

A FIRST CASE OF INCIDENTAL CEREBRAL ANEURYSM AFTER TAKOTSUBO CARDIOMYOPATHY: A CASE REPORT

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INTRODUCTION

Takotsubo syndrome is an acute heart disease that mimics the typical features of acute coronary syndrome (ACS) [1]. Although takotsubo syndrome has an uncertain prevalence in the general population, in women with suspected ACS, the prevalence is estimated to be around 5-6% [2]. The annual incidence is very low and is approximately 0.02% [3][4].

Unlike ACS, TS is reversible and the heart often heals within four to eight changes weeks. The syndrome is characterised by transient systolic and diastolic left ventricular dysfunction with wall motion abnormalities [5][6]. This condition, which was first described by Dote et al. in Japan in 1990 [3][4], usually affects postmenopausal women who have experienced some physical or psychological stress. However, it can also occur in the absence of these triggers [1][7].

The prevalence of saccular aneurysms in the general population is estimated at 3.2%. Approximately 20 to 30% of cases present in the form of multiple aneurysms [8]. Intracranial aneurysms are generally diagnosed after episodes of subarachnoid haemorrhage (SAH), which causes a high rate of morbidity and mortality [9]. Rupture of an aneurysm is believed to be responsible for 0.4 to 0.6% of all aneurysm deaths, and approximately 10% of patients die before arriving at the hospital. [10]

Takotsubo syndrome is generally reported to have an incidence of 0.8-17% in patients with SAH caused by ruptured aneurysm [11]. However, this case report is relevant for the clinical and pathophysiological observation of the possible association between aneurysms of the internal carotid arteries (ICA) and TS, with the latter being able to serve as an alert for possible aneurysms and thus allow for intervention prior to disruption.

CASE PRESENTATION:

A 54-year-old female had a history of systemic arterial hypertension and migraine. She had previously been treated with atenolol 25 mg once daily and hydrochlorothiazide 25 mg once daily. She sought medical care at a secondary hospital due to chest pain, which began suddenly 2h before admission and had irradiated to the left upper limb and back. The initial electrocardiogram (EKG) was normal but showed a troponin curve (33,38 ng/l, 26,42 ng/l, 13,82 ng/l), which led to the hypothesis of non-ST elevation myocardial infarction, Killip I. Loading doses of acetylsalicylic acid (ASA) 300 mg, clopidogrel 300 mg, enoxaparin 60 mg, and nitroglycerin were administered intravenously due to persistent pain. The patient was later

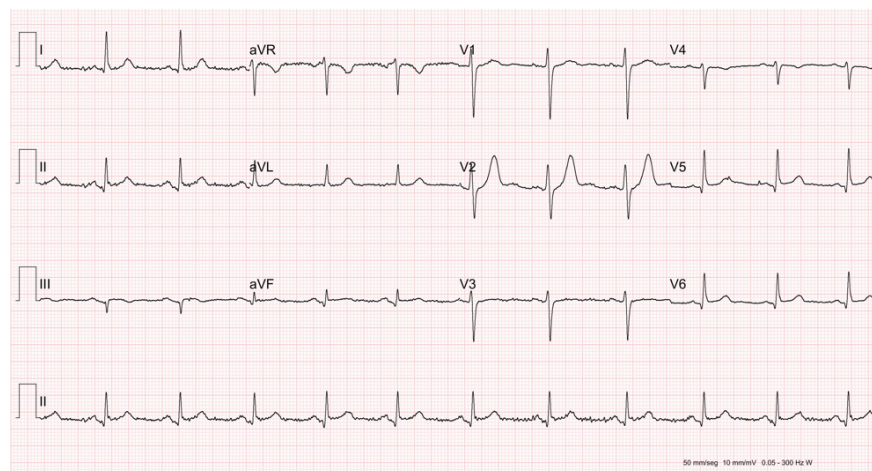
transferred to a tertiary hospital. Upon admission she was lucid, oriented in time and space, and pain-free, with the use of nitroglycerin 8 ml/h. Her blood pressure was 128/74 mmHg, mean blood pressure was 92 mmHg, and heart rate was 78 bpm. Serial EKG showed dynamic changes with ST-segment elevation in DIII, AvF, V5 and V6(**Fig. 1**) . Therefore, urgent cardiac catheterisation was performed, but it did not reveal any obstructive lesions. However, ventriculography revealed hypokinesia in the inferoapical wall(**Fig. 2**) , which supported the hypothesis of takotsubo syndrome. During hospitalisation, the patient experienced a severe refractory headache. Computed tomography (CT) of the head was performed under suspicion of SAH, and the examination results were normal. Subsequently, CT angiography (angio CT) of the head was performed to rule out a rupture of the aneurism. The angio CT identified "mirror" saccular aneurysms in the ophthalmic segment of the ICAs. The largest aneurysm was on the right, and in superior orientation the lesion measured 5 mm x 4 mm with a neck of 3 mm (**Fig. 3**). The patient was subsequently transferred from the cardiology unit to the intensive care unit and underwent lumbar puncture. Clear and colourless cerebral spinal fluid was observed after centrifugation, which confirmed the absence of SAH. The patient was diagnosed with unruptured aneurysm and underwent embolization of a supraclinoid ICA aneurysm using two stents to contain the metal coil. This procedure had no complications. The patient progressed satisfactorily and was discharged with a recommendation for outpatient follow-up in the general cardiology department. She was treated with enalapril, atenolol, atorvastatin, and ASA/clopidogrel.

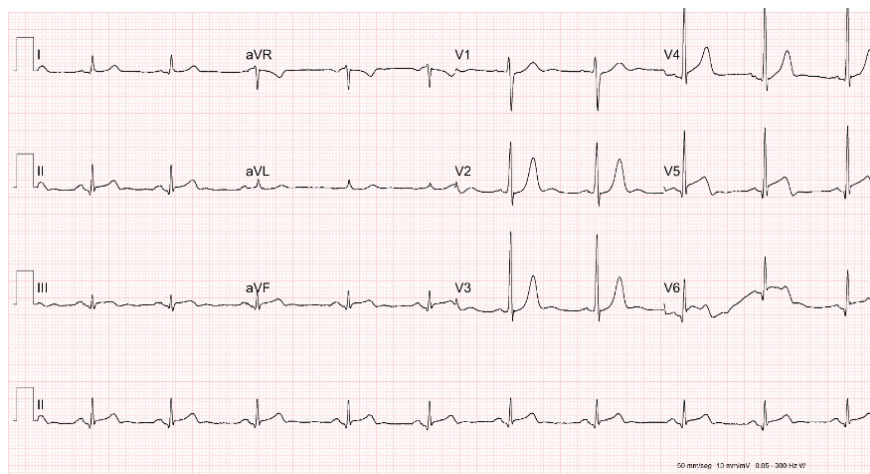
DISCUSSION:

The association between takotsubo syndrome and aneurysmal SAH in some populations has previously been reported. Therefore, it was necessary to perform screening for SAH and the discovery of an unruptured aneurysm in this case report [12, 13].

To the best of our knowledge, this is the first report of takotsubo syndrome and unruptured cerebral aneurysm. Therefore, we believe that patients with a diagnosis of takotsubo syndrome should undergo an angiography scan for cerebral aneurysm, due to the known risk of rupture. Early diagnosis of aneurysms is possible, and acting in a preventive manner with rapid institution of pre-rupture treatment reduces morbidity and mortality. The present case report differs from most cases of takotsubo syndrome described in the literature since it presents unruptured mirror aneurysms, while most cases are diagnosed after intracranial haemorrhage. Thus, to reduce morbidity and mortality, screening for brain aneurysms should be performed as a preventive protocol in patients diagnosed with takotsubo cardiomyopathy.

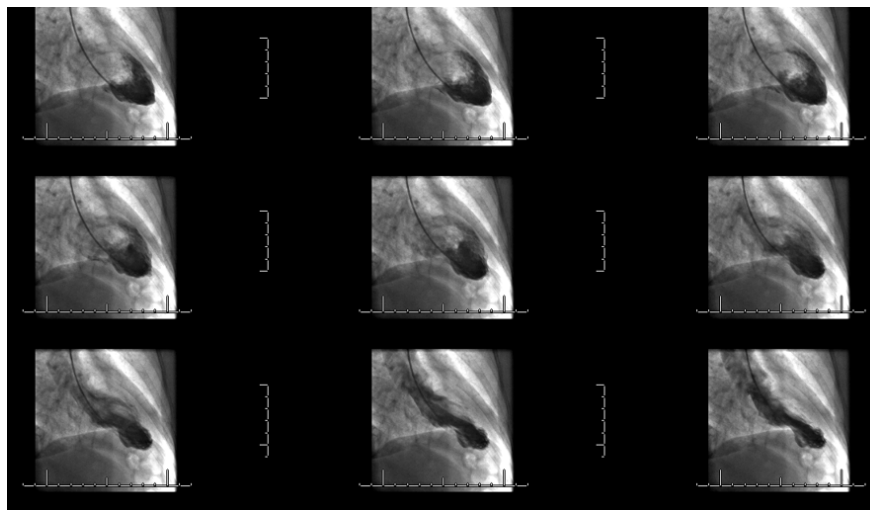
Figure 1





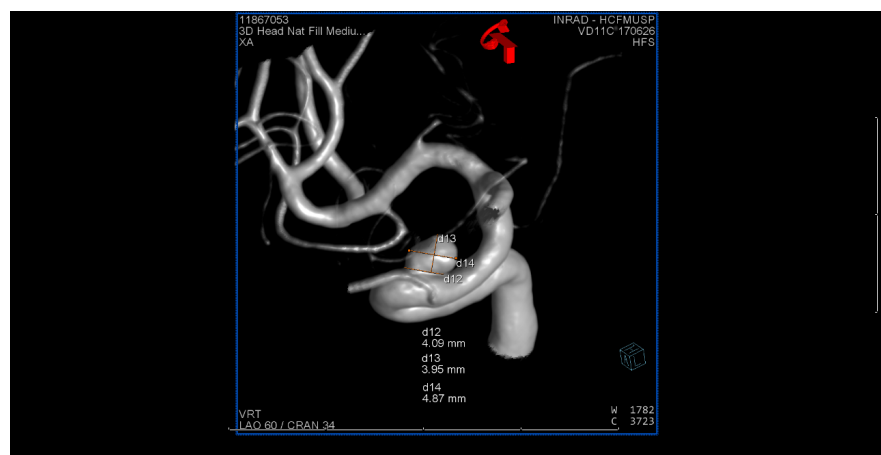
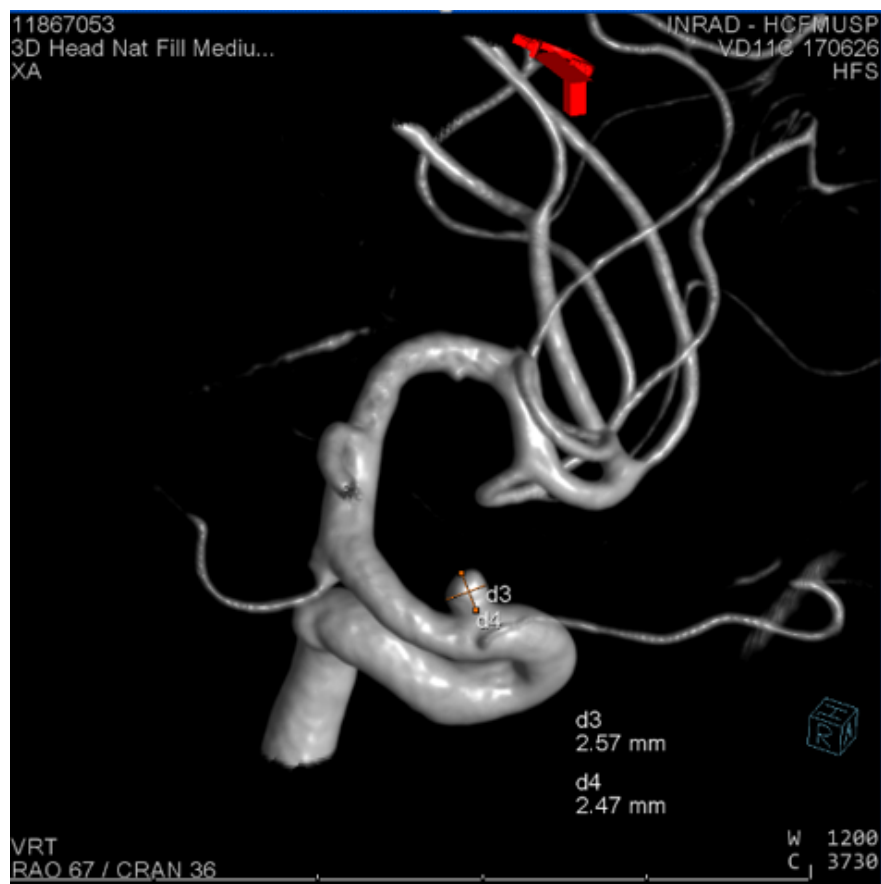
Dynamic electrocardiogram change with ST elevation of DIII, AvF, V5 and V6.

Figure 2



Ventriculography showing hypokinesia in the inferoapical wall of the heart.

Figure 3



Cranial computed tomography angiography, which identified "mirror" saccular aneurysms in the ophthalmic segment of the internal carotid arteries.

STATEMENT OF CONSENT: The authors confirm that written consent for submission and publication of this case report, including images and associated text, was obtained from the patient in line with the COPE guidance.

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