Myocardial noncompaction recognized following a transient ischemic attack

Thromboembolism in young patients with noncompaction cardiomyopathy: more than what we thought

Dear Editor,

I read with interest the case report by Karabulut et al.[1] about a transient ischemic event in a young man with noncompaction of the ventricular myocardium (NCVM). Although this complication was well documented by Oechslin et al.[2] its occurrence in children and young adults is still probably underestimated. The presence of multiple trabeculations with deep intertrabecular recesses leads to blood stagnation and clot formation as was previously reported in three pediatric patients (Figure).[3] It is well documented that the left ventricle function may improve within days of presentation,[3,4] but this event may then provoke embolization, which was reported in children as young as 2 years of age. Serious or even fatal outcome may ensue when the left ventricle thrombus is large, and immediate anticoagulation or thrombolysis should be instituted.[5] Routine use of anticoagulation drugs in NCVM is controversial;[6] however, if there is poor ejection fraction, anti-platelet therapy is mandatory. Awareness about this important life-threatening complication of NCVM in young patients can help prevent/reduce mortality and morbidity.

Sincerely,

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REFERENCES
Dear Editor,

We read with interest the article by Çölkesen et al. [1], which is the first study in the literature evaluating cardiac functions by tissue Doppler echocardiography in the early postoperative period of major lung resection (up to 3 months).

We want to comment on some weak points about the inclusion and exclusion criteria of the patients.

1. In the Methods section, it is clearly stated that patients with diastolic dysfunction were excluded. However, data in Table 2 for preoperative echocardiographic findings include the following:

   - Mitral diastolic velocities (E velocity 90±23 cm/sec, A velocity 92±23 cm/sec)
   - Tricuspid diastolic velocities (E velocity 67±13 cm/sec, A velocity 65±19 cm/sec).

   Tissue Doppler diastolic parameters:

   - Mitral annulus (E’ 9±2 cm/sec, A’ 10±2 cm/sec)
   - Tricuspid annulus (E’ 9±2 cm/sec, A’ 15±3 cm/sec)

   When we analyze these data, we see that the mean values of E and A are close to each other for both mitral and tricuspid diastolic velocities, and the mean value of E’ is smaller than A’.

   Based on these findings, we consider that the patients meet the criteria for stage II diastolic dysfunction (pseudonormal pattern). Therefore, we want the authors to define the method they used to exclude diastolic dysfunction, other than they mentioned in the article.

2. The authors state that patients with an FEV1/FVC ratio less than 0.60 were excluded to avoid right heart modifications related to “severe” chronic obstructive pulmonary disease (COPD). However, it is known that the presence of airflow limitation is defined by a postbronchodilator FEV1/FVC <0.70. According to the criteria for staging the severity of COPD, the FEV1 value must be used. The spirometric classification based on FEV1 for the severity of COPD includes four stages:

   - Stage I: Mild (FEV1/FVC <0.70 and FEV1 ≥80% predicted)
   - Stage II: Moderate (FEV1/FVC <0.70 and 50%≤ FEV1<80% predicted)
   - Stage III: Severe (FEV1/FVC <0.70 and 30%≤FEV1 <50% predicted)
   - Stage IV: Very severe (FEV1/FVC <0.70 and FEV1<30% predicted or FEV1 <50% predicted plus chronic respiratory failure).

   For this reason, to avoid right heart modifications related to severe COPD, we suggest that the authors use FEV1 values for exclusion of severe COPD (stage III and IV).

Sincerely,

On behalf of the authors,
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