

## Letter to Editor

# Combinations of acute coronary syndromes and Takotsubo syndrome

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The timely and refreshing case report by Tota et al, published in the August 16 issue of the *Journal* [1], brings forth a matter that has occupied this author for some time, namely that there must exist combinations of acute coronary syndromes (ACS) and Takotsubo syndrome (TTS) (as “forme fruste” cases of TTS) [2-4]. The authors present a case of a 70 year old woman with subacute stent thrombosis (SST) of the right coronary artery and transient left ventricular apical ballooning with documentation of normal flow in the left and circumflex coronary arteries: thus here we have a case of a patient with an ACS and TS affecting different coronary territories! The authors are careful not to clearly state that the SST was the cause or a consequence of TTS; however they provide evidence from the literature that other acute cardiac or noncardiac pathologies in patients admitted in intensive care units have been associated with TTS, suggesting that such illnesses have acted as “triggers” (emotional or physical stresses) for the emergence of TTS. This author does not have much doubt that the SST caused the TTS, and intuitively it is unlikely that a case of TTS has mediated the SST in another vascular territory, although at this stage of thought evolution on the pathogenesis of TTS we should maintain an open mind. A closely linked matter is whether there are milder cases (i.e., formes frustes) of TTS in significant proportion of patients admitted with ACS. Indeed it is puzzling why some patients with an ACS and associated regional wall motion abnormalities (RWMAs) also reveal transient such RWMAs (hypokinesis or akinesis) in the contralateral myocardial plane to the left ventricular myocardial territory

affected by the ACS, instead of showing the expected compensatory hyperkinetic behavior. Are these cases of mild forms of TTS presenting in combination with traditional ACS? Finally of note is that the presented patient revealed transient attenuation of the QRS complexes in her precordial electrocardiogram (ECG) leads between admission and subsequent follow-up (compare the QRS complexes in leads V3-V6 in the ECGs, recorded 8 days apart of Figure 3A and 3B) [1], a possibly specific diagnostic, ECG sign of TTS, which has just been reported [5].

### Disclosure of conflict of interest

No potential conflict of interest relevant to this letter was reported.

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