We thank Dr Madias for his valuable comments on our paper recently published in Circulation Journal.1 We would like to respond to his important recommendations.

We retrospectively analyzed the cardiac catheterization databases of 3 hospitals. Troponin measurements, such as troponin I or T and qualitative or quantitative, were different. Thus we could not compare troponin levels among the different types of takotsubo cardiomyopathy.

We excluded patients with wall motion abnormality in the anterolateral segment in the right anterior oblique projection on left ventriculography but no wall motion abnormality in the septal segment in the left anterior oblique projection. Thus we might miss focal takotsubo cardiomyopathy with wall motion abnormality only in the anterolateral segment. In fact, we excluded 7 patients with this type of wall motion abnormality. Typical clinical features of takotsubo cardiomyopathy, such as older woman and preceding stress, may be helpful for diagnosis, but not all patients have these features. Thus, it may be difficult to differentiate focal takotsubo cardiomyopathy involving only the anterolateral segment from aborted myocardial infarction in the diagonal branch with absolute accuracy. It is required to find a diagnostic method for this issue.

It is possible that focal takotsubo cardiomyopathy is observed in other segments. Actually, in our database, there was a patient who had a focal wall motion abnormality localized from the mid-inferior to mid-lateral wall. In this case, focal takotsubo cardiomyopathy was confirmed using cardiovascular magnetic resonance imaging.2 Similar cases have been reported from other institutes. Further investigation should be conducted to evaluate the prevalence and clinical features of focal takotsubo cardiomyopathy in other segments.

Focal takotsubo cardiomyopathy may develop after a myocardial infarction that might play a role as a physical stress. We included only patients with wall motion abnormality in both the anterolateral and septal segments. To the best of our knowledge, focal takotsubo cardiomyopathy with wall motion abnormality only in the septal segment has not been reported. Thus it may be less likely that some of our cases developed focal takotsubo cardiomyopathy in the septal segment associated with myocardial infarction in the diagonal branch area. However, it is a very interesting issue and should be investigated.

Conflict of Interest
None declared.

References

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