motility as per protocol, that 9% of these patients had asymptomatic gastroparesis 24 hours after the procedure. In a subsequent analysis, only the onset of phrenic nerve paralysis during the procedure was associated with a higher risk of gastroparesis, although this was transient. A more recent observational study prospectively compared the frequency of onset of gastroparesis among 104 patients undergoing PV cryoablation or radiofrequency. 3 Six cases were detected in the cryoablation group (5% of the sample). Only one case was detected in the radiofrequency group. The patients who received cryoablation and developed gastroparesis had smaller atria (36 ± 2 mm) and lower mean temperatures were achieved (−51 ± 2.3 °C). All these patients received medical treatment and none of them had residual symptoms at 6 months, with the exception of the patient with gastroparesis following radiofrequency.

We describe a complication of PV ablation that is not often associated with a history of PV cryoablation, particularly in cases of late onset and generally with good prognosis. Possible risk factors associated with cryoablation in our patient are low temperature, multiple applications, and the use of a large balloon in a small atrium. Ablation of the right lower PV was particularly complex, as it required 2 balloon sizes, and its anatomical relationship with the esophagus is unknown, as no imaging test was performed in advance, which could have been useful. Fluoroscopic observation of the stomach and distended intestinal loops is useful for the initial diagnosis. Confirmatory diagnosis could be obtained by means of gastric emptying scintigraphy in severe and/or uncertain cases, although this technique is generally unnecessary. Initial treatment is conservative with antisecretory drugs and prokinetics, and endoscopic treatment is reserved for more severe cases.
week, she was completely weaned from dobutamine and the ECMO was discontinued, with full recovery of ventricular function (LVEF, 50%). The patient was discharged with no signs of ECMO complications and was treated with hydroxychloroquine (200 mg/d) and prednisone (15 mg/d) as maintenance therapy. After 1-year follow-up, the patient remains asymptomatic.

LM is a rare manifestation of SLE with a prevalence ranging from 5% to 10%. Clinical features include fever and congestive heart failure. Fulminant LM presenting as cardiogenic shock was described in only 10% of the largest reported series on LM.

In daily clinical practice, LM diagnosis represents a major challenge and is based on high clinical suspicion supported by elevated cardiac biomarkers and echocardiographic evidence of impaired LVEF. Endomyocardial biopsy is the gold standard, but the invasiveness of the procedure and its poor negative predictive value limit its use. Cardiac magnetic resonance is a promising technique but further studies are needed to support its usefulness in SLE patients.

Up to 70% of patients with LM have good prognosis with recovery of cardiac function within days or weeks. However, in the acute phase, 4%-10% of patients die of fulminant myocarditis with cardiogenic shock refractory to medical therapy due to severely reduced ventricular contractility or malignant arrhythmias. In these patients, mechanical circulatory support devices such as ECMO may play a major role as bridging therapy to keep the patient alive and allow time for the potential recovery of the myocardium in response to immunosuppressive treatment.

ECMO has a notable value in fulminant myocarditis compared with left ventricular assist devices. When this severe clinical situation is associated with ventricular arrhythmias, left ventricular assist devices are unlikely to provide sufficient cardiac output when the right ventricle is not pumping effectively, whereas ECMO bypasses biventricular failure.

In the case of fulminant myocarditis where recovery of cardiac function is expected if the patient survives the acute phase of the disease, such as in the case of LM, data from a recent meta-analysis suggest a favorable short- and long-term survival, with more than two-thirds of patients requiring ECMO surviving to hospital discharge.

Treatment of LM is based on high doses of glucocorticoids combined with immunosuppressant agents such as intravenous cyclophosphamide. Anecdotal reports describe good outcomes with intravenous immunoglobulin and plasma exchange and rituximab should be considered in refractory patients. Hence, we describe an SLE patient with fulminant LM, an uncommon but severe cardiac manifestation. The present case highlights the value of bridging therapy with ECMO and the usefulness of ECMO in boosting the long-term outcomes of severe SLE patients.

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Available online 25 January 2017

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Severe Cardiac Complications of Shabu Use: An Emerging Drug in Europe

Complicaciones cardiacas graves por shabu: una droga emergente en Europa

To the Editor,

There are 3 forms of methamphetamine—speed, base, and ice—differing in their purity (ice is 80% pure, whereas speed is 10%-20% pure). Ice is also called crystal and is known by shabu in the Philippines. It is the free base form of methamphetamine, and its most frequent form of consumption is by smoking. Shabu is an emerging drug in Europe with increasing consumption reports, especially in Southeast Asian communities. The 2016 World Drug Report noted an upward trend in the number of seizures of methamphetamine since 2002, reaching a peak of 108 tons in 2014.

Cardiovascular complications due to cardiac toxicity are the second most common cause of death in methamphetamine abusers; associated cardiovascular pathologies include malignant hypertension, aortic dissection, myocardial infarction, pulmonary hypertension, malignant arrhythmias due to prolonged QT, and cardiomyopathy. We conducted a prospective study of Shabu consumers who were admitted for cardiac complications in our hospital. From January 2015 to June 2016, 5 patients were identified. Consumption was recognized by anamnesis (2 patients) or positive urinalysis (3 patients). Urinalysis was performed by immunoassay and the results were confirmed by gas chromatography-mass spectrometry. Shabu can be detected within a 60-hour window. In