Femenina de 74 años con bloqueo de rama bilateral

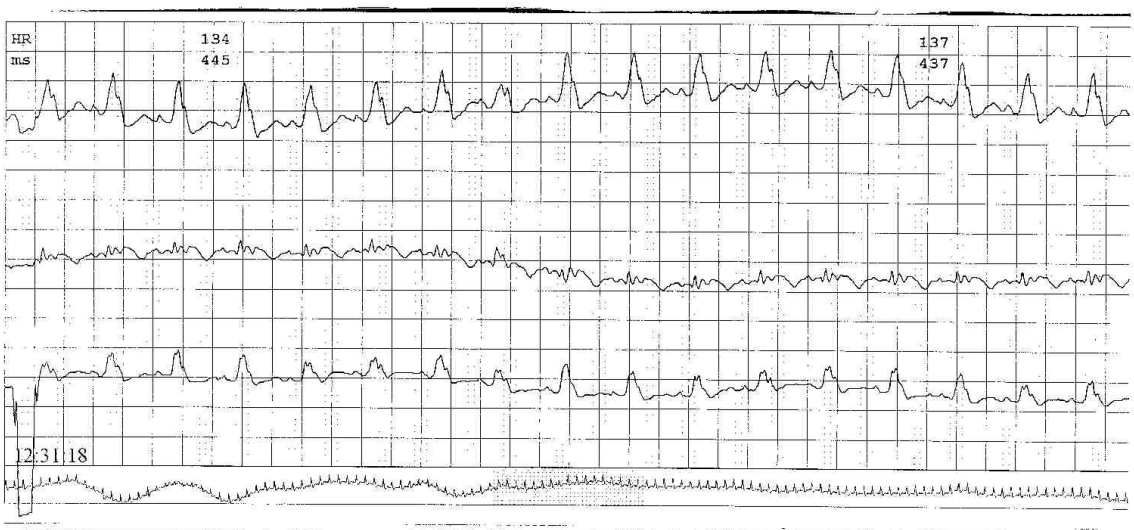
Dr. Benjamín Uribe

Estimados Colegas:
Feliz año 2010. Siempre deseándoles todo lo mejor, principalmente SALUD.
Mi caso:
Femenina de 74 años con diagnóstico de Cardiopatía hipertensiva e isquémica dilatada fracción de eyección 40% trat. Furosemida, 5 mononitrato, enalapril, aspirina, rosuvastatina, carvedilol, clopidogrel
Holter: BCRDHH, BCRIHH . intermitente, migración marcapaso, extrasístoles supraventriculares abundantes, salvas supraventriculares. escape auricular con aberrancia. Escasos ventriculares.
Pregunta: ¿alguien opina sobre el orden del tratamiento y la conclusión del HOLTER?
¿Se suspende carvedilol.si o no?

¿Coronariografía?
¿Estudio electrofisiológico?
¿Marcapaso?

Gracias
Benjamín Uribe

Trazado Nº 1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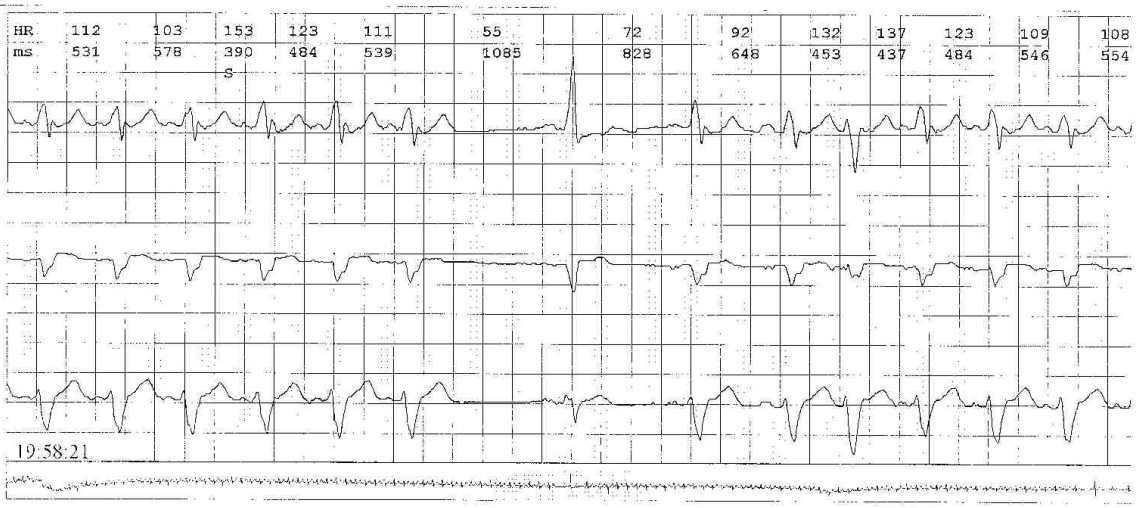
12:31:18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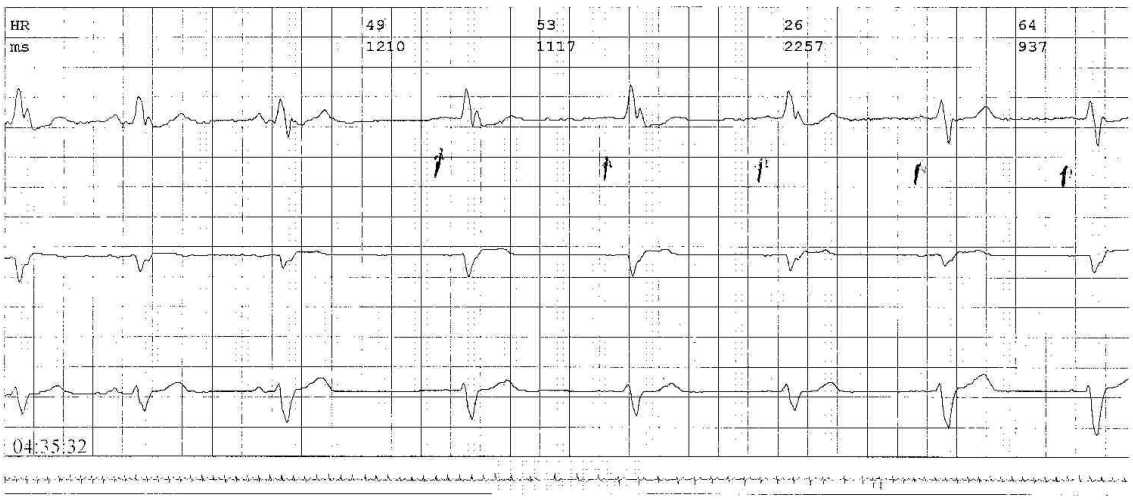
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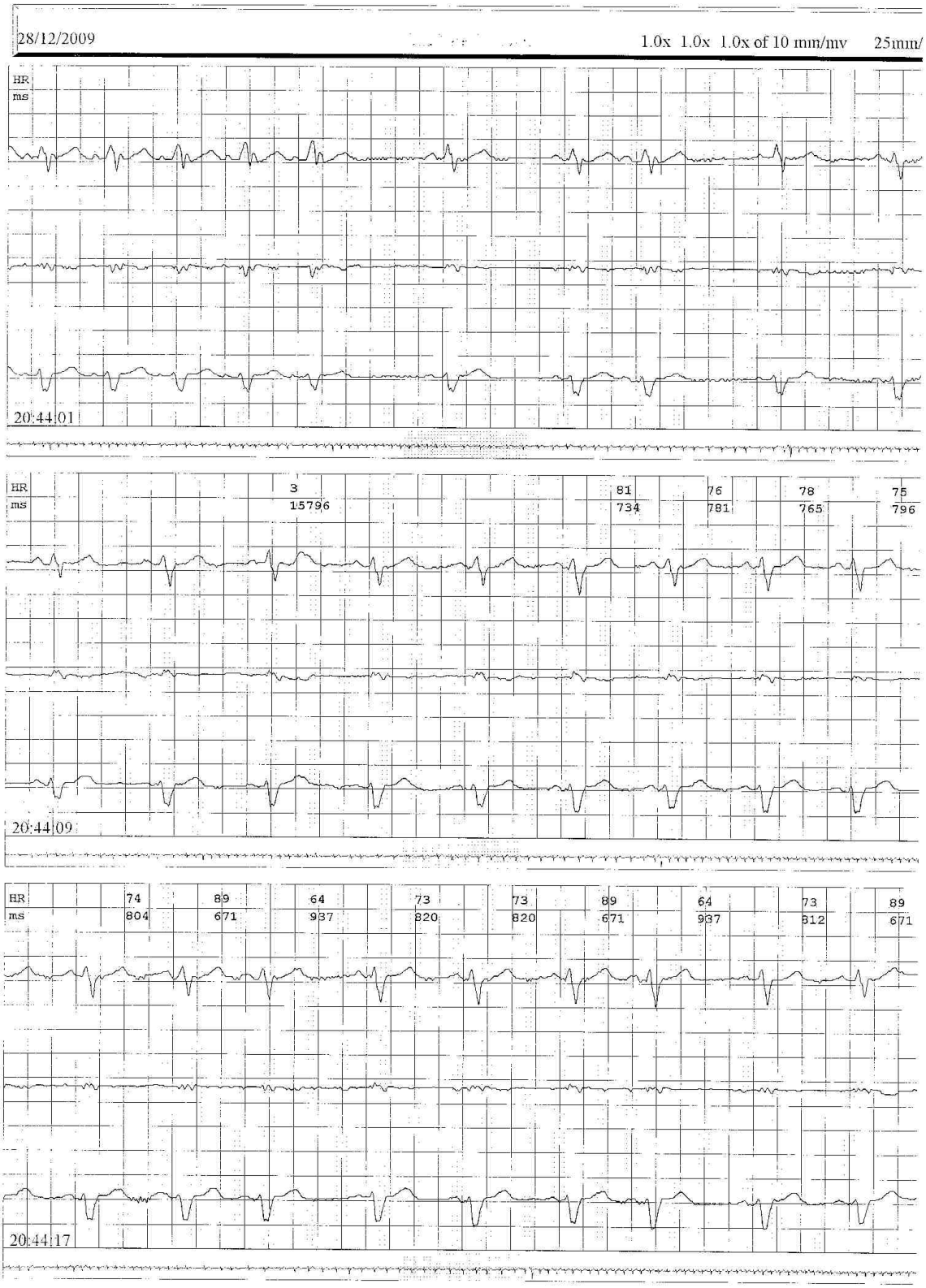
Trazado N.º 2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73
820
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671
20:44:17

Dear Buribe: We observe Bilateral Bundle Branch Block (BBBB) interruption of cardiac impulses through both bundle branches, clinically indistinguishable from third degree (complete) heart block. Is register in the same patient paroxysmal alternating atrioventricular block and bilateral bundle branch block manifested by periods of both RBBB and LBBB and pauses.
This pattern appeared to reflect a lesion involving concomitantly the distal His bundle and proximal bundle branches. In the total group of patients studied by Wu et al (1), wrote in circulation that clinical course is primarily determined by the severity of heart disease and not by occurrence of A-V block. The conduction defect in the majority of patients is surprisingly benign.
On the other hand, mechanisms postulated for alternating bundle branch block are incomplete -and cycle-length-dependent-block in both the right and left bundle branches. A patient with severe longstanding cardiac conduction disease who developed alternating bundle branch block during treatment for advanced ischemic heart disease and malignant ventricular arrhythmia was presented by Gold and From (2). In this patient alternation was induced by PACs as well as spontaneous and pacemaker induced PVCs. RBBB which followed a PACs resulted from the longer refractory period of the RBB.
The maintenance of RBBB at long cycle lengths was presumed to be due to continuous retrograde reentry. This was terminated when a pause following a premature beat allowed functional recovery of the RBB. This patient died suddenly at home with a functioning pacemaker, demonstrating the high risk of death from ventricular dysrhythmia in the post MI patient with a new conduction defect.
Ogura et al (3) describe a 66-year-old woman who had an alternating bundle branch block consisting of coexisting occurrence of RBBB and LBBB combined with Mobitz type II AC block. A prolonged PQ interval was associated with the RBBB pattern whereas it was not apparent in the LBBB pattern. EPS revealed that the LBBB pattern was combined with a double His bundle potential (Splitz HIS). On the other hand, the RBBB pattern was combined with a markedly prolonged HV interval with a low voltage monophasic His bundle potential, which the authors speculated was the former part of the split His bundle potential seen during the LBBB pattern. A combination of the longitudinal dissociation in the His bundle and the gap phenomenon at the intra-Hisian block portion may account for this dromotropic disorder (3).
ACC/AHA GUIDELINE in this case first permanent pacing because we have an equivalent to chronic bifasicular and trifascicular block (level of evidence Class 1B). Maintain carvediolol 25mg 2 x + spironolactone + angiotensin-converting-enzyme inhibitor or angiotensin II receptor antagonist + furosemide + Statins. After Bilateral Bundle Branch Block (BBBB) interruption of cardiac impulses through both bundle branches, clinically indistinguishable from third degree (complete) heart block. Is register in the same patient paroxysmal alternating atrioventricular block and bilateral bundle branch block manifested by periods of both RBBB and LBBB.
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References

1. Wu D, Denes P, Dhingra RC, Amat-Y-Leon F, Wyndham CR, Chuquimia R, Rosen KM. Electrophysiological and clinical observations in patients with alternating bundle branch block. Circulation. 1976 Mar;53:456-464.
2. Gold FL, From AH. Alternating bundle branch block. Electrocardiol. 1980 Oct;13: 405-407.
3. Ogura Y, Kato J, Ogawa Y, Shiokoshi T, Kitaoka T, Suzuki T, Kawamura Y, Tanabe Y, Sato N, Hasebe N, Kikuchi K. A case of alternating bundle branch block in combination with intra-Hisian block. Int Heart J. 2005 Jul;46:737-44.

Andrés R. Pérez Riera

Amigo Buribe
Feliz 2010!

1. No veo bloqueo de rama alternante
2. El ritmo unional (no descripto en su análisis) ocurre a las 4 de la mañana, cuando supongo que la paciente esta durmiendo)
3. Mi secuencia de estudios sería:
    a. ECG de 12 derivaciones para definir cual es el trastorno de conducción predominante (y sospecho que único en esta paciente)
    b. Prueba de esfuerzo (o Eco estress)
    c. Si hay isquemia con la medicación actual, entonces angiografía
    d. No le suspendería el BB por ahora, mas creyendo que la paciente está isquémica
    e. No veo la necesidad de EEF ni marcapasos, por ahora.

Saludos

Adrián Baranchuk

En mi opinión el bloqueo es siempre de rama izquierda. (por lo menos en los registros enviados) En la mayoría de las pausas largas parece haber una P (adelantada) bloqueada (ESV bloq). Las variaciones del QRS son posicionales.

Marigel Beltramino

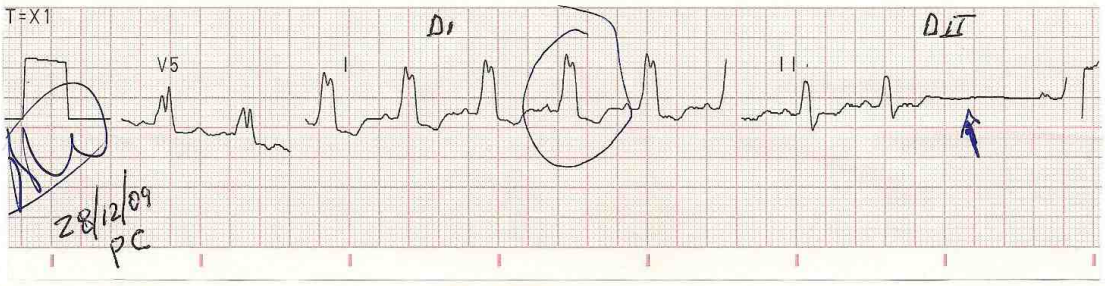
Estimados colegas:

Gracias a los profesores Edgardo, Andrés y Adrián, al igual que a Marigel por sus opiniones.

Ahí les envío un ECG de 12 derivaciones, dos Holter de 12 derivaciones y el eco para que tengan un diagnóstico mas acabado. De la fem. de 73 años con bloqueo intermitente

Mil gracias nueva vez por mantener este foro tan emocionante, interesante, actualizado, dinámico, orientador y sin igual.
Nota: entre google y yo pudimos traducir más o menos la opinión del profesor Andrés, pero quede ávido, sediento, anhelante. Lo que me motiva aprender mas ese idioma.

BURIBE.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DI
II
DII
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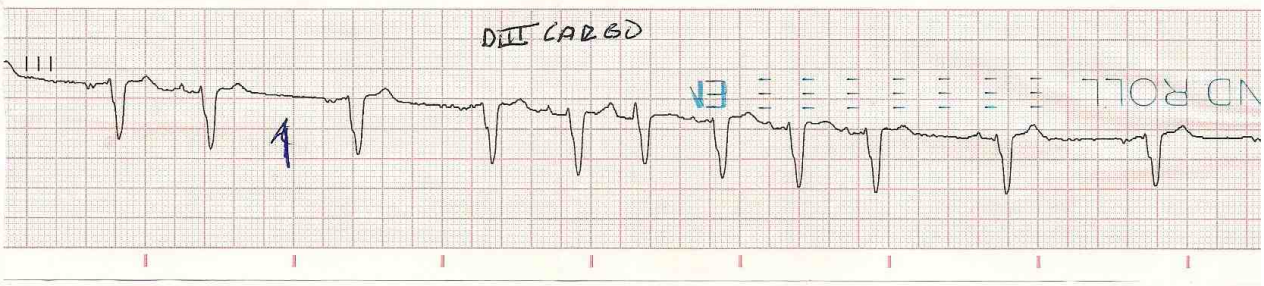
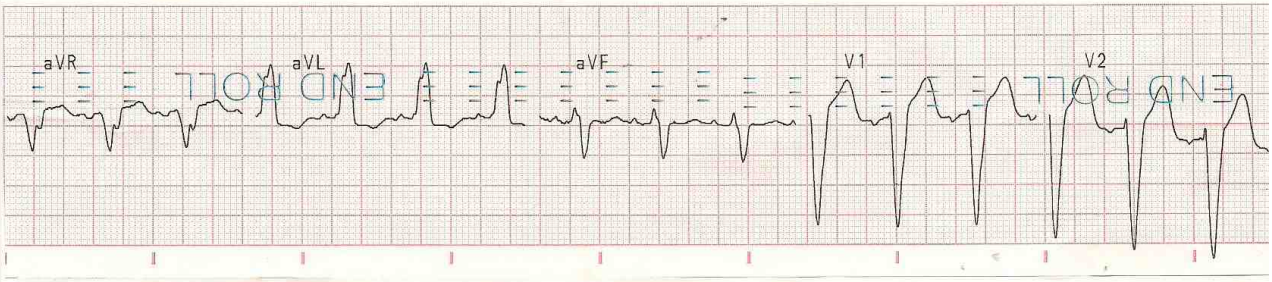
PC


III
DIII CARGD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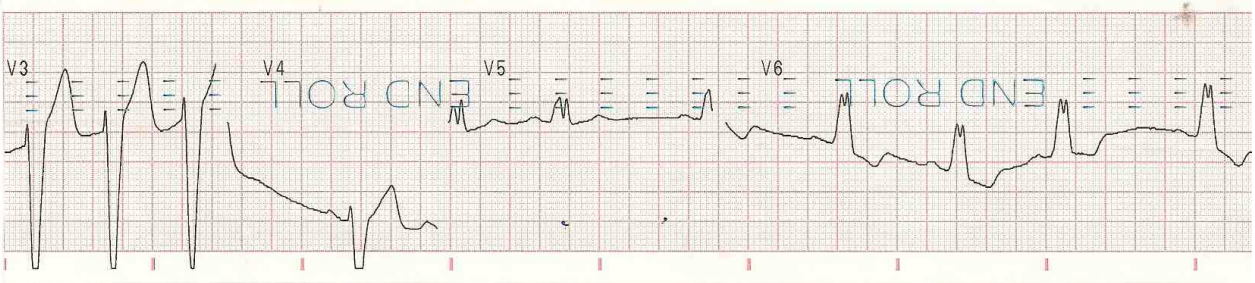
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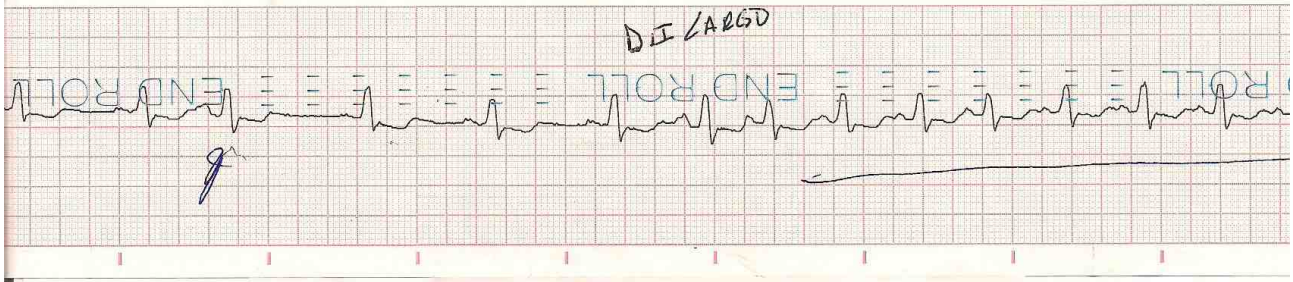
V4
V5
V6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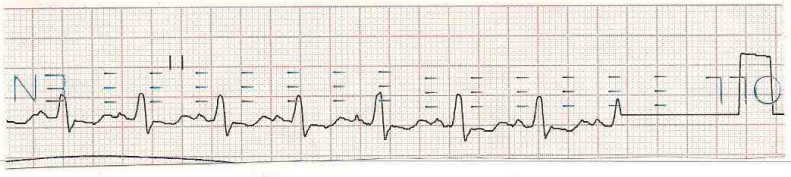
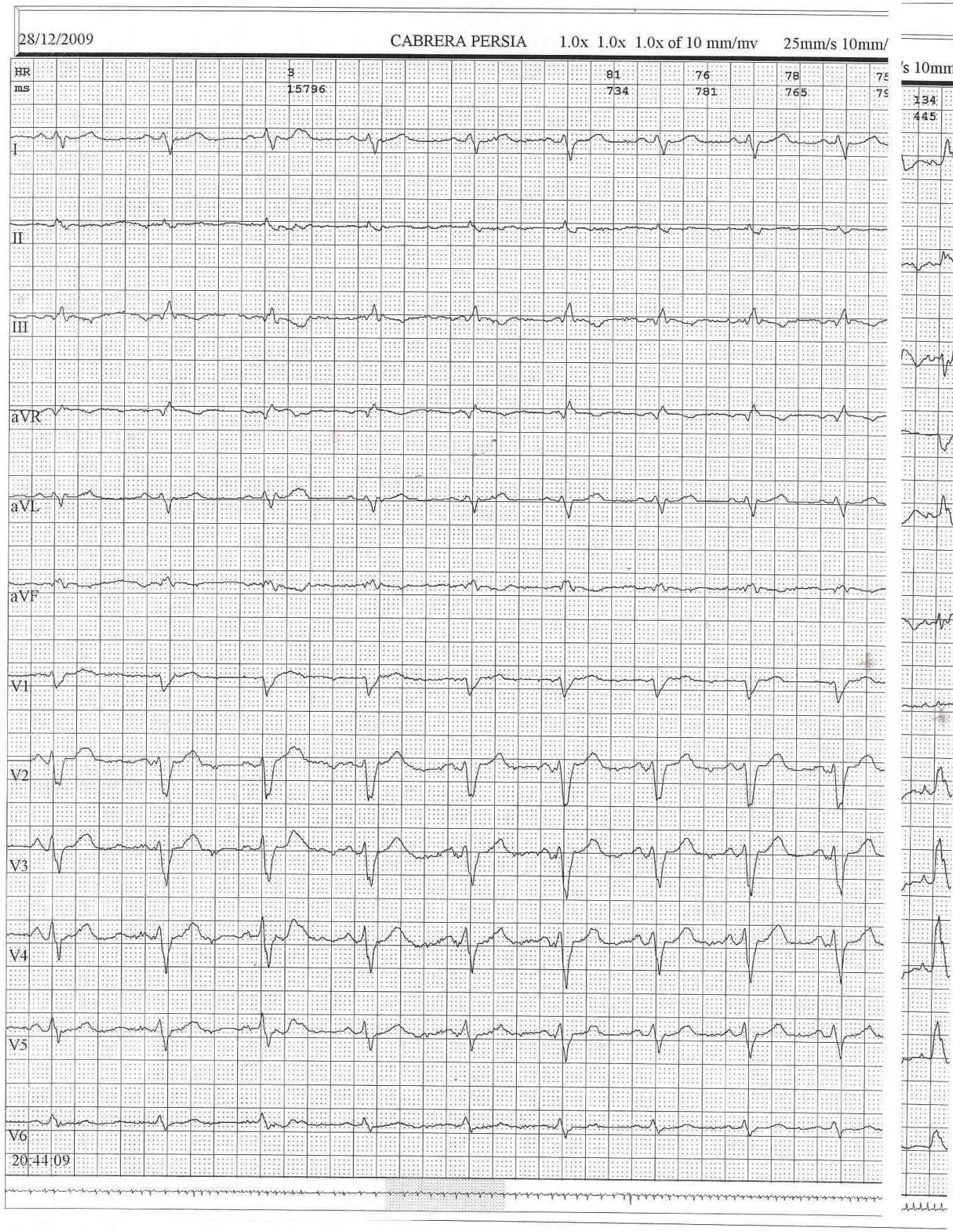

II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