Correspondence

Coronary artery disease – The greatest threat to women’s health

To the Editor,

We have greatly enjoyed reading the recently published article by Pathak LA et al. [1]. There is an overwhelming evidence that gender disparities do exist in the risk factor profile and the management of patients with coronary artery disease (CAD) [2]. The authors have retrospectively analyzed the clinical and angiographic profile of 3250 women undergoing coronary angiogram over a period of 6 years. This is a large cohort and results are likely to influence the future research on the effect of various risk factors on the development of CAD in women. However, we have few concerns:

1. The authors have not analyzed the distribution of various risk factors according to different age categories among women. It would have better reflected the differences in the risk factor profile among young and elderly women and might have provided causal implications.

2. Similarly, it would have been better to look for the differential pattern of angiographic findings across different age categories. Limited contemporary data exist on the differences in angiographic profile among young and elderly Indian women [3].

3. Third, we would like to bring attention towards the possible typographical errors. There are discrepancies in the data provided in the pie-charts and the text. In the pie-chart demonstrating the modes of clinical presentation, it is mentioned that unstable angina/NSTEMI was observed in 60%, STEMI in 20%, stable angina in 16% and atypical presentation in 4%. However, in the text, these percentages are different (NSTEMI 51%, STEMI 13% and stable angina 25%). Similarly, discrepancies exist between the values mentioned in the pie-chart on angiographic profile and the supported text.

4. Lastly, the data were collected retrospectively by authors from a single center in Mumbai, India. Since the characteristics of CAD patients vary with socio-demographic profiles, and 69% of Indian population is rural [2], further studies are warranted across other parts of the country to assess the clinical and angiographic profiles among women. This would help in the planning of preventive health programs against rising burden of CAD among women.

Conflict of interest

None.

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Authors contributions

Criteria for inclusion in the authors’ list= All the authors contributed equally to prepare this manuscript.

Manuscript has been read and approved by all the authors, and the requirements for authorship have been met, and each author states that the manuscript represents honest work.

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Coronary artery disease in women

Dear Editor,

In the recent article titled, ‘Coronary artery disease in women’, Dr. Pathak LA et al., has elucidated well on sex specific morbidity of coronary artery disease in women. While we appreciate the authors’ commendable work for their extensive 6 year research in women, we would like to add few comments.
In the current decade, worldwide there is an increase in the number of women undergoing coronary artery bypass grafting (CABG). This is a surrogate marker of the fact that CAD in women is recognised more often and much earlier than in previous years. This has been reflected in our data. We compared two groups of women undergoing CABG – group I (1998–2002; n = 293) and group II (2010–2014; n = 395). There was an increase from 11% of the total number of female patients who underwent CABG from Group I to 19.5% from Group II. The mean age is higher and there was increase in the percentage of women having previous PCI in group II. Despite the increase in severity of disease and comorbid conditions, improved outcomes were observed.

**Conflicts of interest**

None.

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None.

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**Letter to Editor**

Dear Editor,

The article written by Sharma et al. on “High sensitive C-reactive protein and interleukin 6 in atrial fibrillation with rheumatic mitral stenosis from Indian cohort” is very interesting. Sharma et al. found that, “Increased hs-CRP and IL-6 levels in the paroxysmal and permanent AF group may favour the hypothesis that low grade chronic inflammation could be the cause of atrial fibrillation than a consequence”.

In the methodology part, chronic autoimmune and/or rheumatic disease was not excluded. Glucocorticoids remain at the fist lineanti-inflammatory and immunosuppressive treatment for both acute and chronic inflammations, including rheumatoid arthritis, inflammatory bowel disease, multiple sclerosis, psoriasis and eczema, as well as being used in leukaemias and in following organ transplant. Taking immunosuppressive medications (ex. corticoste-roids and/or IVIG) can affect and change plasma acute phase reactant levels and interleukin levels, can inhibit the activity of crucial transcriptional regulators of pro-inflammatory genes, including NF-κB and AP-1, so patients who taking these drugs should have been excluded from the study. Another missing point is about echocardiographic measurements of left atrial size. Especially in a prospective study, measurement of heart chamber size should be evaluated with 3D echocardiography for obtaining better data. Compared with cardiam magnetic resonans reference, 3D echocardiographic evaluation of left atrial measurement are more accurate than 2D echocardiographic based analysis.

**Conflict of interest**

None.

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**SMS campaign – Can it facilitate prevention of cardiovascular diseases in India?**

To the Editor

We have read with great interest the recently published article by Bishav Mohan et al. Cardiovascular disease (CVD) is the leading cause of death in India and worldwide. Lack of knowledge and motivation regarding risk factor prevention is one of the major

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