Mean platelet volume to platelet ratio may not be reliable to determine the severity of fibrosis in patients with chronic hepatitis C

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Dear Editor,

We read with great interest the retrospective study of Gozdas and Ince about the mean platelet volume (MPV) to platelet ratio as a predictor of advanced fibrosis in patients with chronic hepatitis C [1]. The researchers found that MPV and some related calculations were higher in patients with severe fibrosis. We would like to emphasize some factors that may affect the results of this study.

First, this retrospective study examined the data in a very broad time interval (2011–2019) and in two different centers. It is well-known that preanalytical and analytical errors in retrospective studies adversely affect the reliability and validity of the research data. Undoubtedly, the distribution of study data in a very wide time interval and being carried out in two different centers should have negative effects. Also, the absence of a healthy control group in the statistical comparisons makes it difficult to understand the meaning of the difference between mild and advanced fibrosis groups.

More importantly, MPV measurements have not yet been standardized, and the lack of standardization of the time from blood collection to the measurement alters results significantly. It has been shown that the change in MPV in the first 5 min after contact with ethylenediaminetetraacetic acid can be up to 30% and this change continues incrementally up to 39 h [2]. Various publications have shown that differences in the time from venipuncture to measurement can alter MPV results by 2–50%.[2,3] Noris reported that it would not be appropriate to use it to diagnose or determination of acquired diseases due to lack of standardization in MPV measurement [4].

In conclusion, the use of MPV-based formulations may not be reliable to determine the severity of fibrosis in patients with chronic hepatitis C.

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Conflicts of interest

There are no conflicts of interest.

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Esophageal pneumatosis: a rare case of dysphagia

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We present a 71-year-old man, with history of cirrhosis (Child-Pugh A; Meld 16) and chronic obstructive pulmonary disease (COPD). No regular medication to report. He described a 3-month progressive dysphagia for solids, post-prandial vomiting and retrosternal discomfort while eating. The dysphagia sensation referred to the lower retrosternal area. Dysphagia for liquids, swallowing impairment and neurological dysphagia-related symptoms were denied. No further symptoms to report. Physical examination was normal. Laboratory analysis and thoracic X-ray were normal (Fig. 1). The upper endoscopy reported the presence of several areas of mucosal bulging, depressible to endoscopic compression, translucent, compatible with esophageal pneumatosis (Fig. 1a, b). The computerized tomography (CT) scan assessed disease extension, describing the presence of air only in esophagus wall (Fig. 1c). Patient was admitted for conservative management, based on a 'wait and see' approach, including zero diet, support fluid therapy and continuous monitoring. A progressive diet plan was successfully introduced in the fourth day and the patient was discharged for early reevaluation, after acknowledging alarm symptoms. In nearly 1-month period, total oral patency was reestablished