

520 compared to 380 patients transfused with LL Hb < 10 gm dL⁻¹. Habib and colleagues are correct to point out that the apparent lack of significance in survival between these two groups is more likely a consequence of sample size, with the difference in freedom from death approaching significance in these two groups (96.7 versus 95.4%; $P=0.082$). We take note of their previously published paper [3] that deals with the importance of CPB haemodilutional anaemia on outcomes. We entirely agree that it is best to avoid excessive haemodilution on bypass, *but what is excessive?* We do not have the data to comment on that. Habib and colleagues were right in their paper [3] to suggest that a causal link between increasing haemodilution and morbidity/mortality after bypass can be demonstrated only by a randomised controlled trial.

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doi:10.1016/j.ejcts.2005.05.022

Letter to the Editor

Platelet function tests predict bleeding and thrombotic events after off-pump coronary bypass grafting

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Received 25 April 2005; accepted 9 May 2005; Available online 21 June 2005

Keywords: Aspirin; Resistance; TEG; Cardiopulmonary; Bypass; CABG; Off-pump

We read with great interest the article entitled 'Platelet function tests predict bleeding and thrombotic events after off-pump coronary bypass grafting' written by Poston and colleagues [1]. Platelet function and bleeding is still a big challenge in cardiac surgery. We certainly agree with Poston and colleagues with regard to their comments on TEG-based algorithma.

Our group is now routinely using TEG for screening the coagulation during surgery. We also initially obtain basal TEG analysis before skin incision in all our coronary patients. We routinely do not stop the aspirin before surgery. Therefore, we have a chance to plan our postoperative anti-aggregan therapy. We found so called 30% aspirin resistance in our

patients compared to nearly 10% in your series. We think that this high number might be due to nonspecific kits for aspirin resistance we used in routine. But we do confirm the TEG with aggregometry. As far as to our knowledge there is no single test that definitely shows the aspirin resistance. We think that Aspirin resistance is extremely important issue in Cardiovascular disorders. However, there is no consensus in how to describe Aspirin resistance. The frequency is highly variable like 5-40% in literature [2-4].

We therefore start clopidogrel 6 h after surgery in patients suspicious to have Aspirin resistance before we confirm it with aggregometry, if the patient does not have any excess in chest tube drainage. We believe that this is very important in maintenance of early graft patency. So far we have not seen any side effects due to clopidogrel other than skin eruptions in few patients.

It was not clear in the article as to why the aspirin resistance was diagnosed in POD 3. We think that aspirin resistance is a very important issue in terms of graft patency, not only in Off-Pump patients but also in On-Pump patients. Therefore, do the authors think whether should we start clopidogrel to all our initial suspicious patients or should we wait till we get more accurate results. Our policy is to start clopidogrel as soon as possible in patients who are suspicious to have Aspirin resistance.

In conclusion, aspirin resistance is an important issue and should be considered in all patients with coronary disease. TEG is a useful tool in preoperative screening. It has the advantage of simplicity and is relatively cheap. If the patient is suspicious to have aspirin resistance additional anti-aggregan therapies should be started as quickly as possible.

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doi:10.1016/j.ejcts.2005.05.010

Reply to the Letter to the Editor

Reply to Isbir et al.

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