Correspondence

Do older patients get takotsubo syndrome differently?

Monika Budnik#, Janusz Kochanowski, Martyna Zaleska, Grzegorz Opolski
1st Chair and Department of Cardiology, Medical University of Warsaw, Warsaw, Poland


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We read with great interest case report of 99-year-old patient with takotsubo syndrome (TTS) presented by Yenerçağ, et al.,[1] especially because four years ago, we described the oldest so far person diagnosed with TTS: a 98-year old woman.[2]

During analysis of your article a few comments and questions occurred to us.

TTS is usually preceded with a stress factor.[3] Do you know, or can you suspect the TTS cause in this patient? Was she diagnosed with primary or secondary TTS? TTS often occurs in people with ongoing or previous neurological or psychiatric disorder.[4] The patient had history of Alzheimer’s disease. Did she have any new neurological symptoms during described hospitalization? A very good diagnostic test for TTS is NT-proBNP to troponin I ratio.[5] The authors presented only troponin I level. Is the NT-proBNP level during following days known? There are no randomized trials regarding treatment of patients diagnosed with TTS. That is why this topic arouses controversy. Presented woman did not have any lesions in coronary arteries. Why did she receive dual antiplatelet treatment? What made you decide to continue this therapy after discharge? Additionally, the patient received 40 mg of enoxaparine twice a day. What was the creatinine level?

The elderly are always a diagnostic and therapeutic challenge. Mostly because of superposable symptoms of different diseases and comorbidity. Subjects over 75 constitute about 30% of all patients with TTS. We would highly appreciate your response to our questions.

References


Authors’ reply

Mustafa Yenerçağ, Uğur Arslan#, Güney Erdoğan, Onur Osman Şeker, Osman Can Yontar

Department of Cardiology, University of Health Sciences Samsun Training and Research Hospital, Samsun, Turkey

First of all, we want to thank the journal reader, who was the author reporting the former oldest takotsubo syndrome (TTS) patient, for her/his interest in our case report and constructive contribution to our article entitled “A 99-year-old patient with takotsubo cardiomyopathy recovering from cardiogenic shock” published in the Journal of Geriatric Cardiology in 2019.[1] In the guideline entitled “International expert consensus document on takotsubo syndrome: clinical characteristics, diagnostic criteria, and pathophysiology”,[2] it has been stated that an emotional, physical, or combined trigger may precede the takotsubo syndrome event, but this is not obligatory. We could not find an obvious trigger in
this patient, however emotional stress due to the Alzheimer’s disease might be a trigger for this patient. As we could not clearly identify a trigger, we thought that our patient has a primary TTS. In her follow-up, no new neurological symptom or disorder (i.e., subarachnoid haemorrhage, stroke/transient ischaemic attack, or seizures) developed. Biochemical measurement of NT-proBNP was not available in our hospital at that time, so we did not report about the BNP levels. As you have already mentioned, there are many controversies regarding about the treatment strategies due to lack of randomised trials. According to our clinical experience, we usually start dual antiplatelet therapy because of the non-critical plaques in the coronary angiogram and stop one of them, which is usually acetyl salicylic acid at the first month and continue with a single antiplatelet therapy (clopidogrel in most cases) for at least one year. Herein, we also gave 40 enoxaparine twice a day for three days to prevent thrombus formation in the large ballooning area. The patient weighed 90 kg and creatinine clearance was measured 70 mL/min, so it seemed to be relatively safe to give enoxaparine treatment despite her very old age.

References