Authors' response

We are grateful to Prof. Ercan Varol for his appreciative letter regarding our paper "Correlation between clinical parameters of periodontal disease and mean platelet volume in patients with coronary artery disease: a pilot study" [1].

Prof. Varol writes: "There are significant associations of MPV with type 2 diabetes mellitus, prediabetes, smoking, hypertension, hypercholesterolaemia, obesity, coronary heart disease, metabolic syndrome, statins and some antihypertensive use and atrial fibrillation. There are also significant associations of MPV and inflammatory diseases including rheumatic diseases."

We can only agree with this statement. Indeed, a decrease of MPV simultaneous with a decrease of blood pressure values was reported in the small group consisting of 27 individuals treated with amlodipine. The author of that paper underlined that the phenomenon supposedly cannot be accredited to the type of antihypertensive drug used, but is related to the decrease of blood pressure [2].

For clarity, we reported in our paper the most important clinical data of the studied patients. However, we are happy to provide additional information on their characteristics. In the studied population, there were no active smokers, individuals suffering from diabetes mellitus, or even prediabetes. None of the patients experienced cardiac arrhythmia. In Groups 1 and 2 there were no other inflammatory diseases than periodontitis. Indeed, in Group 1 (CAD and periodontitis), hypertension occurred significantly more often than in the control group, but hypertensive therapy was successful in all individuals, which was confirmed by blood pressure measurements on each visit (three times during the study), and also with the analysis of measurements taken at home. All patients from Group 1 were taking beta-blockers, and the majority of them also angiotensin-converting enzyme inhibitors. Almost all the patients in Group 1 (excluding one person) were taking statins, and the mean total cholesterol concentration in this group was significantly lower than in the control group (166.6 ± 6.66 mg/dL vs. 223.5 ± 50 mg/dL, $p < 0.01$).

Therefore, it seems that hypertension and hypercholesterolaemia should not increase MPV in our population. We also measured other parameters that potentially could influence our results, including body mass index. In Group 1, mean body mass index value was significantly higher than in Group 2 (28.42 ± 0.69 kg/m^2 vs. 25.91 ± 0.99 kg/m^2, $p < 0.05$), but there was no significant difference between Group 1 and the control group (28.42 ± 0.69 kg/m^2 vs. 26.91 ± 0.58 kg/m^2, $p = 0.07$).

Of course, a larger number of studied patients potentially could improve our observations. However, statistically significant differences were noted even in a limited number of patients. In addition, we pointed out the relatively small number of studied groups in the section entitled "Limitations of the study". Moreover, as mentioned in the title of our manuscript, this is a pilot study only.

Currently we are running a larger scale project addressing the potential link between periodontitis and CAD. Once again we thank Prof. Varol for his interest in our study and their valuable comments.

Conflict of interest: *none declared*

References

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