

ablation of atrial fibrillation: The SUCCESS score" (1). Firstly, we agree with the colleague's opinion that remodeling of the left atrium (LA) is assessed more precisely using volume instead of diameter values. Even though the anteroposterior measurement is the most commonly used parameter in size assessment of LA, it does not consider the geometry. The recommendations of the American Society of Echocardiography (ASE) and the European Association of Cardiovascular Imaging (EACVI) state: "[...] this measurement has been used extensively in clinical practice and research, it has become clear that frequently it may not represent an accurate picture of LA size" (2). However, LA volume is not always routinely obtained in all patients, and it was unfortunately also the case in our retrospective study (1). EACVI furthermore states that 3D echocardiography, which is the most accurate form of volume measurement, "is poorly applied in the clinical practice because of the lack of standardized methodology and limited normative data. Although several studies demonstrated the incremental prognostic value of LA strain in diseases such as atrial fibrillation and mitral valve disease, the lack of a dedicated software and standardized methodology prevent its inclusion in a routine echocardiographic report" (3).

We fully agree with the colleague's comment that the LA volume is superior for the risk assessment than the LA diameter; however, the latter is still used more commonly in clinical practice. The main goal of our study (1) was to create a simple scoring system using routinely obtained parameters, and therefore, it included diameter rather than volume. Further, it seems promising to apply a volume-based assessment of the LA size if this data is obtained more routinely in the future as recommended by both ASE and EACVI.

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## Acute fulminant eosinophilic myocarditis due to *Giardia lamblia* infection

To the Editor,

We read the publication on "Acute fulminant eosinophilic myocarditis due to *Giardia lamblia* infection presented with cardiogenic shock in a young patient" with a great interest (1). Avsar et al. (1) mentioned that "To the best of our knowledge, this is the first case report of acute fulminant eosinophilic myocarditis due to *Giardia lamblia* infection presented with cardiogenic shock". In fact, acute fulminant eosinophilic cardiac involvement is a possible rare clinical complication in giardiasis (2). However, it should be noted that the present study is not the first clinical case report as mentioned by Avsar et al. (1). There is at least one case reported previously by Dzierwa et al. (3), in which a patient presented with acute fulminant eosinophilic myocarditis due to giardiasis. In that case, the patient also presented with chest pain, dyspnea, and cardiogenic shock (3).

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gia-coincidenceor causality? (RCD code: III-1B.1.o). J Rare Cardio-vasc Dis 2016; 2: 1. [CrossRef]

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## Author`s Reply

To the Editor,

First, we wish to thank you and the authors for their critical evaluation of and valuable contribution to our case report (1). Acute eosinophilic myocarditis due to Giardia lamblia is a rare clinical entity. Thus far, a few case reports have been published regarding this issue in the literature (1-3). In these reports, patients' clinical presentation and hemodynamic status upon admission to the emergency service were stable without any signs and symptoms of cardiogenic shock (CS). It is well-known that CS is a state of medical emergency characterized by tissue hypoperfusion and hypoxia to multiple vital organs. CS is defined as systolic blood pressure less than 90 mm Hg or systolic blood pressure drop greater than or equal to 40 mm Hg for more than 15 min without new-onset arrhythmia, hypovolemia, or sepsis (4).

Dzierwa et al. (3) previously reported a case of acute eosinophilic myocarditis due to Giardia lamblia infestation and *Garcinia cambogia*. However, our case was different from this report in terms of the clinical presentation and hemodynamic status of the patient upon admission. In contrast to the patient in the previous report, our patient was hemodynamically unstable and presented with ST elevation and myocardial infarction. In fact, the patient was in a state of CS, which was not similar to this previous case.

Also, this was true for the case reported by Robaei et al. (2). Therefore, we do believe that this is the first case of acute fulminant eosinophilic myocarditis due to *Giardia lamblia* infestation presenting with CS in the literature.

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