pISSN 1975-4612/ eISSN 2005-9655
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www.kse-jcu.org

http://dx.doi.org/10.4250/jcu.2016.24.1.88

LETTER TO THE EDITOR J Cardiovasc Ultrasound 2016;24(1):88-89

# Response to Letter Regarding Article, "Biventricular Takotsubo Cardiomyopathy Associated with Epilepsy"

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We appreciated the interest of you in our case report.[1] Fortunately, we had the previous electrocardiogram (ECG) checked in another hospital 7 years ago, in which there was no Q-waves in leads V1–3 and normal amplitude QRS complexes in limb leads (Fig. 1). Until discharge, we checked the serial ECGs and the ECG of her 2 days of hospitalization started to develop

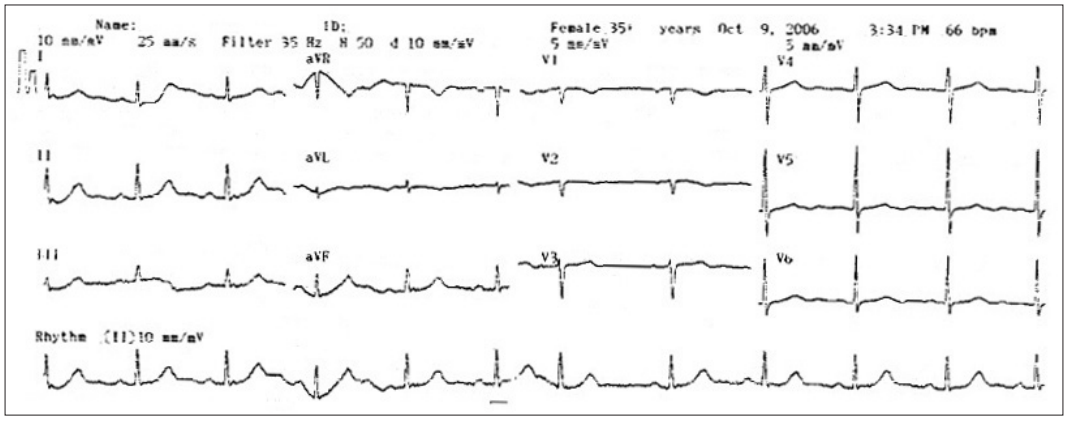


**Fig. 1.** An electrocardiogram taken 7 years ago.

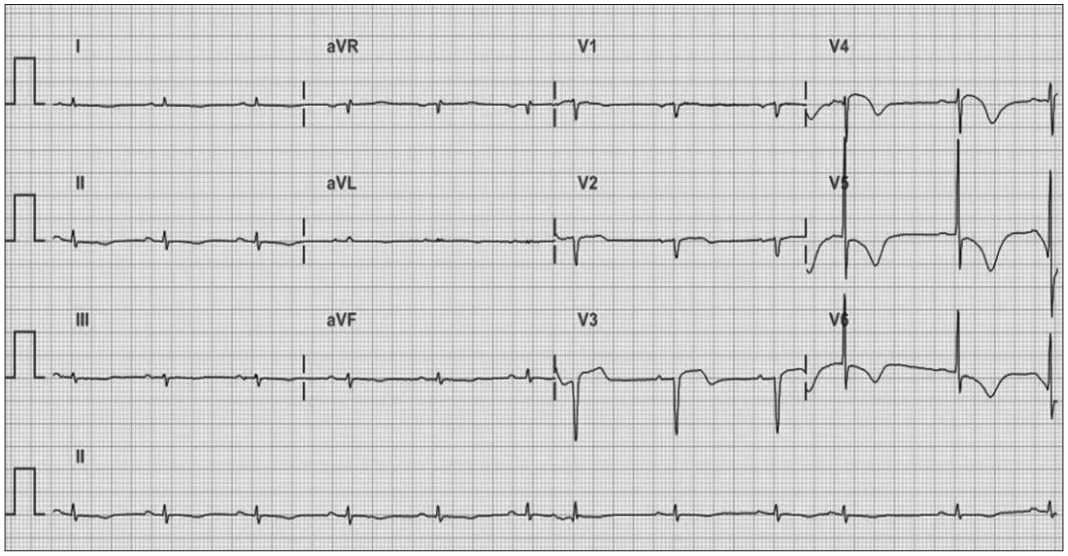


**Fig. 2.** An electrocardiogram obtained before hospital discharge.

• Received: February 18, 2016 • Revised: February 22, 2016 • Accepted: February 23, 2016
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T-wave inversion in leads V5–6 and QT prolongation. The last ECG in our hospital showed persistent low QRS voltages in limb leads and T-wave inversions and QT prolongation in leads V4–6. Also, we found that Q-waves in leads V1–3 lasted despite disappearance of ST segment elevations in V1–3 (Fig. 2). I do not have much clinical experience and have not yet met the patient with recurrent Takotsubo syndrome (TTS) and forme fruste cases of TTS.[2] I agree with the idea that the patients with recurrent chest pain and/or dyspnea and normal coronary artery can be diagnosed as TTS. It is not feasible to evaluate the echocardiography as soon as developed chest pain and/or dyspnea, "smartphone-based technology" is considered a very useful for diagnosis of unexplained chest pain and/or dyspnea especially in Korea, because Korea is one of the countries with the highest smartphone penetration in the world.[3]

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