Correspondence

Takotsubo Syndrome as a Comorbidity, and the Need for a Change in our Mindset

To the Editor:

The case report by Koci and colleagues,[1] about the 63-year-old woman who presented with abdominal pain and had subsequent evidence of pathologic cardiac conditions, should be read and thought about by all hospital clinicians who work in acute medical and surgical care. This case is indeed an instance of takotsubo syndrome as a comorbidity of another illness—surgical abdomen, in this example. We all need to change our mindset and realize that takotsubo syndrome can often present as a morbidity,[2] in either classic or milder forms.[3] Two areas merit particular attention.

First, the authors say that the patient's electrocardiogram (ECG) shows changes from an ECG recorded 2 years earlier.[1] Scrutiny of the tracing of the authors' Figure 1 reveals low-amplitude QRS complexes in all leads except V_2 and V_3. Low-amplitude QRS complex has recently been reported as a diagnostic feature of takotsubo syndrome,[4] and it is attributed mechanistically to myocardial edema, which is usually detected with use of cardiac magnetic resonance. It would be of interest to ascertain whether transient low-amplitude QRS complexes developed on this occasion in comparison with the patient's previous and subsequent ECGs. Second, the authors refer to "how essential bedside echocardiographic evaluation has become for acute management, especially in the emergency department."[1] One could even go further by suggesting that "focused cardiac ultrasound be implemented."[5] In this situation, many members of the hospital management team would use hand-held echocardiographic devices—frequently and early in the clinical course[6]—for all patients who have acute medical and surgical illnesses.

John E. Madias, MD, FACC,
Icahn School of Medicine at Mount Sinai,
New York, New York; and
Division of Cardiology,
Elmhurst Hospital Center,
Elmhurst, New York

References

1. Koci F, Eltibi R, Hadley M, Kumar D. Necrotic bowel induces takotsubo-like myocardial injury. Tex Heart Inst J 2014;41(6):638-40.
2. Madias JE. Why the current diagnostic criteria of takotsubo syndrome are outmoded: a proposal for new criteria. Int J Cardiol 2014;174(3):468-70.
3. Madias JE. Forme fruste cases of takotsubo syndrome: a hypothesis. Eur J Intern Med 2014;25(4):e47.
4. Madias JE. Transient attenuation of the amplitude of the QRS complexes in the diagnosis of takotsubo syndrome. Eur Heart J Acute Cardiovasc Care 2014;3(1):28-36.
5. Spencer KT, Kimura BJ, Korcarz CE, Pellikka PA, Rahko PS, Siegel RJ. Focused cardiac ultrasound: recommendations from the American Society of Echocardiography. J Am Soc Echocardiogr 2013;26(6):567-81.
6. Madias JE. Appropriate implementation of echocardiography in takotsubo syndrome: earlier and more frequently. Echocardiography 2013;30(10):1123-5.

http://dx.doi.org/10.14503/THIJ-15-5085

Letters to the Editor should be no longer than 2 double-spaced typewritten pages and should generally contain no more than 6 references. They should be signed, with the expectation that the letters will be published if appropriate. The right to edit all correspondence in accordance with Journal *style is reserved by the editors.*

http://prime-pdf-watermark.prime-prod.pubfactory.com/ | 2025-02-05