patient in the article entitled “Stuck aortic valve treated by reteplase in a Bentall patient.” published in Anatol J Cardiol 2015; 15: 339-40 by Tanyeli et al. (1). In a patient with prosthetic valve thrombosis, thrombolysis, thrombectomy, or prosthetic valve re-replacement is the currently available option (2). Firstly, the patient’s complaints were acute and life-threatening with a possible acute myocardial infarction. In our paper, we stated that the patient had a huge thrombus material blocking the movement of the aortic valve with resultant severe aortic stenosis; this detection was made in the catheterization laboratory with the aid of transesophageal echocardiography (TEE). Fluoroscopy showed total blockade of the aortic valve, and coronary angiography showed normal coronary angiogram. Although the cardiologists tried to perform transesophageal echocardiography, the patient could not tolerate the procedure. The patient was in acute hypotensive shock status and was immediately sent to our intensive care unit for operation. We thought that the patient had limited time because of total blockade of the aortic valve. Because the patient previously had a Bentall operation with a valved conduit due to aortic dissection, both exploration of the heart in a re-do surgery and excision of the graft material with the valve and coronary ostia would increase operative mortality because these procedures would need a certain period of time. As the authors stated, rapid thrombolysis should only be reserved for certain circumstances, including critically ill patients with prosthetic valve thrombosis or those with stroke or acute myocardial infarction (3), and our patient was in the category of being critically ill. That is the reason we used the rapid infusion strategy, and in case the thrombolysis was unsuccessful, we would immediately take the patient to the operation theater, which had a high risk of mortality. We totally agree with the authors that a slow infusion strategy could be more beneficial in a more stable patient. After bedside evaluation of the patient with TTE, even a small amount of aortic valve motion dramatically improved the patient’s status. Unfractionated heparin was continued for 48 h; thereafter, the patient was on enoxaparin sodium treatment until INR reached 2.5 with oral warfarin treatment.

We agree that such a single case with a good outcome cannot prove that our strategy is universally applicable; however, we also stated that any cardiologists and cardiac surgeons should always be in close collaboration with decision making with the aid of universally accepted guidelines. The patient’s critical status and the risk taken by the operative strategy should never overcome the risk taken by the medical decision-making. This is the reason we stated that thrombolytic therapy (in this case, reteplase) may be kept in mind in re-functioning of the stuck mechanical valves, particularly in high-risk patients.

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ing of the prosthesis is not always possible, the operator should take into account the hemodynamic profile and aortic pressure tracing of the patient to evaluate the functioning of the valve in that position. If the hemodynamic signs are in favor, neglecting an acceptable amount of fluoroscopic malposition would not result in a bad procedural outcome. Operators should keep in mind that hemodynamic monitoring must be a part of the procedure and may be a sign of proper valve positioning.

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Ebola virus disease 2014: Induction of abnormal cardiac rhythm?

To the Editor,

The present outbreak of Ebola virus disease 2014 in Africa is of public health concern. This disease is a deadly infection and has high fatality (1). The clinical presentation is mainly an acute febrile illness with hemorrhagic complication (1). Of interest, there are also other systemic presentations in the patient. The effect of the infection on cardiac rhythm is very interesting. Indeed, in the earlier outbreak in Sudan in 1976, the problem of cardiac rhythm abnormality was not observed (2). However, in the present situation, Ebola 2014, tachycardia is common (3). Bah et al. (3) reported that the mean heart rate of patients was >93 beats/minute. It appears that the new Ebola virus 2014 has a possible cardiac chronotropic action.

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