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## Bizarre ST elevation

To the Editor,

We have read the case report with great interest (1). We have some comments regarding the electrocardiography ST elevation pattern presented in the report. We have a little suspicion about an alternate diagnosis. There are near-identical electrocardiography samples in different case reports with the diagnosis of hypertrophic cardiomyopathy (2, 3). Presence of notching at precordial lead V3 may support anterolateral or apical hypertrophic cardiomyopathy. Further, presence of fibrosis at apical or anterolateral hypertrophic cardiomyopathy on cardiac magnetic resonance imaging (MRI) is consistent with notching at lead V3 (4). In this case, authors did not mention about cardiac MRI. If they performed cardiac MRI in this patient, results may suggest apical or anterolateral hypertrophic cardiomyopathy. In addition, we know that obtaining good echocardiographic image in older patients is difficult. Therefore, taking good image at unusual localization of hypertrophic car-

diomyopathy and especially apical or anterolateral hypertrophic cardiomyopathy with transthoracic echocardiography has important limitations for making diagnosis (5, 6). HCM is associated with a thick and noncompliant left ventricle (LV) resulting in some degree of diastolic dysfunction in nearly all patients. Therefore, patients with HCM are particularly dependent on normal atrial kick to provide optimal LV filling and cardiac output. Patients with HCM are prone to both atrial and ventricular arrhythmias (7). This phenomenon causes atrial dilatation in patients with HCM. In the presented case, the patient has biatrial dilatation and atrial fibrillation. These findings might be due to HCM. At these instances, in the case of diagnosis, cardiac MRI is required to clarify the diagnosis. With the findings mentioned at this paper, the authors' diagnosis of early repolarization abnormality is suspicious and calls for more evidence.

 Özgür Yaşar Akbal,  Berhan Keskin,  Aykun Hakgör,  
 Ali Karagöz

Department of Cardiology, Koşuyolu High Specialization Training and Research Hospital; Istanbul- Turkey

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**Address for Correspondence:** Dr. Ali Karagöz,  
Koşuyolu Yüksek İhtisas Eğitim ve Araştırma Hastanesi,  
Kardiyoloji Bölümü,  
Denizer Cad. Cevizli Kavşağı, 34865 Kartal,  
İstanbul- Türkiye  
Phone: +90 531 790 92 25  
E-mail: draliko@yahoo.com



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