We read the article by Fawzy et al. and congratulate the authors on their study [1]. However, there are some conflicting points that should be highlighted. First of all, in the Patients and Methods’ section, the authors mentioned several exclusion criteria. Among these, we did not note atrial dilatation, left ventricular aneurysm, long aortic clamping, long cardiopulmonary bypass time, electrolyte abnormalities and hypothyroidism, pathologies that can also cause postoperative atrial fibrillation (POAF) [2,3]. However in the same section, the authors stated that “all of the patients in both groups had preoperative B-blockers and no prophylactic anti-arrhythmic drugs were given to any patient postoperatively”. B-blockers withdrawal is also related to the increased risk of developing POAF [3]. Were B-blockers given to patients in both groups postoperatively or were B-blockers included prophylactic anti-arythmic drugs postoperatively? If not, in the postoperative period, B-blockers should have been used in both groups. As a result, all of these situations maybe a confounding factor for the purity of the study and the authors should have added these situations in the exclusion criteria.

In the Patients and Methods’ section, the authors stated that “echocardiography was performed on the third and fifth postoperative days and before discharge and the patient was considered to have POAF when an episode of AF persisted longer than 30 min even after correction of hypoxia and electrolyte imbalance”. We wonder why authors did not start echocardiographic follow-up on the first two postoperative days and why they chose 30 min to determine AF? Also in the same section, we did not note any information on using low-molecular weight heparin, standard heparin or anti-aggregating drugs in early postoperative period? If so, these drugs can cause an increased risk of developing POAF. This situation maybe a confounding factor for the purity of this study.

In the Results section, the authors stated that “15 patients in Group I developed mild and moderate pericardial effusion vs 50 patients in group II”, but they did not mention what mild and moderate pericardial effusion means and which method or classification system they used for this situation.

In the Results section, the authors showed that the incidence of cardiac tamponade and AF was lower in the study group. As a matter of fact, these results have been shown in many studies in the literature and are common knowledge. For example, in 1999, Kuralay et al. have already shown that posterior pericardiotomy lowers the risk of developing cardiac tamponade, PE and AF in 200 coronary artery bypass patients [4].

Conflict of interest: none declared.

References

