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Letter to the Editor

Most of the patients classified under "Myocardial infarction with non-obstructive coronary arteries (MI-NOCA)" have either no MI or no NOCA

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I read with great interest the recent report on 292 patients with myocardial infarction with non-obstructive coronary arteries (MI-NOCA) published by Hausvater et al. [1] in International Journal of Cardiology [1]. According to the study, takotsubo syndrome (TS) was defined on cardiac magnetic resonance (CMR) imaging by "typical wall motion pattern extending beyond a single coronary territory in the absence of late gadolinium enhancement (LGE)". However, studies have demonstrated LGE in the regions of ventricular wall motion abnormalities in up to 41% of patients with TS if CMR imaging is performed during the first few days of admission [2]. The signal intensity of LGE found in TS may be lower than that usually documented in MI or myocarditis and usually resolved during follow-up CMR imaging [2,3]. This implies that almost one third of patients who in fact had TS may have been included in myocarditis group because of the presence LGE.

In the current study, 234 of 288 (81%) had no MI. Furthermore, 12 of 54 (22%) in patients with signs of MI on CMR imaging had ST-elevations MI (STEMI) changes on ECG and higher troponin elevations. Such finding indicates that these patients had missed occlusive coronary arteries (OCA) and not NOCA. Spontaneous coronary artery dissection (SCAD) is classified under MINOCA [4]. SCAD is an obstructive coronary artery disease (CAD) and erroneously classified under MINOCA [5]. Consequently, is it justifiable to continue in using MINOCA when ≪15% of patients fulfil MINOCA criteria i.e. MI plus NOCA? It will be more sensible to use the acronym TE-NOCA (troponin elevation with NOCA) instead of MINOCA for such group of patients provided that an obstructive CAD such as SCAD or peripheral coronary embolism has not been missed.

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