H.pylori and myocardial infarction

To the Editor

We have read with interest the paper by Dr. Mansour Al-Nozha and colleagues, which was on a very current and topical subject in cardiology, inflammation and coronary artery disease (CAD).[1] However, we were surprised that the authors came to a negative conclusion, based only on ECG findings. It is well known that resting ECG is normal in approximately half of the patients with chronic stable angina pectoris, and even patients with severe CAD may have a normal tracing at rest. Furthermore, the authors did not perform the simple stress test, which is the standard test to rule out CAD in any of the patients studied. Only 4 patients out of 143 underwent meaningful investigations to rule out CAD. As a matter of fact, 74% of their patients were considered positive for CAD based on history and this is not in support of the drawn conclusion. As the authors have mentioned, in other areas such as Japan, *H.pylori* infection has been significantly associated with acute myocardial infarction, independent of the classic coronary risk factors in younger individuals.[2] We respectfully submit these comments for the consideration of the authors as well as for the benefit of younger colleagues who may wish to study the subject in their institutions.

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Reply from the Author

We thank Dr. Kinsara for his interest in our paper.[1] The role of inflammation in CAD is well established from many studies.[3,4] However, the role of infection by *H.pylori*, *Chlamydia pneumoniae* and cytomegalovirus is still controversial.[5-8] Most studies looked at patients with established CAD and tested them for evidence of infectious etiology. Although some studies showed associated evidence of one or more of these infectious agents, other studies showed negative results. Our study is a retrospective one and we looked into patients with evidence of Hp infection and whether they had any suggestive evidence of CAD based on available data from history, ECG, stress ECG, nuclear scan, echocardiography and or coronary angiography. We are aware of the limitation of resting ECG in detecting CAD, nonetheless, we did not exercise these patients since this was a retrospective study. All that we are saying is in a group of patients with Hp, there was no suggestive evidence of CAD from the available data we have presented and we totally agree that we can not rule out 'completely' the presence of underlying CAD. In due course, we will be publishing our prospective controlled data on a group of patients with CAD and tested for evidence of *H.pylori*, *Chlamydia pneumoniae*, and mycoplasma. The results showed no difference in seropositivity of patients with CAD and controls.

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