drinking water might not be promptly available or may be technically difficult. Thus, ODT use offers a safe, effective, and convenient alternative way of ticagrelor administration in patients with ACS.

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The authors attest they are in compliance with human studies committees and animal welfare regulations of the authors' institutions and Food and Drug Administration guidelines, including patient consent where appropriate. For more information, visit the Author Center.

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Phosphodiesterase-5 Inhibitors in Men With Stable Coronary Artery Disease

Andersson et al. (1) recently investigated the efficacy of phosphodiesterase 5 inhibitor against alprostadil in men with stable coronary artery disease (SCAD). However, the following concerns need to be further interpreted.

As described in their abstract, "All Swedish men with a prior MI or revascularization were included" (1). We therefore understand that the participants included are patients with SCAD with a history of previous myocardial infarction (MI) or revascularization. Under these circumstances, some included patients may be patients with SCAD without a history of MI, but who required revascularization treatment. However, as defined by the risk categories of patients with SCAD, this study (1) used the conclusions from Bohula et al. (2). It should be emphasized that the study population in Bohula et al. (2) comprised patients with stable ischemic heart disease and previous MI, not patients with prior MI or revascularization. Thus, it could be determined that the populations involved in those 2 studies are not the same.

Therefore, it is inappropriate to directly carry over the conclusions from Bohula et al. (2). For patient risk stratification in the study by Andersson et al. (1), according to the 2013 European Society of Cardiology guidelines (3), patients with SCAD could be stratified into high, intermediate, or low risk based on clinical evaluations, ventricular functionalities, responses to stress testing, or coronary anatomy. Among them, clinical evaluations are the most basic requirement. Additionally, considering the complexity inherent in clinical parameters, it is challenging to combine all clinical variables into an integrated risk score. The 2013 guidelines (3) therefore recommend using angina severity in risk stratification and prognosis evaluations in patients with SCAD. From our perspective, it might be more accurate and reliable to use the criteria recommended by the 2013 guidelines (3) for risk stratification among patients with SCAD.

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The authors attest they are in compliance with human studies committees and animal welfare regulations of the authors' institutions and Food and Drug Administration guidelines, including patient consent where appropriate. For more information, visit the Author Center.

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Macrotroponin Probably Contributes to a Difference in Patient Stratification in Suspected Acute Coronary Syndromes

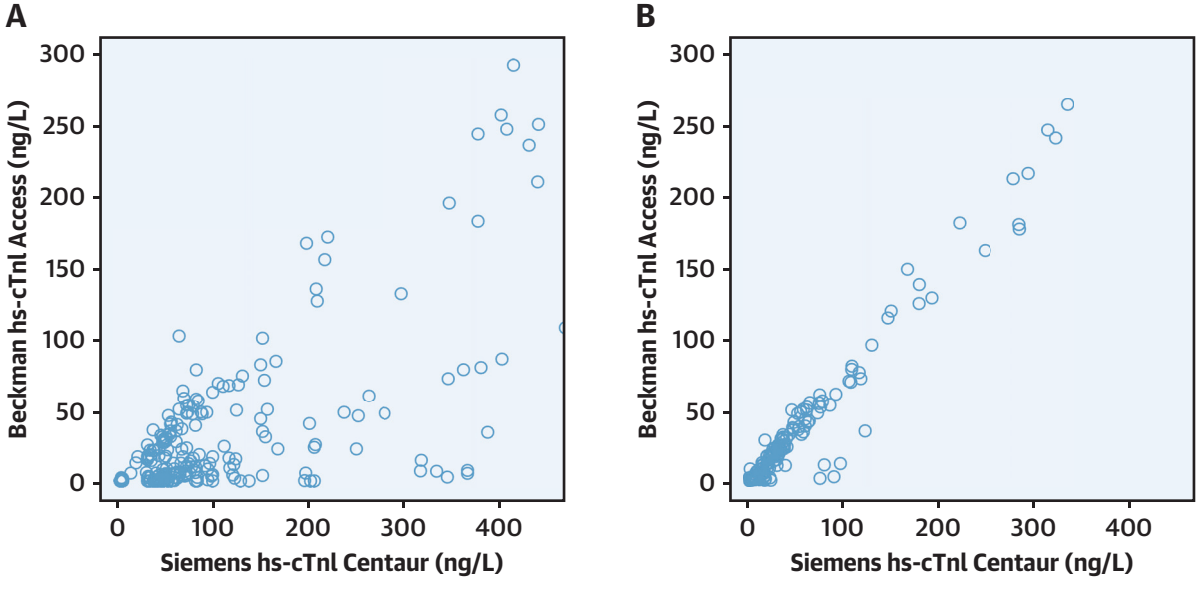
We read with interest the investigation by Karady et al (1) to determine the concordance between 3 high-sensitivity cardiac troponin (hs-cTn) assays in a cohort with suspected acute coronary syndrome. Significant differences were found among assays in stratifying patients using clinical decision algorithms.

Current hs-cTn results are a summation of heterogenous cTn components, and not all assays react equally to these components. Several hs-cTn assays, including the 3 in this investigation, have been shown to measure autoantibody-bound cTn, or macrotroponin (2,3), accounting for approximately 5% of elevated cTnI results in 1 assay (2). Although more prevalent in those with established cardiomyopathy, cardiac troponin autoantibodies (cTnAABs) have also been identified in apparently healthy individuals (4).

In a study of community patients, all cTn assays (n = 6), including cardiac troponin T, were analytically affected by the presence of macrotroponin to varying degrees. Elimination of macrotroponin improved correlation among assays (**Figure 1**) (3).

To date, to our knowledge, there have been no systematic studies to identify samples with cTn results below the limits of detection caused by macrotroponin (false negative results), but autoantibodies to cTn that reduce troponin assay reactivity have been described (5). The investigation by Karady et al (1) included patients with low cTn (below the limits of detection) but other indicators of myocardial damage (Supplemental Table 6B in the article by Karady et al [1]), strongly supporting the need for investigation in this area.

FIGURE 1 Potential for Harmonization of hs-cTnI Assays



Effect of 2 commercially available hs-cTnI assays **(A)** before and **(B)** after immunoglobulin depletion (223 specimens). Compared to the Beckman hs-cTnI assay, the Siemens hs-cTnI assay demonstrated greater reactivity to macrotroponin. Immunoglobulin depletion removes cardiac troponin autoantibodies and macrotroponin. Results after immunoglobulin depletion are corrected for volumetric changes using an internal standard. See Lam et al (3) for further details. Note: Immunoglobulin-depleted cTn results cannot be provided in real time and have not been validated for diagnostic use. hs-cTnI = high-sensitivity cardiac troponin I.