In addition, right ventricle dysfunction and mitral valve disease (both tricuspid regurgitation and PAPs is a strong determinant of functional tricuspid regurgitation severity. It is well established that pulmonary hypertension is an important cause of functional tricuspid regurgitation, and its severity (our biostatistician whose name is revered amongst the co-authors approved the above remarks). We believe that Dr. H. Sadeghian is also aware that factors such as initial MS grade, mitral valve area, and MS severity change all affect TR severity improvement through changes in the pulmonary artery pressure and no one can claim that these factors directly affect the tricuspid valve in the right heart side.

With respect to pulmonary artery hypertension, we agree that in the references cited in the paper, PAPs > 35 mmHg is defined as elevated PAPs. We found it reasonable to use this cut point to define pulmonary artery hypertension in the same manner as many other studies.7-10 We would believe that if every investigator is restricted to define the study variables as guidelines, no new findings and conclusions can be added to our knowledge and future guidelines. In this study, we grouped the patients based on PAPs > 35 mmHg so as to report only the frequency of the patients with pulmonary artery hypertension. We applied PAPs as a continuous variable in determining the cut-off value of the amount of PAPs reduction in relation with TR severity improvement, which means that even changing the definition would not influence the achieved cut-off point.

Finally, we should stress that all the patients with right ventricular dysfunction were excluded from the study. Also, no difference was found between the men and women regarding changes in PAPs and TR severity. These should have been mentioned in the method section, and we are grateful to have the opportunity to explain it in this reply.

We hope these lines will allow the esteemed readers to better understand the views mentioned.

References

2. American college of cardiology/American heart association task force on practice guidelines; Society of cardiovascular...
In addition, right of PAPs reduction showing TR severity improvement; and PAPs is expected to decline following MBV. In the mentioned PAPs and the higher the severity of TR grade. The increased higher the severity of mitral stenosis (MS), the higher the of increased PAPs secondary to severe mitral stenosis; the that in these patients, functional TR has been a consequence valvoplasty (MBV). Our analysis was on the basis of the fact patients with mitral stenosis who underwent mitral balloon mitral stenosis and regurgitation). Our study was aimed, as the manuscript title clearly reflects, regard changes in PAPs and TR severity. These should have no difference was found between the men and women re ventricular dysfunction were excluded from the study. Also, influence the achieved cut-off point. We studied a sample of patients with mitral stenosis who underwent mitral balloon valvoplasty (MBV). Our analysis was on the basis of the fact that in these patients, functional TR has been a consequence of increased PAPs secondary to severe mitral stenosis; the higher the severity of mitral stenosis (MS), the higher the PAPs and the higher the severity of TR grade. The increased PAPs is expected to decline following MBV. In the mentioned study, we presented a possible cut-off point for the amount of PAPs reduction showing TR severity improvement; and the ROC (receiver-operating characteristic) analysis, which demonstrated a cut-off point of $\geq 19$ mmHg reduction in PAPs with a 71.9% specificity and 52.7% sensitivity, might show at least a one-grade regress in TR severity. It is deserving of note that we did not claim that we would aim either to identify the predictors of TR improvement or to find out the factors in association with PAPs. It is obvious that the determination of the predicting factors for the improvement of TR severity or the factors associated with increased PAPs (none of them was the aim of this study) requires a large sample size. Hopefully in the near future with a large study population, we will be able to present all the potential predicting factors for TR severity improvement in patients suffering from TR for any reasons, not just organic MS and its severity (our biostatistician whose name is revered amongst the co-authors approved the above remarks). We believe that Dr. H. Sadeghian is also aware that factors such as initial MS grade, mitral valve area, and MS severity change all affect TR severity improvement through changes in the pulmonary artery pressure and no one can claim that these factors directly affect the tricuspid valve in the right heart side.

With respect to pulmonary artery hypertension, we agree that in the references cited in the paper, PAPs $> 35$ mmHg is defined as elevated PAPs. We found it reasonable to use this cut point to define pulmonary artery hypertension in the same manner as many other studies. We would believe that if every investigator is restricted to define the study variables as guidelines, no new findings and conclusions can be added to our knowledge and future guidelines. In this study, we grouped the patients based on PAPs $> 35$ mmHg so as to report only the frequency of the patients with pulmonary artery hypertension. We applied PAPs as a continuous variable in determining the cut-off value of the amount of PAPs reduction in relation with TR severity improvement, which means that even changing the definition would not influence the achieved cut-off point.

Finally, we should stress that all the patients with right ventricular dysfunction were excluded from the study. Also, no difference was found between the men and women regarding changes in PAPs and TR severity. These should have been mentioned in the method section, and we are grateful to have the opportunity to explain it in this reply.

We hope these lines will allow the esteemed readers to better understand the views mentioned.

**References**

2. American college of cardiology/American heart association task force on practice guidelines; Society of cardiovascular


4. Trichon BH, O’Connor CM. Secondary mitral and tricuspid regurgitation accompanying left ventricular systolic dysfunction: is it important, and how is it treated? Am Heart J 2002;144:373-376.


Arezou Zoroufian
Assistant Professor of Cardiology
Department of Cardiology
Tehran Heart Center
North Kargar Street
Tehran
Iran
1411713138
Tel: +98 21 88029256
Fax: +98 21 88029256
E-mail: arezou.zoroufian@yahoo.com