Guidelines for Diagnosis of Takotsubo (Ampulla) Cardiomyopathy

To the Editor:

We congratulate Dr Kawai and colleagues on their guidelines for diagnosis of takotsubo (ampulla) cardiomyopathy (TC),1 which give a concise overview of the important clinical issues in the diagnosis of this disease entity. Respectfully we would like to make the following comments. It seems that there is a tendency towards overemphasizing the importance of “apical ballooning”. In fact, the authors entirely excluded variants of TC without apical involvement (also called inverted takotsubo) from their guidelines. As the guidelines were approved in 2004, we assume that the importance of variants of TC was probably underestimated at that time. In our experience variants are quite common. Data from the German Registry on Takotsubo Cardiomyopathy presented by Schneider et al2 at the 73rd Annual Meeting of the German Society of Cardiology in Mannheim revealed that about one-third of patients with TC present with variants of the disease. Besides, even in classical TC careful examination of the left ventricular angiogram will reveal that in an occasional patient the true apex is not akinetic but rather hypokinetic (Fig 1). In these patients “apical ballooning” is rather a misnomer.

Another important issue is the exclusion of patients with significant coronary artery disease. We have recently described 4 patients with TC who also had >50% diameter stenosis of the left anterior descending (LAD) artery.3 Coronary artery disease and TC may coincide and are not mutually exclusive entities. An incidental finding of a lesion in the LAD, even if significant, should not automatically lead to the dismissal of a diagnosis of TC. In their set of diagnostic criteria, Abe and Kondo4 have proposed ischemic myocardial stunning as an exclusion criterion. Endorsing this proposal, instead of a strict exclusion of patients with significant coronary artery disease, will leave room for a case-by-case decision process in everyday clinical practice.

References


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