Authors have nothing to disclose with regard to commercial support.

of our article.² The well-established reduction in red cell and platelet transfusion requirements seen with tranexamic acid (Table 1)⁴ is one mechanism by which tranexamic acid could reduce the risk of major adverse cardiovascular events after cardiac surgery.⁵ That is, tranexamic acid could have an indirect antithrombotic effect because of the reduction in bleeding and transfusion requirements. This will avoid transfusion-related prothrombotic effects, which may well increase the risk of early coronary graft thrombosis and subsequent late/long-term cardiac events. Our data, both 30-day⁴ and long-term,² provide compelling evidence to reassure readers that tranexamic acid is free of such adverse effects and may well be protective. Furthermore, tranexamic acid has immune modulatory effects that suppress inflammation and immunosuppression⁶; these effects could improve recovery after many types of major surgery.

We reject the assertion that we had made “flashy” or “over-the-top” conclusions. We remind readers to consider the rationale for our trial, the veracity of the trial findings, and our discussion outlining why the findings could be clinically important. As we concluded in our article, we look forward to further mechanistic investigations on the deleterious effects of blood transfusions and

possible beneficial effects of tranexamic acid on late cardiovascular events.

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TABLE 1. Further details of the blood-sparing effects of tranexamic acid in the Aspirin and Tranexamic Acid for Coronary Artery Surgery (ATACAS) trial²

Blood transfusion requirements in the ATACAS trial			
Blood product	Tranexamic acid (N = 2311)	Placebo (N = 2320)	P value
Platelets			
Intraoperative	195 (8.4)	308 (13.3)	<.001
Day 1	174 (7.5)	430 (18.5)	<.001
Fresh-frozen plasma			
Intraoperative	95 (4.1)	168 (7.2)	<.001
Day 1	204 (8.8)	476 (20.5)	<.001
Red cells			
Intraoperative	277 (12.0)	391 (16.9)	<.001
Day 1	406 (17.6)	708 (30.5)	<.001
Any blood transfusion			
Within 24 h of surgery	721 (31.2)	1130 (48.7)	<.001
Total, during hospitalization	875 (37.9)	1269 (54.7)	<.001

Values are n (%).

HACKED BY THE RUSSIANS OR FAKE NEWS

Reply to the Editor:

The issue at stake is the importance of using strict methodology in our articles, especially in the abstract section, the most widely read portion of any article. Personal interpretation of the results should be in the discussion section only.

There are no reasonable explanations that a short-acting and prothrombotic drug such as tranexamic acid “may reduce the risk of late cardiovascular events” as stated in the conclusion of the article of Myles and colleagues,¹ in view of contradictory results from long-term use of antithrombotic medication in the COMPASS trial² and others.

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I was asked by the Editor of the *Journal* to provide a commentary to that article, because my repeated requests for Myles and colleagues¹ to change their statement to one more factually correct (such as, “A trend in improving MACE at 1 year has been observed, possibly explained by avoiding blood products at time of surgery. The mechanism remains unclear, but this hypothesis needs to be resolved with further research.”)³ were ignored, giving me the queasy feeling that these authors were trying to “pull a fast one” on us.

While I called their bluff on this issue, my real target was the surgical community at large, to remind us all to stick to

the facts and use the strictest methodology in our articles. Otherwise, it is all “fake news.”

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