Mujer de 57 años con cuadro de insuficiencia cardíaca congestiva y taquicardia de complejo ancho – 2019

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Case report

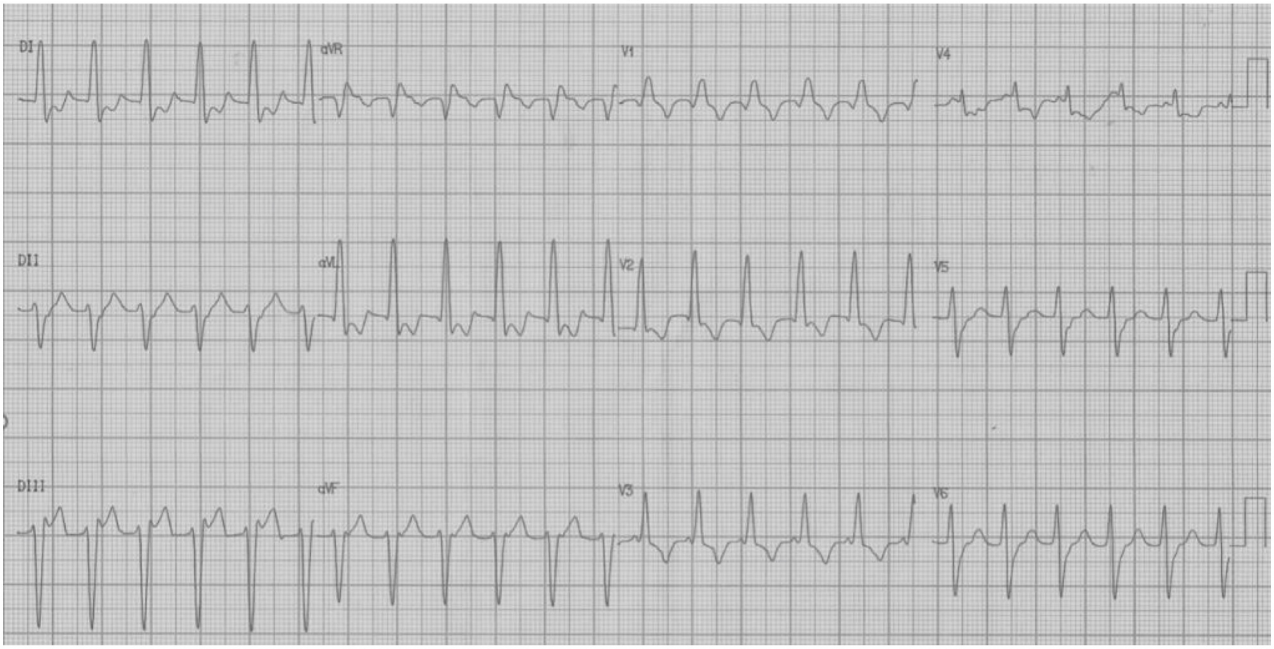
Female, 57 years old, married, white, clerk, natural from Fortaleza, Ceará, Brazil (stopped working 15 years ago) She was hospitalized with picture of congestive heart failure (CHF).
Main complaint "heart grown" about five years ago.
Family history: One of the five siblings died by “cardiomegaly". Negative epidemiology for Chagas disease.

Pathological personal history:

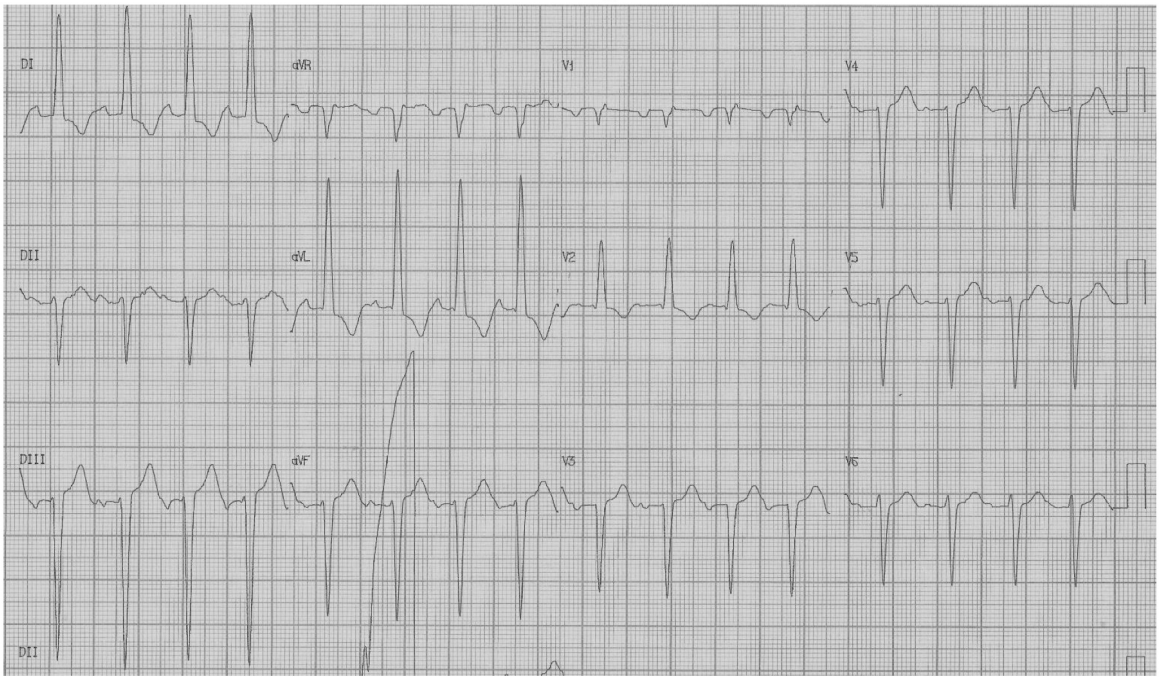
She was smoker from 16 to 28 years old.
Systemic hypertension since 2012 in irregular treatment.
In 2014 presented the first major CHF that led to hospitalization for 15 days. At that time, rheumatoid arthritis was diagnosed with mild joint aggression. After two years she stopped the medication on her own and presented a new CHF causing a second hospitalization.
In April 2019 a sudden cardiac arrest was reversed. The event was interpreted as a resulting from not confirmed "acute myocardial infarction". Cardiac catheterization shows normal coronary arteries and left ventricular dilatation.
Transthoracic echocardiogram: significant increase of the left ventricle with eccentric modality. Left ventricular mass = 290g (increased), LV diameters = 62/52, LVEF = 32%.
Questions:

1. Which is the diagnosis of this wide QRS complex tachycardia of tracing A or 1?
2. Why is the width of ECG B different from ECG C?
3. What is the electrocardiographic diagnosis of each of the three tracings?

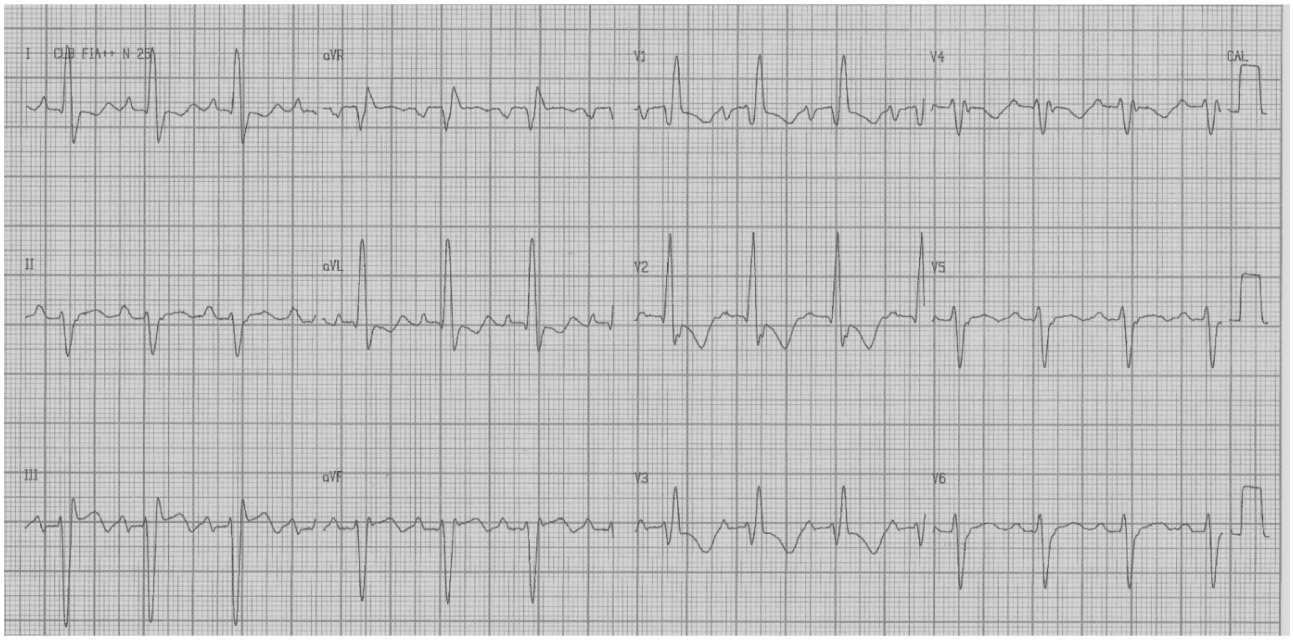
Tracing A or 1



Tracing B or 2



Tracing C or 3



OPINIONES DE COLEGAS

Hola Andrés

Presenta una TSV con diferentes grados de abarranca de las fibras medioseptales de acuerdo a la Frecuencia de lo que impresiona una taquicardia auricular ectópica.

En el 3er ECG ritmo sinusal y continúa con bloqueo del fascículo ánteroseptal y signos de CAD. Con FAP.

No descartaría una miocardiopatia por taquicardia asociada a hipertensión pulmonar o TEP.

Un abrazo

Martín Ibarrola

Hola amigo

No es fácil, pero arriesgo:

Respuesta 1

Taquicardia supra ventricular 145 por min. compatible con AA o TA con aberancia por trastorno conducción preexistente por BFAI, asociado a FAP (fuerzas anteriores prominentes) que evocan fibrosis necrosis ínfero lateral de VI

Respuesta 2

ECG 2 se diferencia de 3 por la asociación al BFAI, un RECD o BRD tipo Kennedy 3, persistiendo las FAP

Respuesta 3

los ECG evocan una miocardiopatia dilatada no chagásica ni Isquémica, probablemente de causa infiltrativa intra o extraceluar a predominio de afectación de segmentos ínferolateral

Saludos cordiales

Juan José Sirena