
To the Editor:

First, I thank Dr Ozaslan for his valuable feedback. Our study, published in the June 2010 issue of The Canadian Journal of Gastroenterology, was a retrospective analysis of patients with gastrointestinal (GI) bleeding due to distinct benign lesions. The patient population suffered from a heterogeneous group of disorders, each requiring a different treatment procedure. It would be ill-advised to make a general assumption based on this study alone and, indeed, we avoided making very bold statements in our report. Instead of providing details of all patients, we preferred to discuss a few of the more striking cases, while summarizing the remaining patient data in a table. Patient data presented in the table were sorted according to their underlying disorder, not chronologically. Ankaferd Blood Stopper (ABS) was used as a primary method of achieving hemostasis in patients for whom we believed it would be successful. In the methods, results and discussion sections of our article, we mentioned that ABS was used either as a primary or as an adjuvant to conventional modalities, depending on the case. For example, for patient 2, conventional modalities were limited, while patient 12 had persistent bleeding despite previous attempts to stop the bleeding. The table also clearly shows that patients who developed postbiopsy or postpolypectomy bleeding were either on medication affecting hemostasis (acetylsalicylic acid or warfarin) or had a coagulopathy (cirrhosis). These patients were chosen particularly for the persistent nature of bleeding after the procedures. Furthermore, aside from the cases mentioned by Dr Ozaslan, there are many reports demonstrating the efficacy of ABS in patients with defective hemostasis. The first case report on the success of ABS was of a child with hemophilia A (1) who underwent a circumcision, whose bleeding persisted despite treatment with factor VIII, rVIIa, factor VIII inhibitor bypass activity, cyclophosphamide and prednisolone. ABS was also used successfully in a young girl with afibrinogenemia who presented with a finger cut (2). Similar results have been reported for dental bleeding (3). Contrary to what Dr Ozaslan suggested, the efficacy of ABS has, in fact, been demonstrated in several experimental studies on patients with defective hemostasis (4,5).

As we mentioned in our article, ABS has been shown to be effective against arterial GI bleeding (6,7). Moreover, reblooding did not occur in any of the patients from our series who were treated with ABS for tumor bleeding (8). We previously demonstrated decreases in microvessel density after application of ABS (9), which we believed may have been responsible for this sustained hemostatic effect. ABS is relatively inexpensive when compared with other conventional antihemorrhagic measures for GI bleeding (Table 1).

Moreover, the same vial of ABS can be used to treat different patients. It is still too early to categorize the topical application of ABS as a hemostatic modality for GI bleeding. Further randomized, controlled studies are necessary to unequivocally establish the potential benefit of ABS in the setting of GI bleeding. Side effects from ABS were discussed in detail in our article.

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REFERENCES

TABLE 1
Summary of materials and equipment used at the Ankara, Turkey for the management of gastrointestinal system bleeding

<table>
<thead>
<tr>
<th>Material/equipment</th>
<th>Cost, €</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adrenaline (1 mL ampule)</td>
<td>0.08</td>
</tr>
<tr>
<td>Sclerotherapy needle</td>
<td>19.85</td>
</tr>
<tr>
<td>Argon photocoagulation catheter (front firing)</td>
<td>1156.67</td>
</tr>
<tr>
<td>Argon photocoagulation catheter (side firing)</td>
<td>248.14</td>
</tr>
<tr>
<td>Heater probe (7 Fr)</td>
<td>694.88</td>
</tr>
<tr>
<td>Hemoclips (one piece)</td>
<td>11.03</td>
</tr>
<tr>
<td>Hemoclip set (one piece)</td>
<td>58.95</td>
</tr>
</tbody>
</table>

*Unavailable at the Ankara, Turkey for the management of gastrointestinal system bleeding

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