Dear Readers,

I have always found it challenging to find the best strategy for sudden cardiac prevention in patients with new diagnosed or potentially reversible cardiomyopathies. At least on one occasion I have encountered the situation where the insertion of an implantable cardioverter-defibrillator (ICD) seemed unnecessary few months after the device was implanted. On the other hand, I have had the unfortunate incidence of a fatal or near fatal arrhythmia occurring in a patient where an ICD was not implanted because of a cardiomyopathy that was thought to be reversible. While robust data exist to guide the management of patients with long-standing cardiomyopathies, the literature is sparse regarding the treatment of patients with newly diagnosed or potentially reversible cardiomyopathies. Many studies have demonstrated that the risk of sudden cardiac death is significant early after the diagnosis of cardiomyopathy. Conversely a recent study have showed that up to 25% of patients who receive ICDs for primary prevention no longer meet guideline indications for ICD use at the time of generator change.

Patients with Takotsubo cardiomyopathy or stress-induced cardiomyopathy represent a perfect example of this treatment dilemma. This form of cardiomyopathy has been increasingly recognized as a form of reversible cardiomyopathy with an overall favorable prognosis. Full recovery and normalization of the ejection fraction occurs in a large percentage of patients. However mortality has been reported in up to 8% in some studies. Ventricular arrhythmias are not uncommon with this disease and occur in more than 9% of the patients. As a result of these opposing realities the decision on the optimal strategy for sudden cardiac death prevention in these patients can be difficult. Committing a patient to an ICD for a condition that may be reversible can lead to significant predicament.

The article by Deeprasertkul et al. in this issue of the Journal of Innovations in Cardiac Rhythm Management represents an important step towards a better understanding of the nature and history of arrhythmias in patients with Takotsubo cardiomyopathy. The authors demonstrated that this form of cardiomyopathy is associated with a significant risk of death due to tachyarrhythmias. They also reported that wearable cardioverter-defibrillators were used with high compliance and detected ventricular arrhythmias reliably. I believe that this article is hypothesis-generating and motivates the design of a randomized study to investigate the role of wearable defibrillators in this population. More importantly this report brings attention to the need to generate new studies and guidelines to help with the determination of the optimal approach for sudden cardiac death prevention in early cardiomyopathies in a broader patient population that is not limited to Takotsubo cardiomyopathy.

As always, I hope that you find this issue of the Journal beneficial to you and your practice. Best wishes for a great summer.

Warm regards,

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