Author’s response to reviews

Title: Basal wall hypercontraction of Takotsubo cardiomyopathy in a patient who had been diagnosed with dilated cardiomyopathy: a case report

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Author’s response to reviews:

Response to the Editor’s Comments

Q1

Please provide a CARE checklist with the revised version.

Response to Q1

We added the CARE Checklist with the revised manuscript.

In addition, according to the CARE checklist, we changed the title as follows.

In the original manuscript
Basal wall hypercontraction of Takotsubo cardiomyopathy in a patient who had been diagnosed with dilated cardiomyopathy
In the revised version of the manuscript

Basal wall hypercontraction of Takotsubo cardiomyopathy in a patient who had been diagnosed with dilated cardiomyopathy: a case report

Response to the Reviewers’ Comments

Response to the Reviewer 1

Q1

The authors present an interesting case of transient takotsubo cardiomyopathy in a patient with pre-existing nonischemic dilated cardiomyopathy. It is certainly intriguing to see that the basal segment of the left ventricle which was hypocontractile at baseline, became hypercontractile transiently, and then reverted back to baseline. This case adds to the growing body of literature on stress induced cardiomyopathy.

Response to Q1

Thank you very much.

Response to the Reviewer 2

Q1

The authors should be congratulated for reporting a very rare and previously unreported case of Takotsubo cardiomyopathy in a patient with pre-existing idiopathic dilated cardiomyopathy.

Response to Q1

Thank you very much.

Q2

Page 4 Line 39: "Eft ventriculography" - should be read as "left ventriculography"
Response to Q2
We apologize for our carelessness.

We changed the sentence as follows.

In the original manuscript
…and basal hypercontraction were demonstrated by eft ventriculography…

In the revised version of the manuscript
…and basal hypercontraction were demonstrated by left ventriculography…

Q3
Page 5, Line 39: What do authors mean by "typical chest symptoms"? There is no such standardized term in medicine, please re-word if they mean "typical symptoms of acute coronary syndrome or obstructive coronary disease or anginal chest pain"

Response to Q3
As the reviewer pointed out, we changed the sentence as follows.

In the original manuscript
…may not be able to be recognized or diagnosed when it is not associated with typical chest symptoms…

In the revised version of the manuscript
…may not be able to be recognized or diagnosed when it is not associated with anginal chest pain…
Q4
How was this patient managed in the hospital for 15 days? Please briefly describe the hospital course.

Response to Q4

We added following sentence regarding how the patient was cared during hospitalization.

In the revised version of the manuscript

In addition to the treatment with diuretic drugs, the patient was treated with anticoagulant drugs because of the thrombus formation in the left ventricular apex – intravenous administration of heparin for 12 days followed by the oral administration of warfarin. Administration of beta blocker, bisoprolol, was also started.

Q5
Are videos available of the echos/angiograms? If yes and the journal permits, these would be very beneficial.

Response to Q5

We apologize for that the video information of echocardiography is not readily available. For ventriculography, the apical wall hyperkinesis, we hope, may be apparent in the photographic image in Figure 2.

Q6
Was there a precipitating trigger/stressor for the takotsubo cardiomyopathy during the current admission?

Response to Q6

Although the patient did not have apparent triggering event, she might have had asthma attack before the occurrence of heart failure, and she had been treated with anti-asthma medication for a few days. On the other hand, that episode might be, in fact, heart failure symptom, and as we are not very sure of the presence of asthma attack, it was not described as the past history.

There were no apparent psychological triggering events.
Q7
At the time of discharge, did LV function return to normal or did it return to baseline (same as 1 year ago?) - are echo pictures available from that time (1 year ago).

Response to Q7
Thank you for the comment.
As shown in the Figure 3C, the apical ballooning that was observed on admission (Figures 2B, C) was ameliorated on day 15, before the discharge.

Q8
In the table depicting laboratory values - were troponins measured serially? If yes, please add that to the table.

Response to Q8
Thank you for the comment.
Troponins were not measured repeatedly.

Q9
The anterior deep T wave inversions did not return to baseline (2.5 years ago) at the time of discharge - based on the ECG shown. Was another follow up ECG obtained? What do the authors think on this finding - please describe in the discussion section briefly.

Response to Q9
Thank you for the valuable comment.
The extent of T-wave inversion was getting less prominent, and ECG 3 months after the discharge was returned to normal and kept being normal at 8 month after the discharge.

We added the following sentence in the revised manuscript.

In the revised version of the manuscript
Finding of electrocardiogram, T-wave inversion, normalized at 3 months after the discharge and it remained normal at 8 months after the discharge.