromboembolic potential. There is therefore no doubt that those patients need to receive life-long oral anticoagulant (OAC), which, unfortunately, is associated with an increased risk of hemorrhagic complications (1).

Ovarian hemorrhages is rarely seen in healthy women and usually has a little clinical importance. However, more serious and even life-threatening bleeding episodes have been described in women treated with anticoagulants (2, 3).

We reported results of ten patients under sodium warfarin treatment for prosthetic heart valves and treated surgically for intraabdominal hemorrhage as a result of ruptured corpus luteum were analyzed retrospectively. Additionally, follow-up treatment modalities were assessed by phone interview.

Patients’ demographic data, biochemical and hematologic parameters, surgical procedure, volume of intraabdominal bleeding, transfusion characteristics are demonstrated in Table 1. None of patients was using effective contraceptive method at time of admission.

All patients were discharged with advice of a depot medroxyprogesterone acetate (DPMA) for ovulation suppression in follow-up treatment. Nine of the ten patients were contacted by phone interview in order to determine if they used follow-up treatment or not. The time interval between operation time and phone interview ranged between 32-43 months. Eight women started to use DMPA a month after the operation till day of interview. None of these patients experienced any ovarian bleeding episode until now. 3 of them also stated that they have been amenorrheic since 6 months after DMPA, and 5 of them mentioned oligomenorrhea. Bloating, headache and breast tenderness were the reported complaints in 2, 2, and 1 patients, respectively.

Table 1. Patients characteristics and surgical properties

<table>
<thead>
<tr>
<th>Case</th>
<th>Age</th>
<th>Gynecologic history</th>
<th>Duration of OAC (Months)</th>
<th>Admission hemoglobin (g/dL)</th>
<th>Admission INR</th>
<th>Amount of hemoperitoneum</th>
<th>Surgery</th>
<th>Require second surgery</th>
<th>Blood transfusion</th>
</tr>
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<tbody>
<tr>
<td>1*</td>
<td>33</td>
<td>G1P1</td>
<td>60</td>
<td>7.4</td>
<td>4.3</td>
<td>2000 cc + 800 cc</td>
<td>Suturing</td>
<td>Yes (SOF)</td>
<td>8 U FFP 3 U RBC</td>
</tr>
<tr>
<td>2*</td>
<td>43</td>
<td>G3P2</td>
<td>120</td>
<td>8.5</td>
<td>2.8</td>
<td>800 cc</td>
<td>SOF</td>
<td>No</td>
<td>4 U FFP 2 U RBC</td>
</tr>
<tr>
<td>3*</td>
<td>35</td>
<td>G2P2</td>
<td>83</td>
<td>7.9</td>
<td>&gt;5</td>
<td>1500 cc</td>
<td>Suturing</td>
<td>No</td>
<td>7 U FFP 3 U RBC</td>
</tr>
<tr>
<td>4*</td>
<td>33</td>
<td>G6P4</td>
<td>22</td>
<td>7</td>
<td>&gt;5</td>
<td>2000 cc</td>
<td>SOF</td>
<td>No</td>
<td>8 U FFP 4 U RBC</td>
</tr>
<tr>
<td>5*</td>
<td>32</td>
<td>G0P0</td>
<td>11</td>
<td>5.5</td>
<td>&gt;5</td>
<td>3000 cc</td>
<td>SOF</td>
<td>No</td>
<td>8 U FFP 6 U RBC</td>
</tr>
<tr>
<td>6</td>
<td>24</td>
<td>G1P0</td>
<td>46</td>
<td>6</td>
<td>3.6</td>
<td>3500 cc</td>
<td>SOF</td>
<td>No</td>
<td>4 U FFP 4 U RBC</td>
</tr>
<tr>
<td>7*</td>
<td>36</td>
<td>G1P1</td>
<td>36</td>
<td>6.5</td>
<td>&gt;5</td>
<td>1900 cc</td>
<td>Suturing</td>
<td>No</td>
<td>4 U FFP 4 U RBC</td>
</tr>
<tr>
<td>8*</td>
<td>39</td>
<td>G3P3</td>
<td>892</td>
<td>6.8</td>
<td>4.9</td>
<td>2400 cc</td>
<td>Suturing</td>
<td>No</td>
<td>5 U FFP 4 U RBC</td>
</tr>
<tr>
<td>9</td>
<td>32</td>
<td>G0P0</td>
<td>23</td>
<td>5.7</td>
<td>4.8</td>
<td>2300 cc</td>
<td>Suturing</td>
<td>No</td>
<td>6 U FFP 4 U RBC</td>
</tr>
<tr>
<td>10*</td>
<td>40</td>
<td>G4P3</td>
<td>144</td>
<td>7.5</td>
<td>3.9</td>
<td>1800 cc</td>
<td>SOF</td>
<td>No</td>
<td>4 U FFP 3 U RBC</td>
</tr>
</tbody>
</table>

*Patients receiving concomitant 80mg/day aspirin therapy;  ●Patients had a history of previous surgery for ruptured corpus luteum;  □ Patients with regular cardiology visit;  ♦ Patients had a ruptured corpus luteum on the right side.

DPMA - depot medroxyprogesterone acetate, FFR - fresh frozen plasma, G - gravida, OAC - oral anticoagulant, OC - oral contraceptive pill, P - parita, RBC - red blood cell, SOF - salpingooopherectomy