LETTER TO THE EDITOR

Other correlates of “lambda wave” in patients with takotsubo syndrome?

Dear Editor,

I read with great interest the report by Tarantino et al. (2018), about the correlates of electrocardiogram (ECG) “lambda wave” (LW) in five patients out of 158 patients admitted with takotsubo syndrome (TTS); peak ST-segment elevation (+ST) of LW was reached by 6 hr, after admission, with a peak between 6 and 12 hr, and gradual decrease by 24 hr, and was associated with higher prevalence of physical stressors, admission and peak levels of troponin I levels, and in-hospital adverse events, with one patient developing endo-ventricular thrombosis, and two dying with cardiogenic shock, and higher long-term follow-up adverse events compared to the remaining 153 patients (Tarantino et al., 2018). I have a few comments/questions for the kind consideration of the authors: (a) did the LW patients present to the hospital earlier than the rest? (b) the LW has some resemblance with the “spiked helmet” ECG marker described in the past in association with the very early phase of an acute anterior myocardial infarction, resuscitation from ventricular fibrillation, in the midst of ventricular tachycardia, seizures, sudden death, a stormy clinical course, high mortality, TTS, Prinzmetal's angina, and the early phase of experimental coronary occlusion in the dog (Madias, 2018); (c) was there any chest pain during the time duration of LW, particularly at its onset? (d) one wonders whether nitroglycerine has any effect on the LW; (e) did any fortuitous echocardiography performance at the time LW was present detected localized left ventricular dyskinesis, instead of akinesis (Madias, 2013)? (f) since the authors are referring to the stellate ganglia activation, in the future monitoring of the sympathetic autonomic input to the heart, using ECG based technology (Madias, 2017), may be of value; (g) since the amplitude of QRS complexes of the two patients depicted in fig. 4 of the paper (Tarantino et al., 2018) show some changes over the course of hospitalization, and the one in fig. 4b shows low-amplitude in both limb and precordial leads, it would be of interest to compare the ECGs in these five patients, recorded in the hospital with the ones prior to admission and the ones recorded at post-discharge follow-up, in regard to transient low-amplitude QRS complexes in connection with TTS, attributed to myocardial edema (Madias, 2014).

DISCLOSURES

None.

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