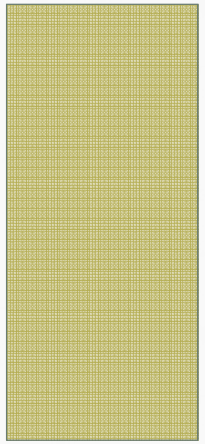
CARDIOPATHIE DE STRESS

JÉRÉMY ROSMAN

DESC REANIMATION – OCTOBRE 2015



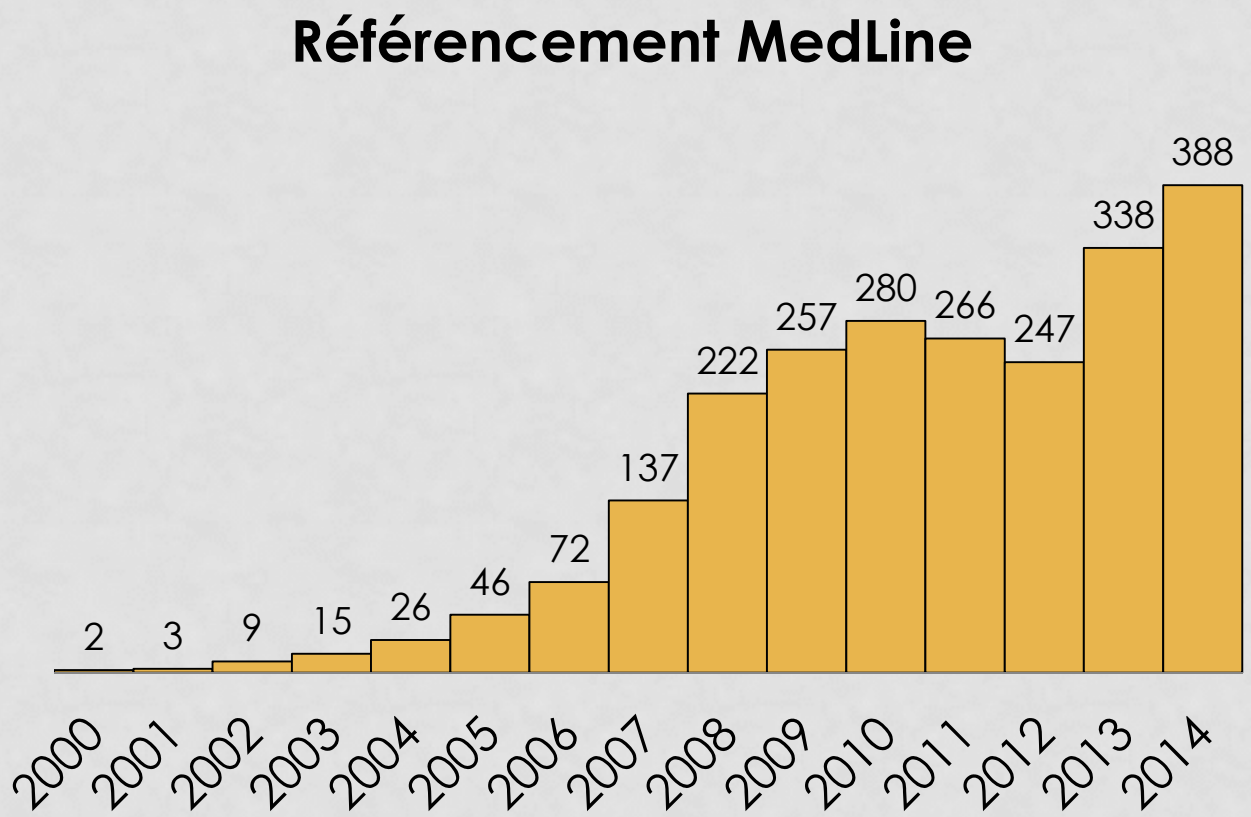
HISTORIQUE

HISTORIQUE

- 1er cas clinique : 1990

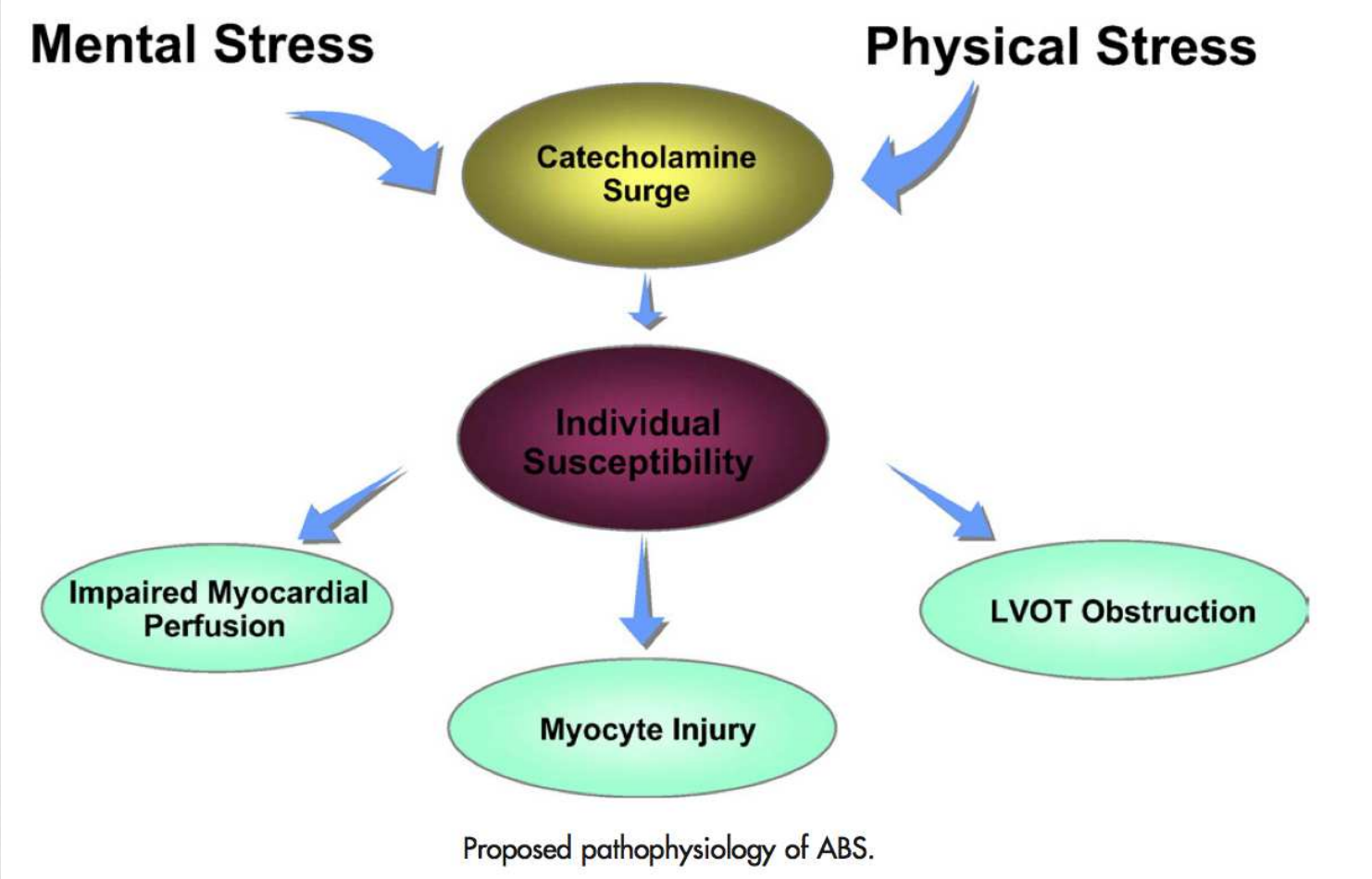
Sato, Tokyo: Kagakuhyoronsha Publishing, 1990.

HISTORIQUE


Référencement MedLine
2
3
9
15
26
46
72
137
222
257
280
266
247
338
388
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014

PHYSIOPATHOLOGIE

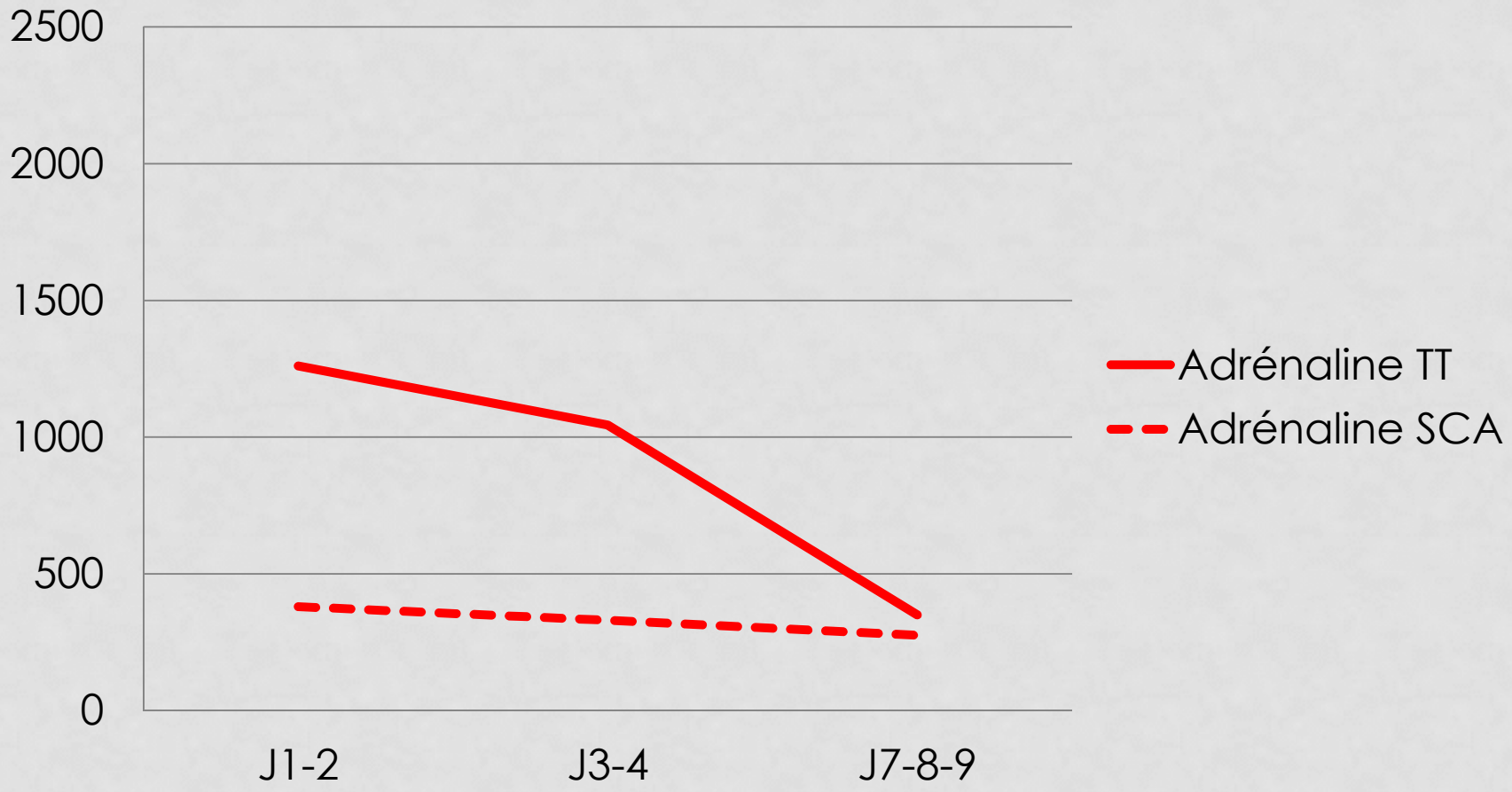
PHYSIOPATHOLOGIE



Proposed pathophysiology of ABS.

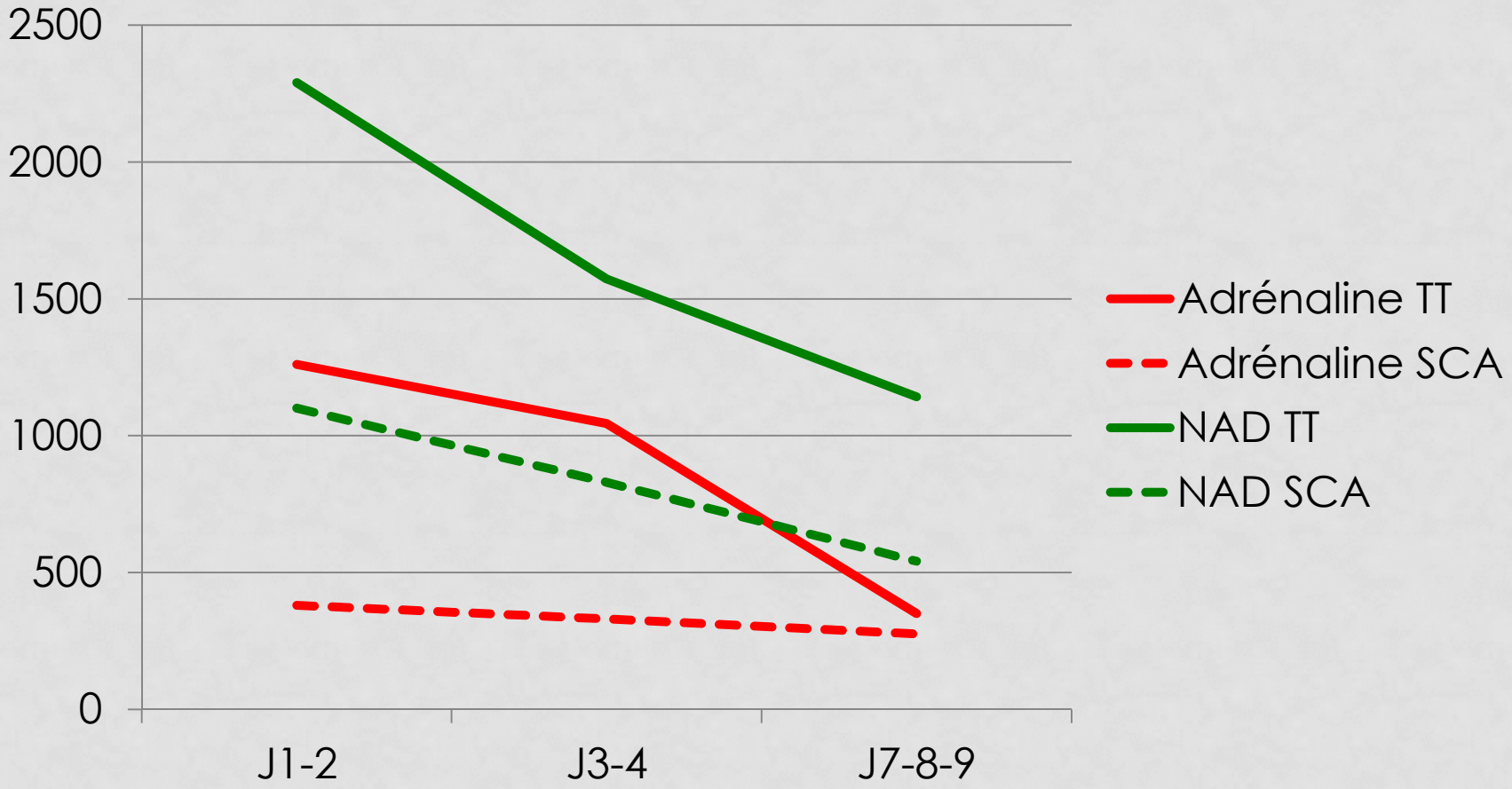
Samuels, Circulation 2007.

PHYSIOPATHOLOGIE



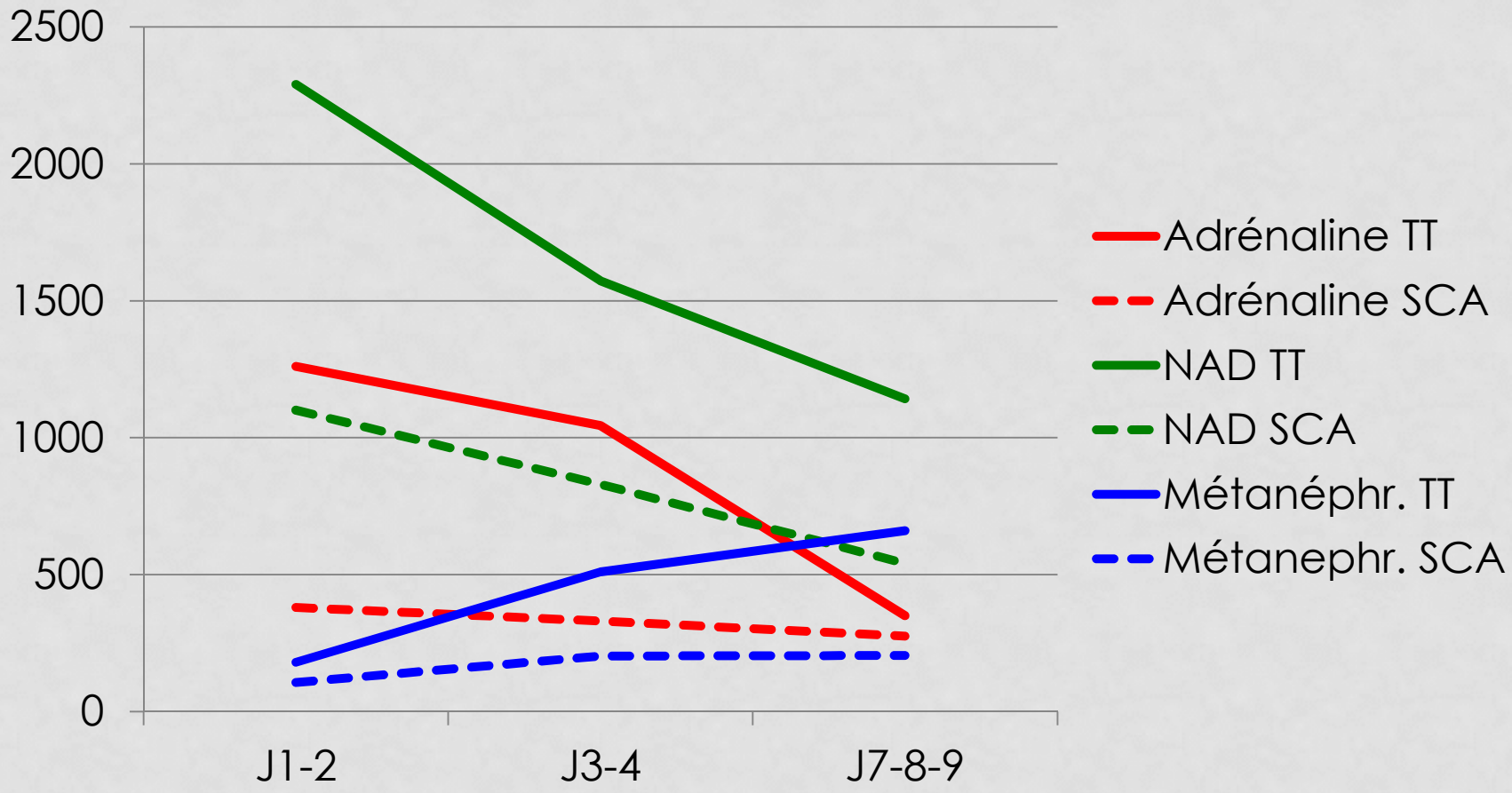
Wittstein, NEJM 2005.

PHYSIOPATHOLOGIE



Wittstein, NEJM 2005.

PHYSIOPATHOLOGIE



Wittstein, NEJM 2005.

PHYSIOPATHOLOGIE

Josué, *C R Soc Biol (Paris)*. 1907

DIAGNOSTIC

ORIGINAL ARTICLE

Clinical Features and Outcomes of Takotsubo (Stress) Cardiomyopathy

C. Templin, J.R. Ghadri, J. Diekmann, L.C. Napp, D.R. Bataiosu, M. Jaguszewski, V.L. Cammann, A. Sarcon, V. Geyer, C.A. Neumann, B. Seifert, J. Hellermann, M. Schwyzer, K. Eisenhardt, J. Jenewein, J. Franke, H.A. Katus, C. Burgdorf, H. Schunkert, C. Moeller, H. Thiele, J. Bauersachs, C. Tschöpe, H.-P. Schultheiss, C.A. Laney, L. Rajan, G. Michels, R. Pfister, C. Ukena, M. Böhm, R. Erbel, A. Cuneo, K.-H. Kuck, C. Jacobshagen, G. Hasenfuss, M. Karakas, W. Koenig, W. Rottbauer, S.M. Said, R.C. Braun-Dullaeus, F. Cuculi, A. Banning, T.A. Fischer, T. Vasankari, K.E.J. Airaksinen, M. Fijalkowski, A. Rynkiewicz, M. Pawlak, G. Opolski, R. Dworakowski, P. MacCarthy, C. Kaiser, S. Osswald, L. Galiuto, F. Crea, W. Dichtl, W.M. Franz, K. Empen, S.B. Felix, C. Delmas, O. Lairez, P. Erne, J.J. Bax, I. Ford, F. Ruschitzka, A. Prasad, and T.F. Lüscher

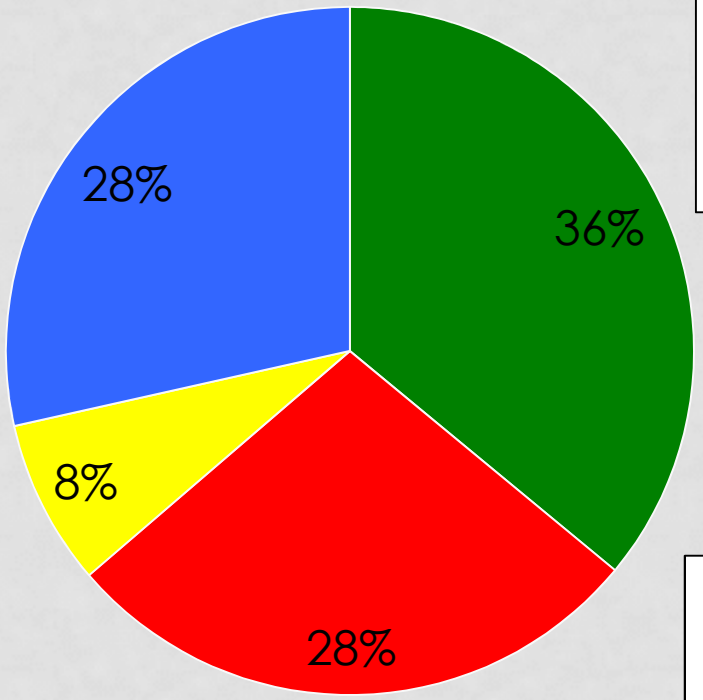
DIAGNOSTIC

- Registre international du Takotsubo
- 9 pays, 26 centres
- Récupération rétrospective de 1750 cas entre 1998 et 2014 :
  - Clinique
  - Thérapeutique
  - Pronostic
- Comparaison avec cas de SCA (pairées âge/sexe)

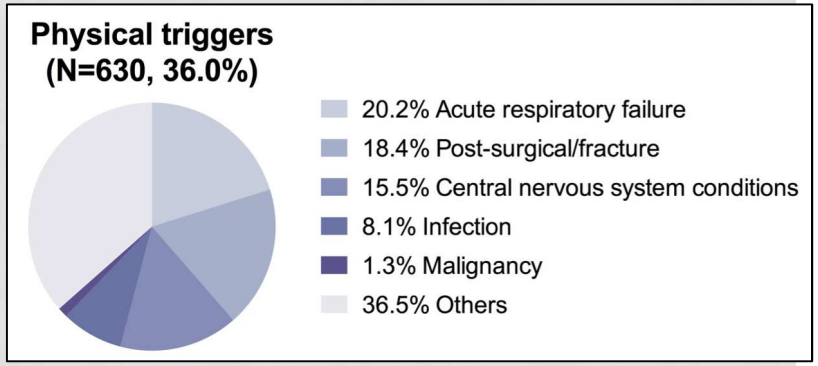
InterTAK Registry

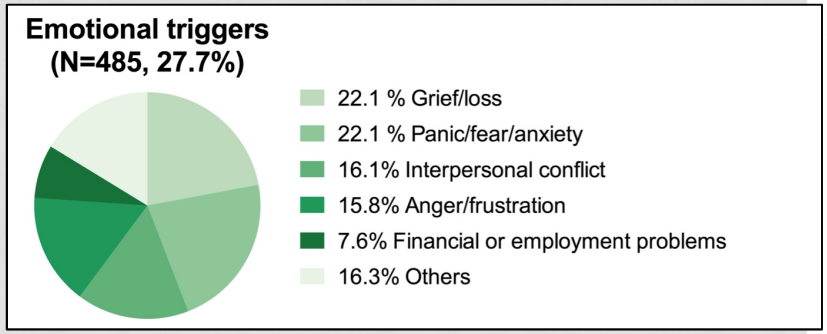
Templin and al., NEJM 2015.

DIAGNOSTIC
FACTEURS DECLENCHANTS



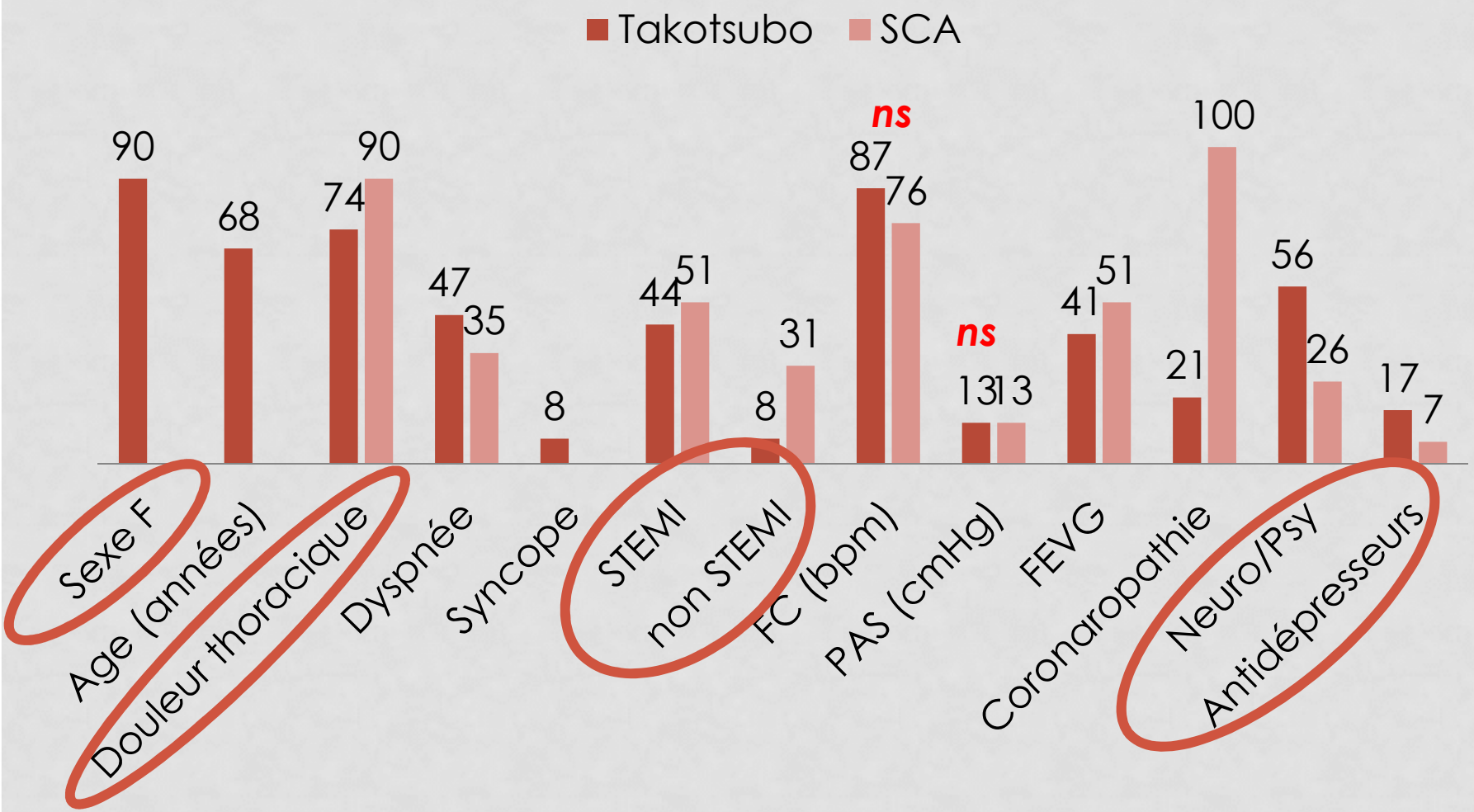
- Physique
- Emotionnel
- Les deux
- Non retrouvé





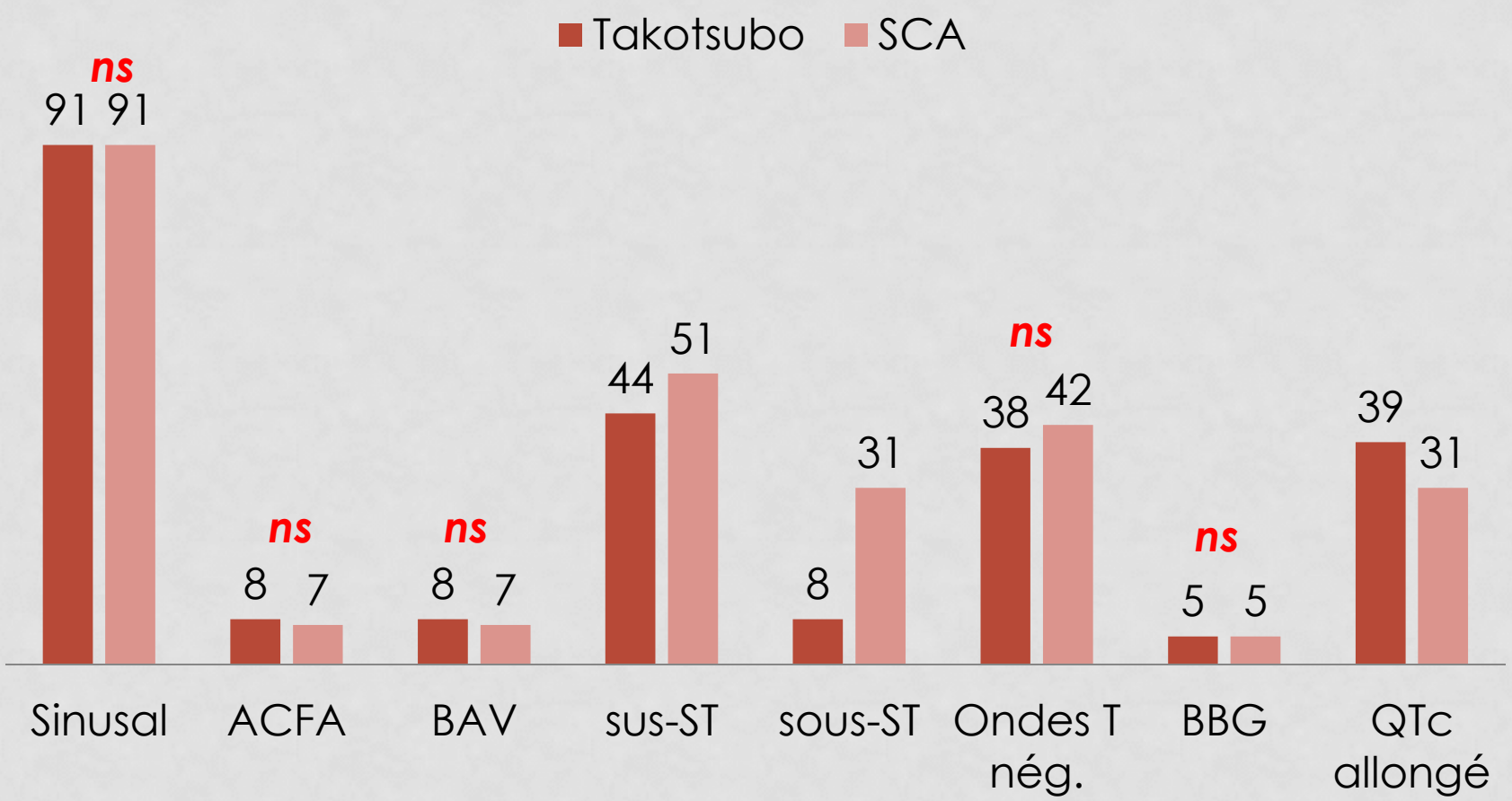
Templin and al., NEJM 2015.

DIAGNOSTIC CLINIQUE

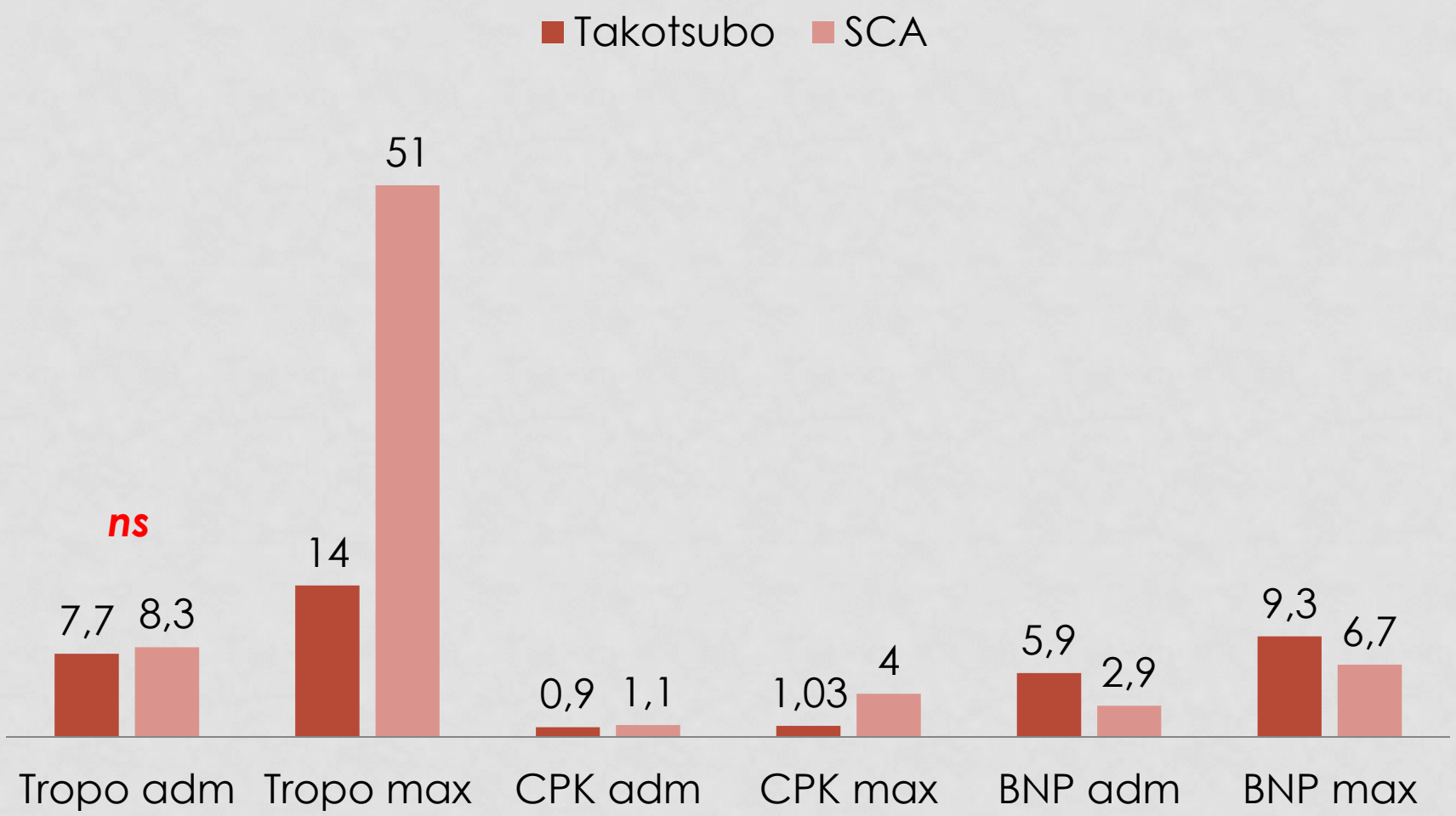


Templin and al., NEJM 2015.

DIAGNOSTIC MODIFICATIONS ECG (%)

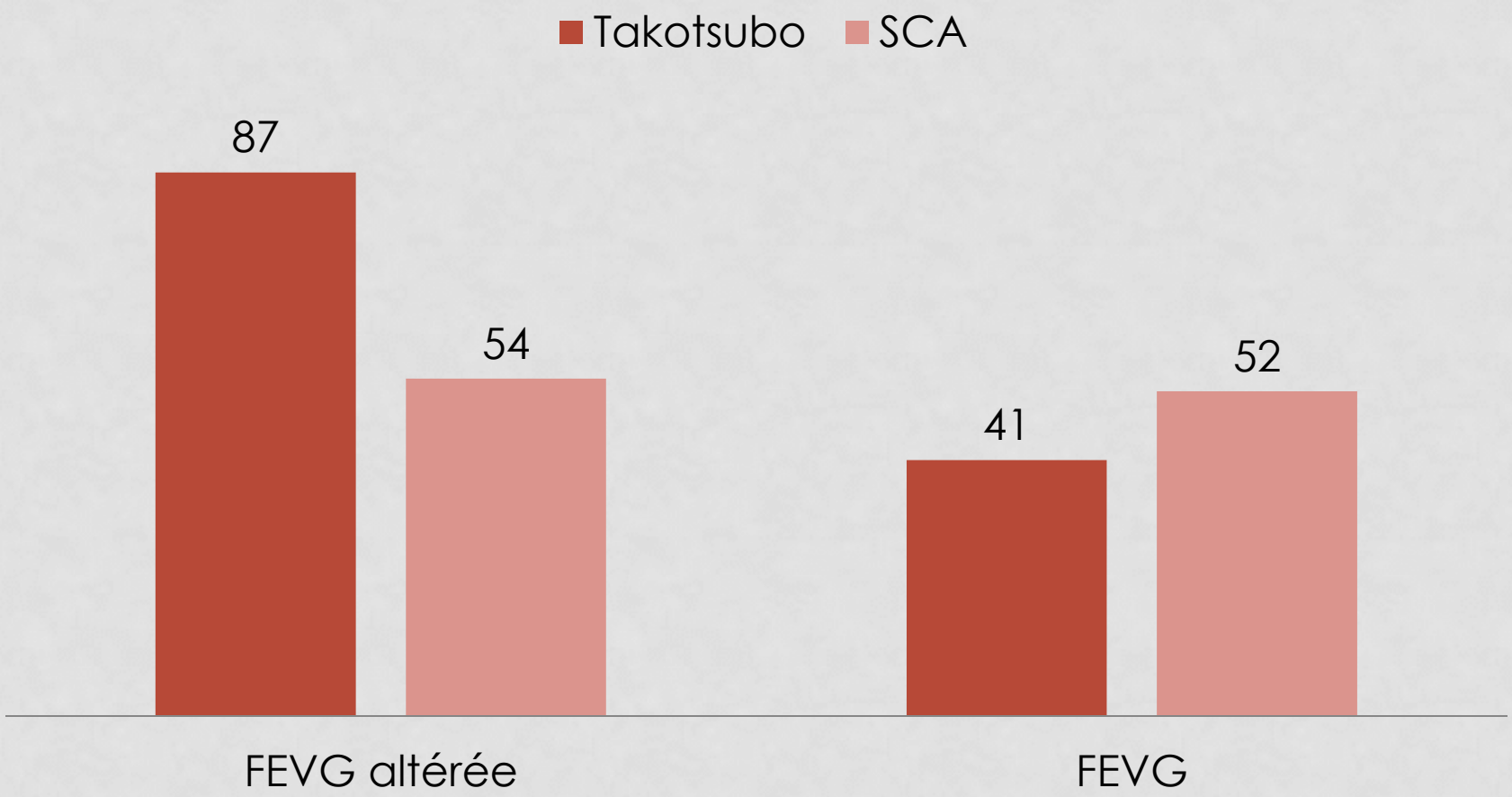


DIAGNOSTIC
BIOLOGIE (% LIMITE SUP)



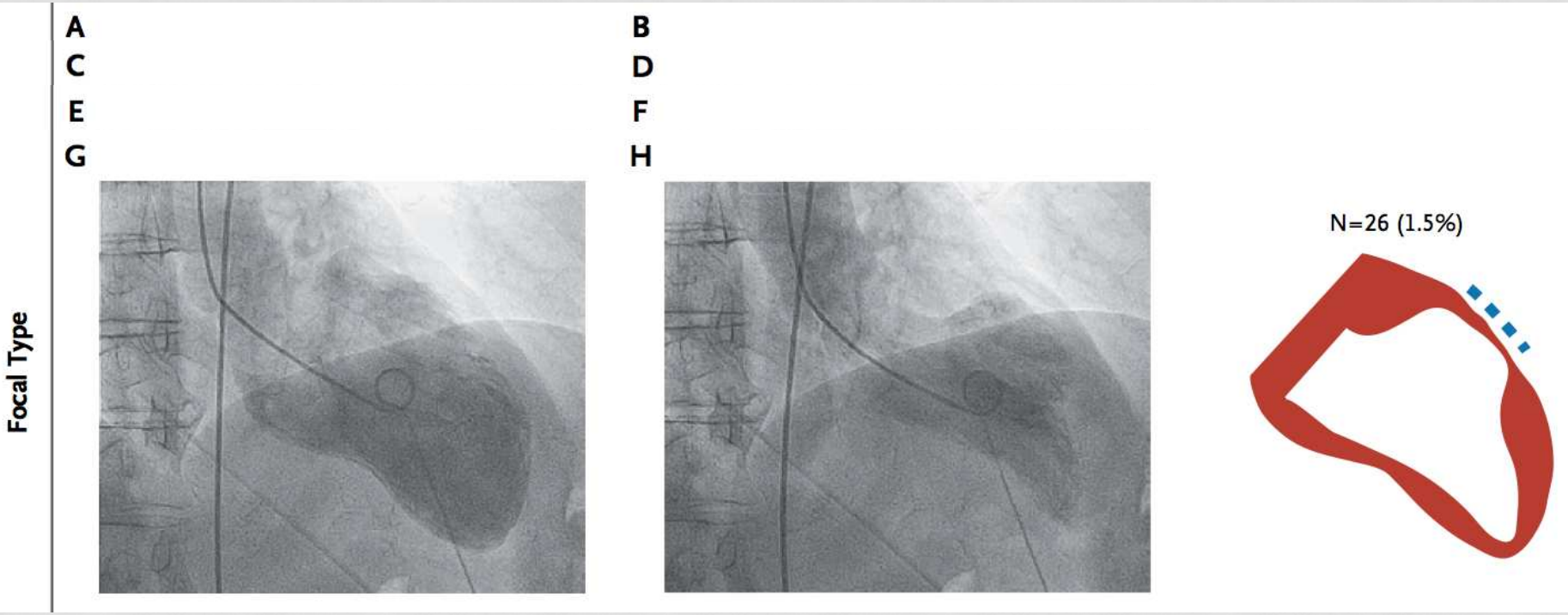
Templin and al., NEJM 2015.

DIAGNOSIC MORPHOLOGIE



DIAGNOSTIC MORPHOLOGIE

DIAGNOSTIC MORPHOLOGIE



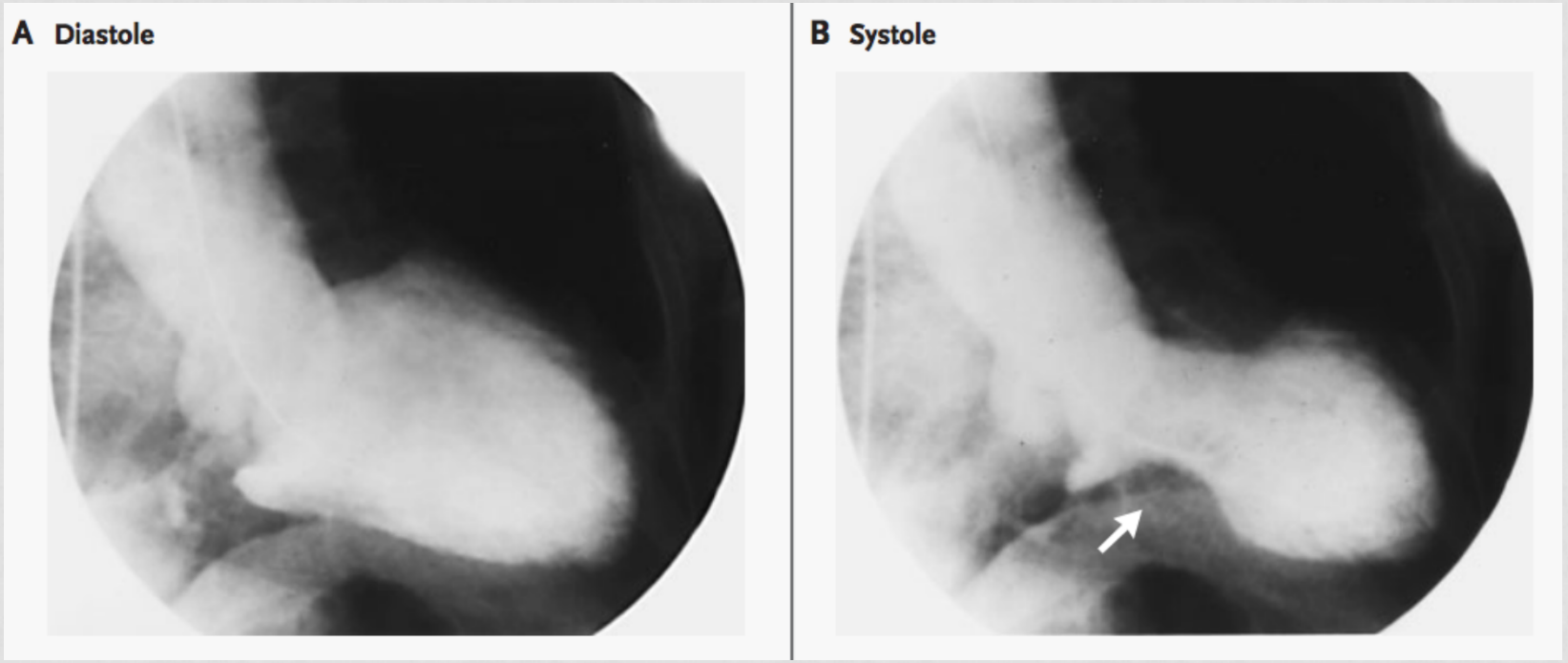
Templin and al., NEJM 2015.

DIAGNOSTIC MORPHOLOGIE

Templin and al., NEJM 2015.

DIAGNOSTIC CORONAROGRAPHIE

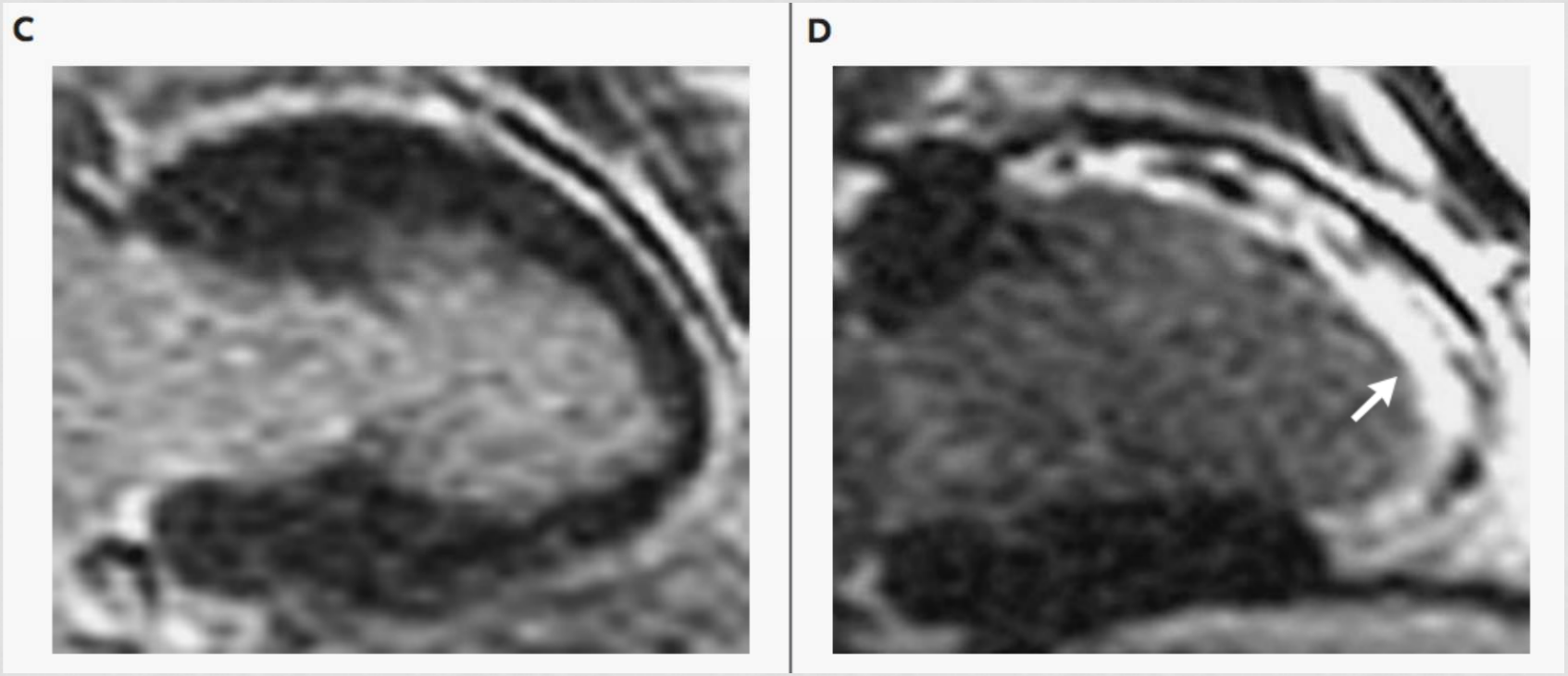
- Pas de lésion significative
- Ventriculographie



Wittstein, NEJM 2005.

DIAGNOSTIC
IRM-GD

- Prédiction de la récupération de myocarde
- Elimination diagnostics différentiels



Wittstein and al., NEJM 2005.
Thomson and al., J Magn Reson Imaging 2004

DIAGNOSTIC
IRM-GD

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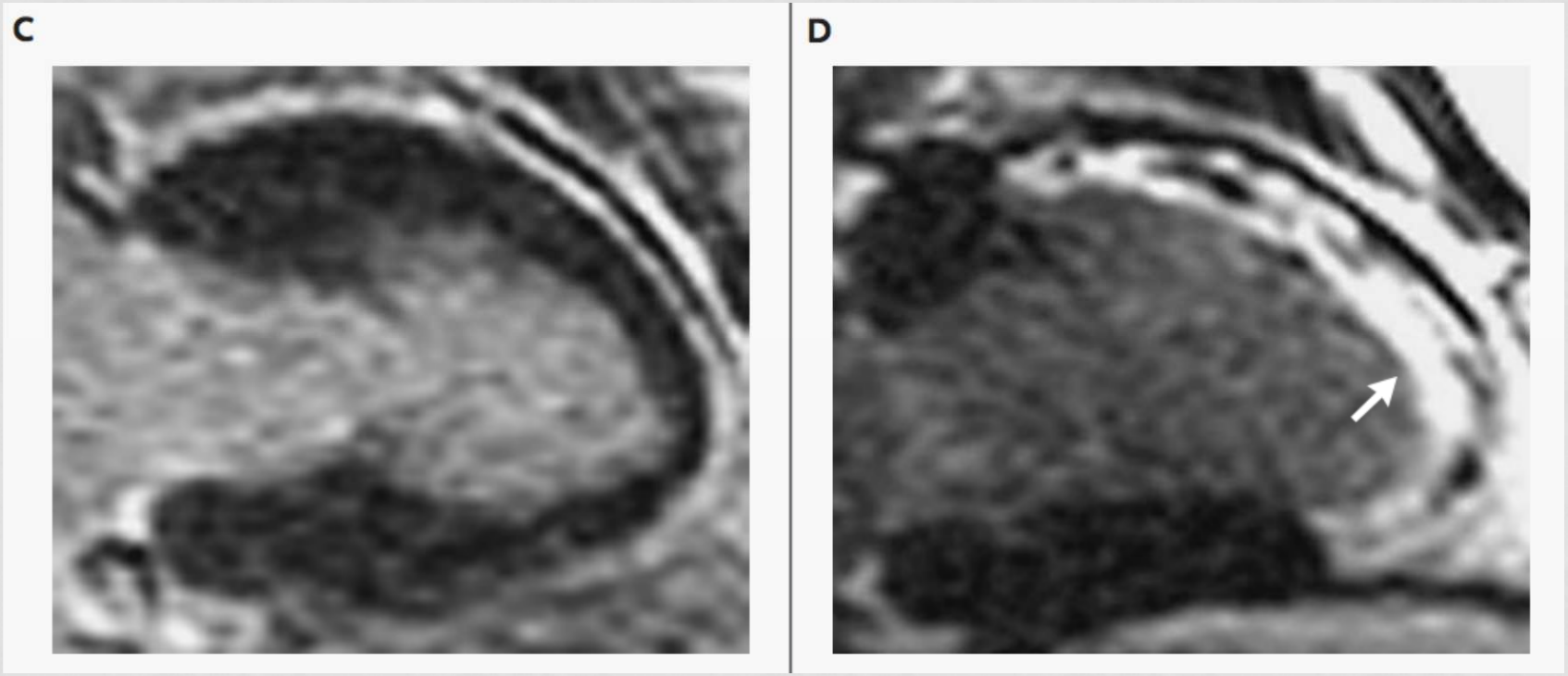


Wittstein and al., NEJM 2005.
Thomson and al., J Magn Reson Imaging 2004

CRITERES DIAGNOSTIQUES

Table II. Proposed Mayo Clinic criteria for ABS

1. Transient hypokinesis, akinesis, or dyskinesis of the left ventricular mid segments with or without apical involvement; the regional wall motion abnormalities extend beyond a single epicardial vascular distribution; a stressful trigger is often, but not always present. *
2. Absence of obstructive coronary disease or angiographic evidence of acute plaque rupture. †
3. New electrocardiographic abnormalities (either ST-segment elevation and/or T-wave inversion) or modest elevation in cardiac troponin.
4. Absence of:
   Pheochromocytoma
   Myocarditis

In both of the above circumstances, the diagnosis of ABS should be made with caution, and a clear stressful precipitating trigger must be sought.

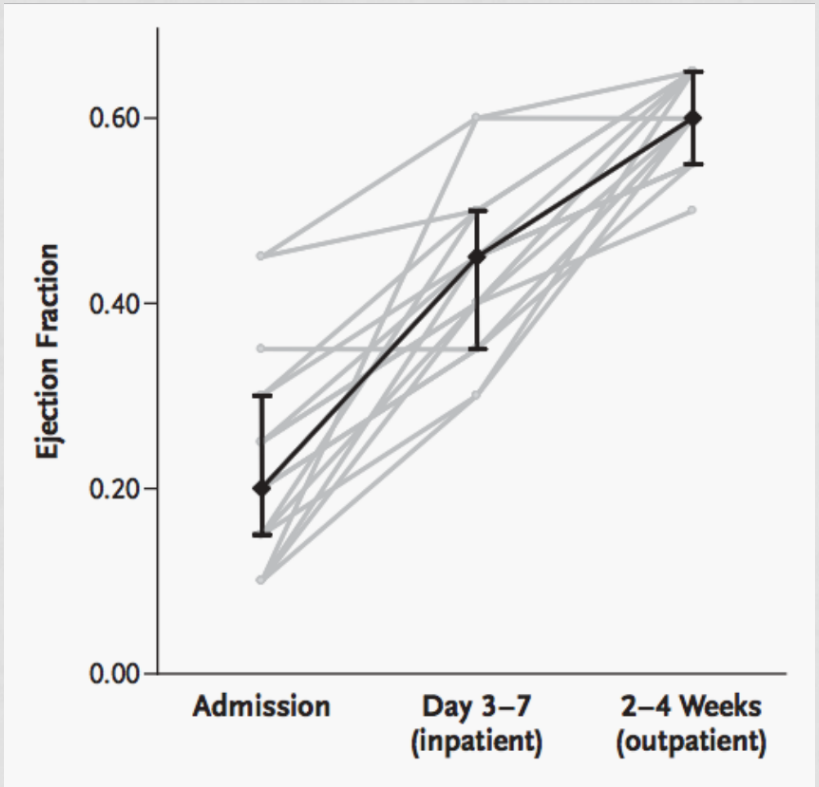
* There are rare exceptions to these criteria such as those patients in whom the regional wall motion abnormality is limited to a single coronary territory.

Prasad and al., Am Heart J 2008

EVOLUTION

EVOLUTION

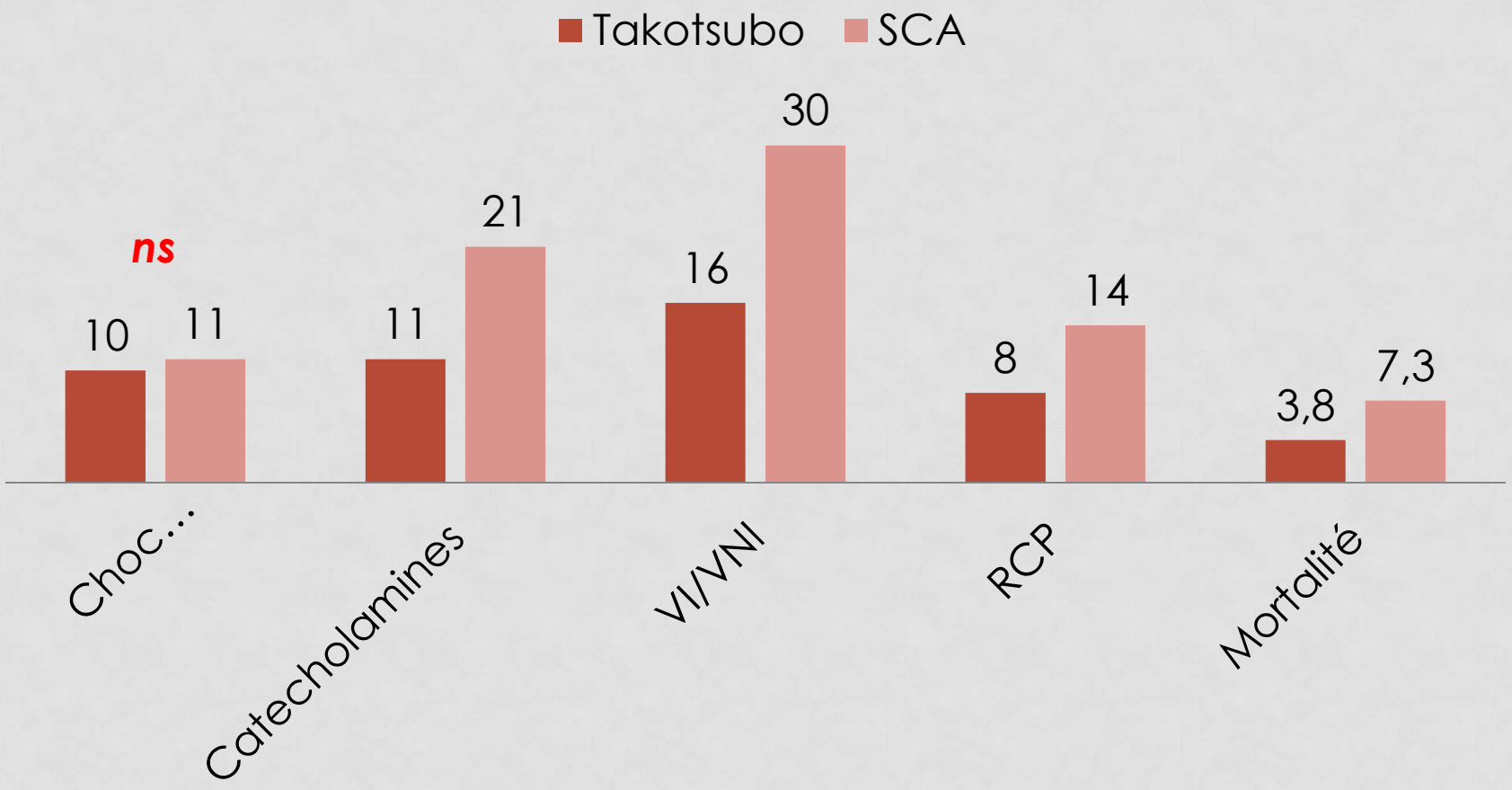
- Récupération *ad integrum* de la fonction cardiaque



Wittstein, NEJM 2005.

COMPLICATIONS

COMPLICATIONS INTRA-HOSPITALIERES (%)



Templin and al., NEJM 2015.

COMPLICATIONS LONG TERME

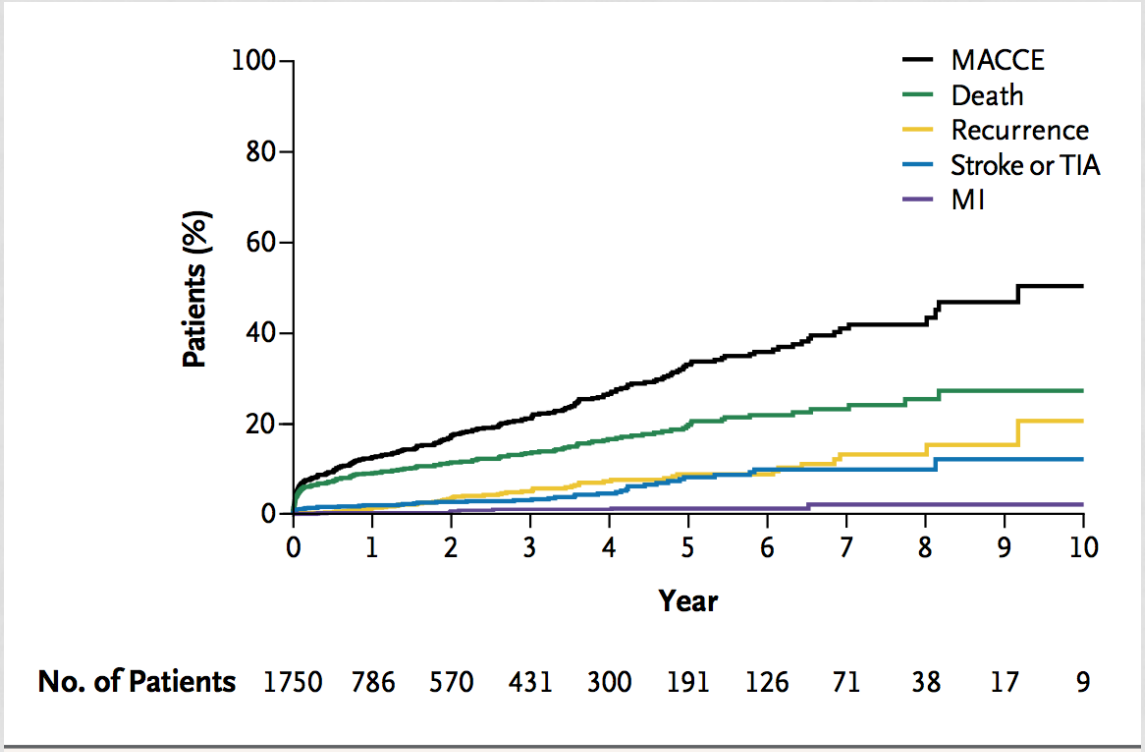
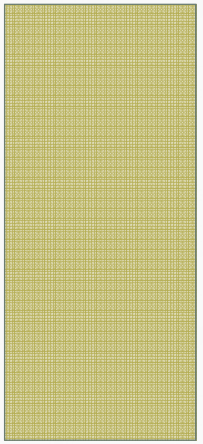


Figure 3. Kaplan–Meier Estimates of 10-Year Outcome Events.

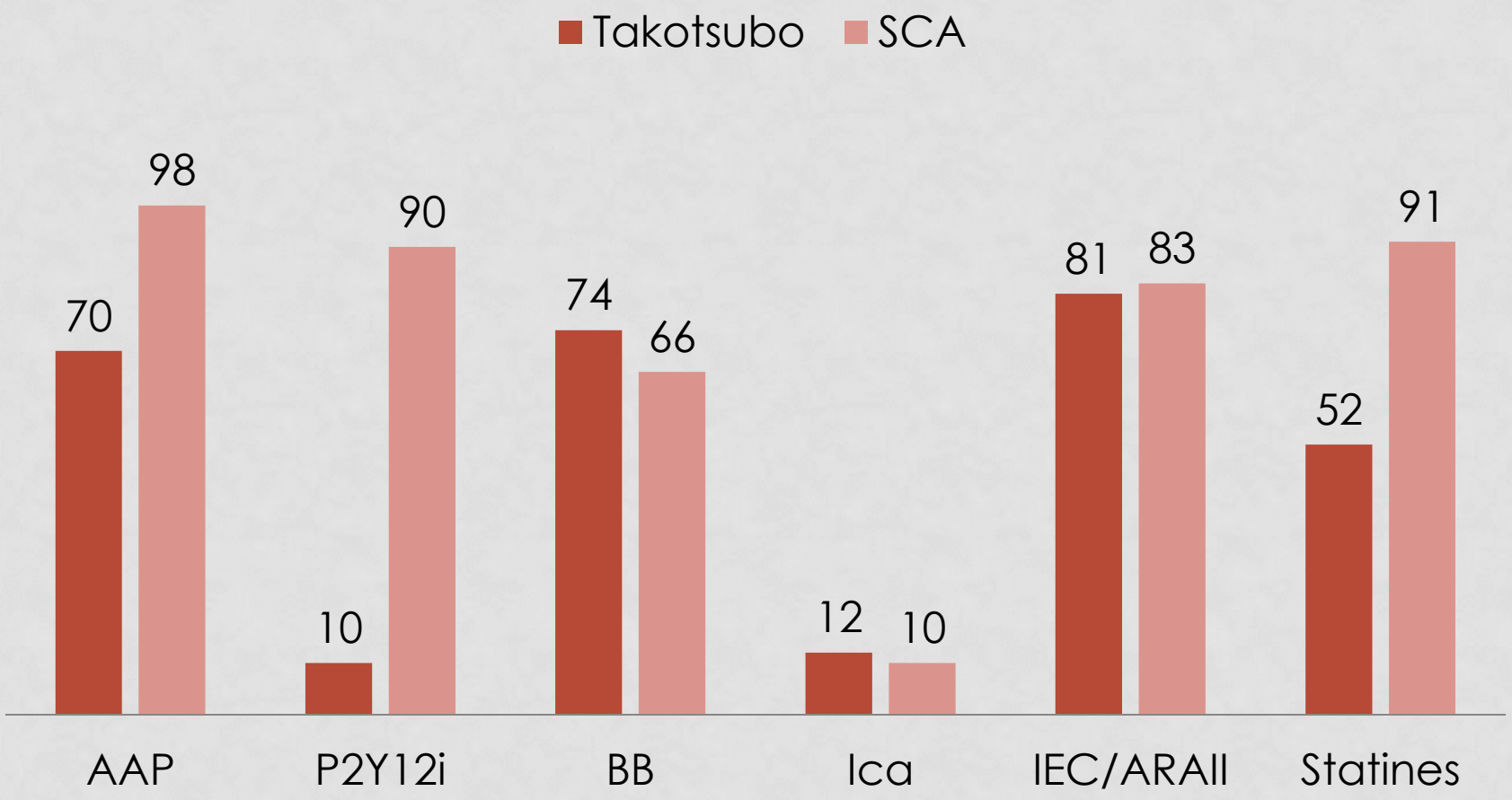
Shown are the proportions of patients with any major adverse cardiac and cerebrovascular event (MACCE), which was a composite of death from any cause, recurrence of takotsubo cardiomyopathy, stroke or transient ischemic attack (TIA), or myocardial infarction (MI).

Templin and al., NEJM 2015.

TRAITEMENT

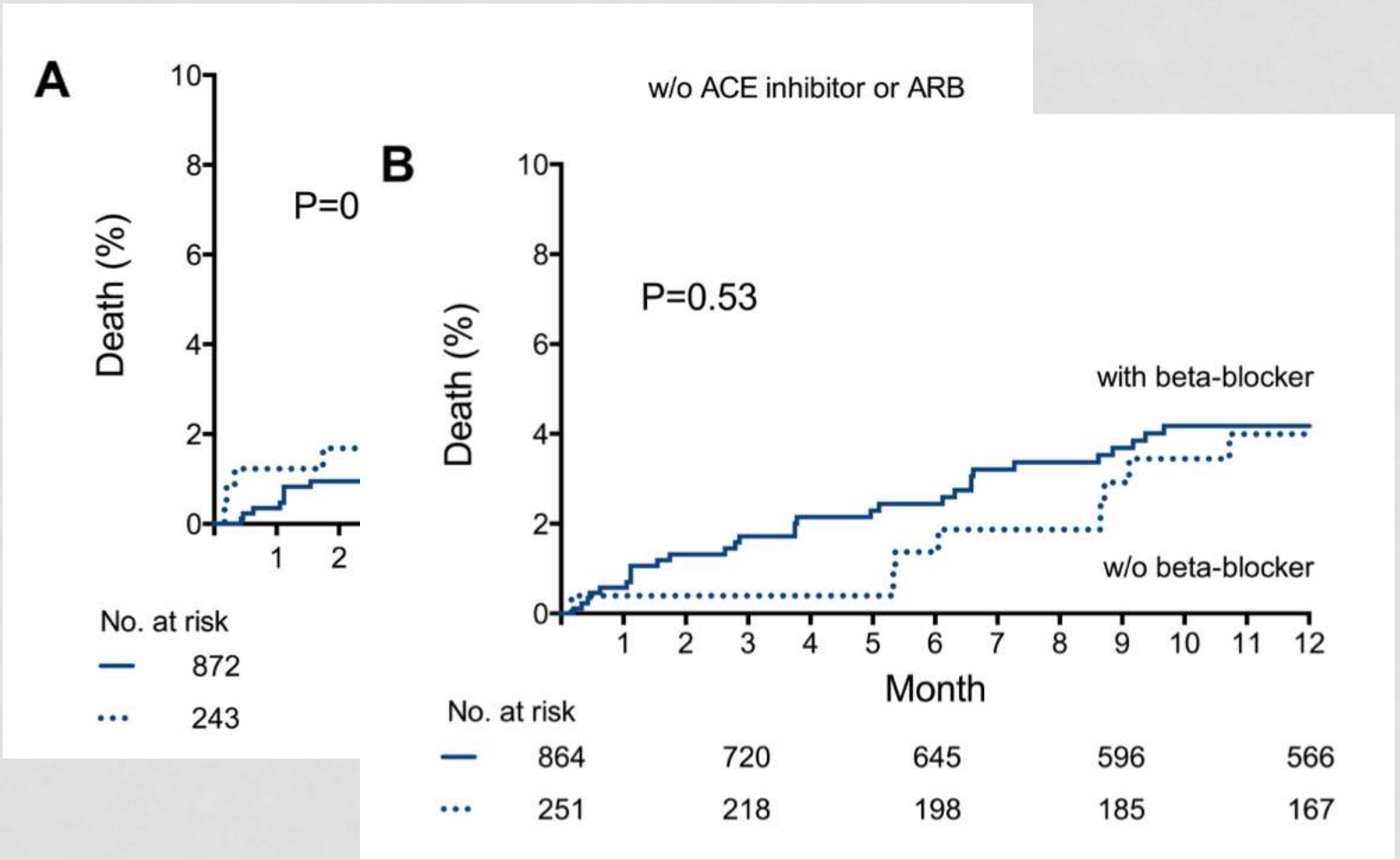


TRAITEMENT



Templin and al., NEJM 2015.

TRAITEMENT



Templin and al., NEJM 2015.