Introduction

Takotsubo Syndrome is an acute heart failure that affects predominantly postmenopausal women. It is similar to acute coronary syndromes with ST segment elevations, therefore, it’s estimated that 1% to 2% of all acute coronary syndromes are Takotsubo cardiomyopathy. There’s also a relation to physical and psychological stress factors, without an exact physiopathology [1]. A previous RETAKO trial, observed that more than half of their patients had some type of psychological stress [2]. Takotsubo cardiomyopathy etiology has been divided between a primary and secondary form, with the former being caused by physical and psychic stress, as well as an idiopathic cause. This group has a better long term prognosis when compared to the secondary form, which includes sepsis, intracranial hemorrhage, cerebrovascular disease, recent surgery, or critical illness [3].

The hyperkinetic characteristics of the right ventricle’s function with cardiogenic shock can reflect an adaptive state due to a low left ventricle preload [4]. Kosuge’s electrographic criteria is used to differentiate between an acute infarction with an ST segment elevation and anterior topography with Takotsubo cardiomyopathy, which includes an ST depression at the aVR lead and an absence of an ST elevation at the V1 lead [5].

Case Presentation

64 year old female with the following history: Aguascalientes resident, married, house wife, chronic exposure to wood smoke, systemic arterial hypertension. Intense psychic stress during the week prior to admission. No chronic or degenerative diseases.

Problem on Admission

The patient begins with precordial pain associated with an ST segment elevation in her electrocardiograph, as well as a Troponine elevation. Thrombolysis was performed without reperfusion criteria, which afterwards developed into acute heart failure. Afterwards, she was sent to the Cardiology Unit of our hospital where we performed coronary angiography and ventriculography, which demonstrated intense apical dyskinesia and normal coronary arteries. We also found a left ventricle outflow tract obstruction through echocardiography. Due to the remission of the outflow tract obstruction, apical dyskinesia and acute heart failure, we concluded that our diagnosis was a case of Takotsubo cardiomyopathy.

Keywords: Takotsubo cardiomyopathy; Apical dyskinesia; Acute heart failure; Left ventricle outflow tract obstruction
echocardiogram where we observed a left ventricle outflow tract gradient of 91 mmHg, as well as apical dyskinesia (Figure 2 & 3).

Ventriculography also highlighted an intense apical diskinesia. After observing coronariography results, our differential diagnosis was of myocarditis versus Takotsubo myocardiopathy. After magnetic resonance imaging, we found a late highlight absence of the left ventricle at T2, as well as a short axis apical hyperintensity, such findings suggest Takotsubo cardiomyopathy, which also excluded myocarditis (Figure 4).

Coronariography

Due to the clinical status of the patient, electrocardiography signs and biomarkers, we decided to do a coronariography study, in which there was no evidence of angiographic injuries.

Magnetic Resonance Imaging

Four chamber apical cut at T2 phase where we observe an absence of a late highlight of the left ventricle (Figure 5). Short axis apical cut at black sequence phase where we observe a hyperintense highlight at the apical endocardium (Figure 6).

Figure 1: 12 Lead electrocardiograph with an ST elevation from V2 to V6, with an asymmetric inversion of T wave branches [1].

Figure 2: Left ventricle outflow gradient of 91 mmHg (Taken at admittance).

Figure 3: Left ventricle apical dyskinesia as seen with a 4 chamber apical view.

Figure 4: Left anterior oblique ventriculography with important apical dyskinesia.

Figure 5

Figure 6
Clinical Evolution

After our final test results, we began treatment for acute heart failure with diuretics, inotropics, vasodilators, did not require ventricular assist devices post-treatment improvement in one week. Our final diagnosis was of Takotsubo cardiomyopathy complicated with a dynamic obstruction of the outflow tract of the left ventricle, follow up was carried out at the outpatient cardiology clinic, with a two month follow up echocardiogram which showed gradient resolve at the outflow tract, therefore backing up our diagnosis.

Discussion

In this case, the main differential diagnosis was an acute coronary syndrome which was excluded when normal coronary arteries were found. Subsequently, a protocol for MINOCA (Myocardial Infarction With Non Obstructive Coronary Arteries) was performed. In the ventriculography an intense apical dyskinesia was observed, thus suspecting the syndrome of takotsubo which finally corroborated through magnetic resonance due to the absence of delayed enhancement with gadolinium and apical edema. Finally, we concluded that the trigger was a psychic stress event that the patient had attended the days prior to admission.

Conclusion

This particular case showed an interesting behavior of Takotsubo disease that mimicked an acute coronary syndrome, insomuch initial treatment was of thrombolysis. Despite this, after initial studies and usage of Mayo Criteria, we concluded that the diagnosis was of Takotsubo cardiomyopathy, complicated with a dynamic obstruction of the left ventricle outflow tract, a disease described in current literature as rare and transitory, just as presented in our case study.

References