We appreciate the comments of Balta et al. [1]. With regard to the differential diagnosis such as anaemia, thyroid function tests, renal or hepatic dysfunction, all patients were assessed clinically by the anaesthesiologist for thyroid disease, as this is a specific anaesthetic risk factor for cardiac surgery. Patients on thyroid medication, and/or a history of thyroid disease, had their thyroid status normalized prior to surgery, as assessed via thyroid function tests. With regard to renal dysfunction, dialysis was a covariate in the multivariate analyses, Table 3 in [2]. We agree that glomerular filtration rate would have been a more accurate variable to analyse, but this was not available. The association between hepatic dysfunction and Red cell distribution width (RDW) is debated [3].

With regard to nutritional deficiency (i.e. iron, vitamin B12 and folic acid) and ethnicity, our population is 99% Caucasian, and the coronary artery bypass grafts (CABG) population in the western world is seldom malnourished, as was mentioned in our paper, having a mean body mass index of 28.4 kg/m².

Elevated levels of inflammatory molecules and poor outcomes are well described in a number of areas of cardiovascular disease; however, the interaction with RDW remains speculative as no studies exist. Aspirin is only associated with changes in RDW if anaemia exists [4], a condition that we adjusted for. We are unaware of any evidence that cardiovascular medications affect RDW.

All our RDW samples were analysed within 1–6 h of collection; however, this was not recorded. We were unable to find any publications dealing with delays as a cause of error in RDW measurement.

We thank Balta et al. for their insightful comments.

REFERENCES