

Letter to the Editor

Silent Myocardial Ischemia: A Challenge in Management

Dear Editor,

We have greatly enjoyed reading the article by Giglioli, et al.¹ entitled “Cryptogenic Myocardial Infarction in Young Patients: Which is the Optimal Diagnostic and Therapeutic Management?”, which was published in the previous issue of Archives of Iranian Medicine. The authors¹ presented a case of young male patient with a previous cryptogenic myocardial infarction (MI) and multiple embolic small renal infarctions. Although the current case is well-presented, and we commend the authors for the excellent management, some comments may be of interest.

Silent myocardial ischemia (SMI) is an asymptomatic coronary syndrome without a history of infarction, and is associated with a higher risk of cardiovascular events.^{2,3} SMI is usually detected incidentally during routine controls. Although there is a high prevalence in elderly female patients, routine screening is not recommended.^{2,3} As in this current case, in patients with SMI, in addition to aspirin, statin, and angiotensin receptor blockers, beta blocker therapy should be considered in the treatment.⁴ The routine use of proton pump inhibitors is not recommended in patients taking daily doses of aspirin.⁴

The contemporary incidence of left ventricular (LV) thrombus after acute MI is approximately 5 %, and systemic embolization in patients with LV thrombus is mostly associated with decreased LV ejection fraction and LV aneurysm.⁵ Most episodes of systemic embolization occur in the first two weeks after acute MI.⁵ In patients with multiple systemic embolic infarctions, further investigation including cardiac evaluation with transthoracic echocardiography (TTE) as an initial diagnostic test should be carried out to detect an embolic origin.⁵⁻⁷ Transesophageal echocardiography (TEE) is suggested to perform in clinical conditions when there is a question about the information obtained using TTE. TEE is especially recommended in identification of cardioembolic source, assessment of left atrial appendage, and intracardiac masses.^{6,7} Anticoagulation with warfarin sodium should be prescribed to patients found to have an LV thrombus or embolic phenomenon. Prophylactic anticoagulation could be considered even in patients with LV dysfunction and extensive wall motion abnormalities that do not have a thrombus.^{4,5}

Actually, even the authors have discussed the necessity of TEE and anticoagulant therapy in patients with cryptogenic MI; in this current case, there was no clear evidence about the association between multiple systemic embolization and MI.

In conclusion, in patients with systemic embolization, there is no doubt that TEE should be performed even in clinical suspicion of cardioembolic source, and anticoagulant therapy should be considered as an acceptable option for initial therapy whatever the cause is.

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Author's Reply

We are very pleased that our work “Cryptogenic Myocardial Infarction in Young Patients: Which is the Optimal Diagnostic and Therapeutic Management?” published in Archives of Iranian Medicine (2013; **16**: 308 – 311), has aroused interest and further reflections about the diagnostic and therapeutic management of cryptogenic myocardial infarction especially in young patients. With regard to the considerations expressed in your Letter to the Editor, especially the paragraphs regarding the use of oral anticoagulation over antiplatelet therapy in these patients, as well as the role of transesophageal echocardiography, they are in agreement with those we had already exposed in our discussion. We just wanted to remark that the transesophageal echocardiography can be also useful for excluding the presence of intracardiac shunts like the presence of a patent foramen ovale as possible source of paradoxical embolism, as we reported in page 310, line 45 – 50.

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