

PSEUDO-WELLENS PATTERN A, TRIGGERED BY TAKOTSUBO SYNDROME

EDWIN A. RODRÍGUEZ¹, CRISTINA ESPINOSA DE LA OSSA¹,
ÁLVARO F. VARGAS PELAEZ², SANDRA P. SWIESZKOWSKI¹

¹Unidad de Cuidados Intensivos Cardiovasculares, Hospital de Clínicas José de San Martín, Universidad de Buenos Aires, Buenos Aires, Argentina, ²Memorial Cardiac and Vascular Institute, Hollywood, Florida, USA

E-mail: edwin2721rodriguez@gmail.com

A 71-year-old woman with a medical history of hypertension was admitted for a 1-week evolution of heart failure and angina. On admission heart rate was 109 beats per minute, her respiratory rate was 27 cycles per minute, and her oxygen saturation was 93% on room air. Physical examination revealed 3/3 jugular turgor, orthopnea and crackles up to the midfield bilaterally. Electrocardiogram (ECG) showed a biphasic component of the T wave in leads V2-V4, and inversion of the T wave in V5-V6 constituting type A Wellens pattern (Fig. 1A). Laboratory showed high-sensitivity troponin I of 1196 µg/L (RV: 0-19 µg/mL) and NT pro-BNP

of 14.630 ng/mL (RV 0-125 ng/mL). Echocardiogram revealed akinesia of the apical segments with hypercontractility of the basal segments, moderately depressed left ventricular ejection fraction (LVEF 33%) (Fig. 1B). Due to suspicion of acute coronary syndrome a coronary angiography was performed showing no significant coronary lesions, and a ventriculogram that showed apical ballooning (Fig. 1C). After coronary angiogram and ventriculogram, the clinical course was redefined as takotsubo's syndrome with a pseudo Wellens pattern A on ECG. The patient was discharged with normalization of LVEF and ECG changes (Fig. 1D).

Figure 1 |

