To the Editor:

It was refreshing to read the paper by Kato et al recently published in the Journal, about focal takotsubo syndrome (TTS) in 10 patients out of a total of 144 patients, 85 of whom had apical TTS, and 49 who had the mid-ventricular TTS variants. The authors, who have previously published on the focal type of TTS, as have some other workers, emphasized the difficulties of differentiating the focal variety of TTS from an aborted acute myocardial infarction (MI) in the absence of underlying coronary artery disease (CAD). It is not surprising that the mean left ventricular ejection fraction (LVEF) of the patients with focal TTS was higher than in those with the other 2 variants of TTS, considering that the focal variant reflected a smaller myocardial territory transiently involved with the disease. It would have been informative if the authors had provided levels of troponin rise (measured in 137 patients) in the 3 different variant TTS groups, to explore whether the focal TTS patients had the lowest troponin rise, which would parallel their highest LVEF.

The authors were very careful in defining focal TTS, and distinguishing it from aborted MI in the absence of obstructive CAD or severe spasm, and stressed the importance of using biplane left ventriculography, or in its absence, cardiac magnetic resonance imaging, or single-photon emission computed tomography, using 123I-metaiodobenzylguanidine or 123I-β-methyl iodophenyl pentadecanoic acid. However, they admitted that “there may be patients with focal TTS who have regional wall motion abnormality only in the anterolateral segment or the basal-septal segment” and that “focal TTS might be observed in other segments”. And in this respect querying their catheterization database, searching for focal TTS in other territories, may be enlightening. Also, the authors found that focal TTS is not rare, and this phenotype may be an atypical or milder form of TTS.

Finally, one wonders whether focal TTS could be present as a “comorbidity phenotype”, or “TTS component” in patients with an acute MI, involving the myocardial territory contralateral to the MI, and in this respect the authors could further their concept of focal TTS by querying their database of patients with obstructive CAD and acute MI. Indeed, such patients exist and relevant cases have been published.

Conflict of Interest

There is nothing to disclose that could be construed as a conflict of interest in connection with the submission of this letter.

References


John E. Madias, MD
Icahn School of Medicine at Mount Sinai, New York, NY; The Division of Cardiology, Elmhurst Hospital Center, Elmhurst, NY, USA
(Released online July 26, 2016)