

A Minimum Difference Between 2 Syndromes

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To the Editor:

We are grateful to Kotsiou et al [1] for their excellent explanation of the similarities and differences between Kounis syndrome and Takotsubo syndrome. The information these authors provide in their letter will be of enormous help to the scientific community and will play a key role in educating health professionals about these syndromes.

With respect to the case we reported [2], I agree that the diagnosis could be Takotsubo syndrome, because it shares several clinical and diagnostic criteria with Kounis syndrome. Although full details are not provided in our case report, the patient underwent ergometry with echocardiography before and after the test while he was an inpatient, and the results were normal. Consequently, we ruled out the diagnosis of Takotsubo syndrome, because the diagnostic criteria defined by Abe and Kondo [3] and after that by researchers from the Mayo Clinic [4,5] are as follows:

1. Transient hypokinesia, akinesia, or dyskinesia in the left ventricular mid segments with or without apical involvement; regional wall motion abnormalities that extend beyond a single epicardial vascular distribution; and frequently, but not always, a stressful trigger
2. Absence of obstructive coronary disease or angiographic evidence of acute plaque rupture
3. New ECG abnormalities (ST-segment elevation and/or T-wave inversion) or modest elevation in cardiac troponin
4. Absence of pheochromocytoma and myocarditis

Obviously, with the absence of this complementary study, the diagnosis could be Takotsubo syndrome or Kounis syndrome. However, the echocardiography-confirmed myocardial function rules out Takotsubo syndrome, because ergometry and/or electrocardiography can be temporally altered in this condition.

On the other hand, and depending on the etiology reported, Takotsubo syndrome can occur after a stressful trigger, including sepsis, although it is typically described in patients experiencing very intense emotional or physical stress [4,6-10].

No association with drug intake has been reported, unless this occurred in patients with sepsis.

To conclude, I also agree with the observations of Kounis et al [11] in their recent article on Kounis syndrome after intake of levofloxacin, because it is very important to improve our knowledge of Kounis syndrome and other similar syndromes associated with the release of mediators, as is the case in Takotsubo syndrome. A firm diagnosis is essential in order to improve treatment and prevent new cases (if this is at all possible) and deaths diagnosed as acute and severe myocardial infarction. A comprehensive clinical report and *in vivo* and *in vitro* complementary tests could facilitate clinical practice in these conditions.

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Conflicts of Interest

The authors declare that they have no conflicts of interest.

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