incomplete block along the mitral isthmus line because of the risks and inability of getting close to the mitral prosthesis, as we mentioned in the Discussion section of our original study (1). However, surgical scarring in the MVP group, combined with eventual incomplete block, could very well facilitate complex macro-reentrant arrhythmias. Finally, in our Conclusions section, we acknowledge the fact that AF ablation should ideally be performed at the time of MV replacement when feasible.

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Myocardial Infarction in the Absence of Obstructive Epicardial Coronary Disease

We read with interest the study by Dokainish et al. (1) reporting characteristics and outcomes of patients with acute coronary syndromes in the absence of obstructive epicardial coronary disease in a post hoc analysis of the TACTICS-TIMI-18 trial. Six percent of patients presenting with an apparent acute coronary syndrome (ACS) and troponin elevation were found to have no significant epicardial disease at angiography. These patients were more likely to be female, and rates of death and reinfarction were lower in this group at six months when compared with those who had angiographically significant coronary disease, regardless of troponin elevation.

The investigators discuss potential mechanisms of myocardial infarction in patients without significant epicardial coronary disease, but they do not consider transient left ventricular apical ballooning syndrome (TLVABS) as a potential explanation in some of these patients (2–6). In a recent systematic review of TLVABS, we and others have pointed out that these patients are typically postmenopausal females who present with acute-onset ischemic cardiac symptoms, electrocardiographic changes, mildly elevated cardiac biomarkers, and characteristic yet transient apical and midventricular wall motion abnormalities in the absence of obstructive epicardial coronary disease (7). The risk of mortality associated with the syndrome appears to be low and recurrence uncommon. It may be that some of the reported patients presenting with an apparent ACS with troponin elevation in the absence of obstructive epicardial coronary disease had TLVABS, which in turn may explain the observed lower rates of mortality and reinfarction in this patient cohort.

Finally, TLVABS is underrecognized and should be considered in the differential diagnosis of patients presenting with an apparent ACS in the absence of obstructive coronary artery disease. The mechanisms responsible for TLVABS are unknown and deserve further investigation.

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Lack of Prognostic Impact of Elevated Troponin Levels in Patients Without Coronary Artery Disease

The study by Dokainish et al. (1) addresses an interesting subgroup of patients with acute coronary syndromes (ACS), namely those with elevated troponin but without significant coronary artery disease (CAD) on angiography. The investigators conclude that a 6.3% incidence of death, reinfarction, and rehospitalization in this patient cohort. However, surgical scarring in the MVP group, combined with eventual incomplete block, could very well facilitate complex macro-reentrant arrhythmias. Finally, in our Conclusions section, we acknowledge the fact that AF ablation should ideally be performed at the time of MV replacement when feasible.

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