Paciente masculino de 61 años cursando infarto de miocardio hiperagudo – 2008

Dr. Andrés R. Pérez Riera

Edgardo,

Este caso nos fornece grande ensinamento.

Paciente em fase hiper-aguda de infarto anterior.

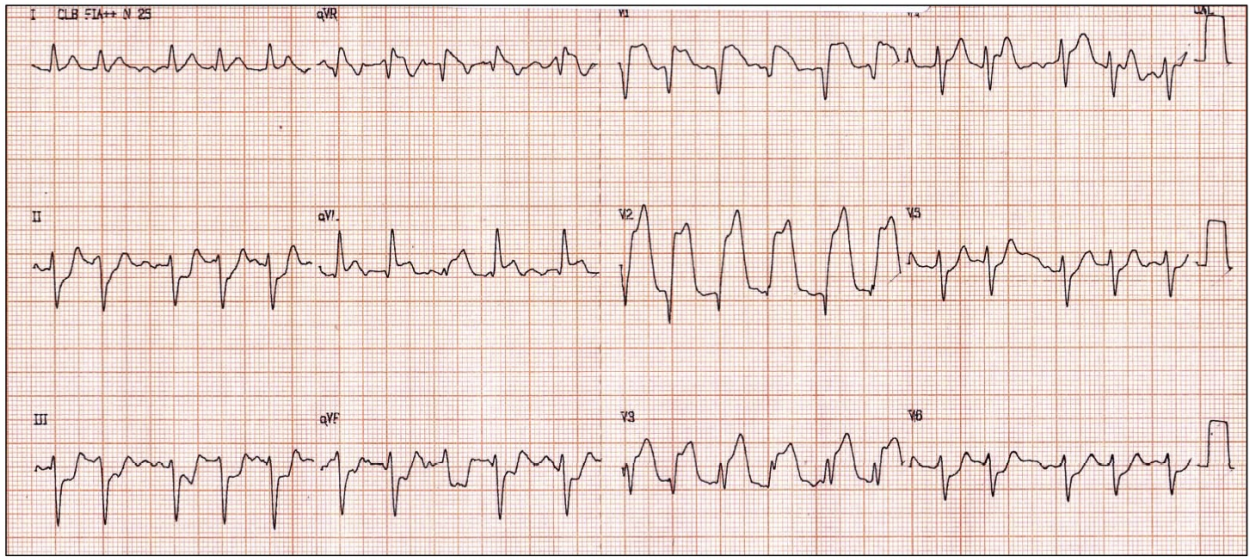
O nivelamento do segmento ST na parede inferior permite deduzir que a obstrução da artéria DA é proximal e não distal.

Caso muito interessante para o fórum.

Andrés.

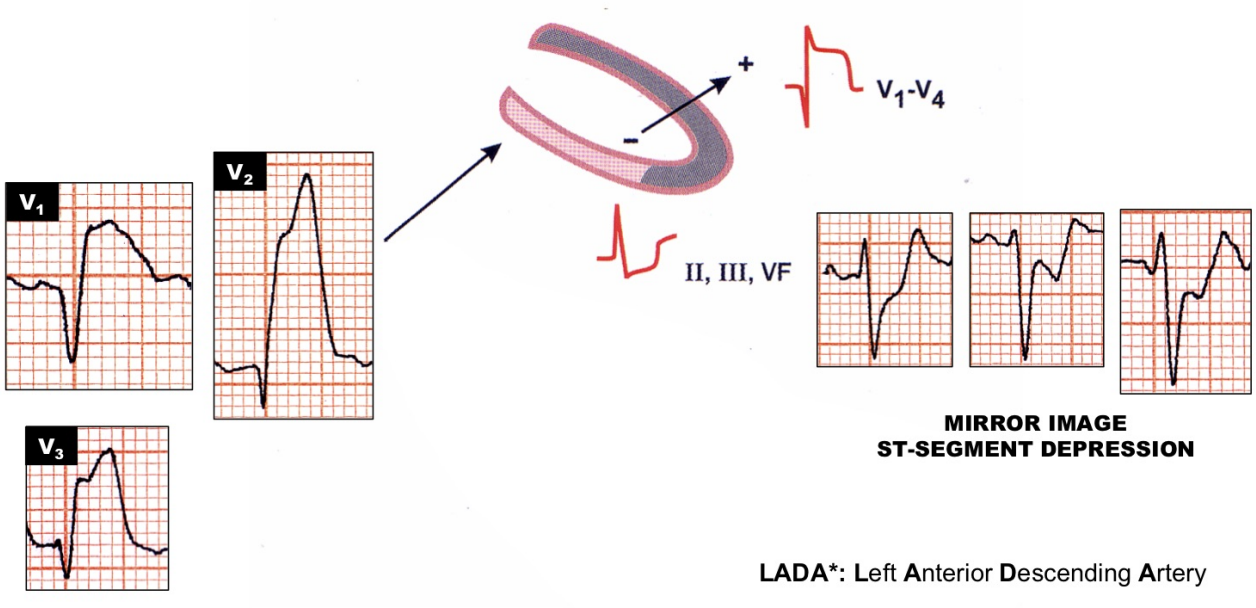
Name: CF **Sex:** Male **Age:** 61 yo. **Race:** Caucasian
Weight: 82 Kg **Height:**1,72 m **Biotype:** Normoline
Medication:

Date: 05/01/2008 **Time:** 11:25AM



Clinical Diagnosis: Myocardial Infarction in hyperacute phase (<1 hour of typical clenched fist chest pain). Proximal obstruction of a long left anterior descendent coronary artery.
ECG diagnosis: Rhythm: atrial fibrillation with rapid ventricular response + LAFB + hyperacute phase anterior MI (anteroseptal zone).
The question is: which is the diagnosis following the new ECG classification of Q-wave myocardial infarction based on correlations with cardiac magnetic resonance ? A1, A2, A3 or A4?

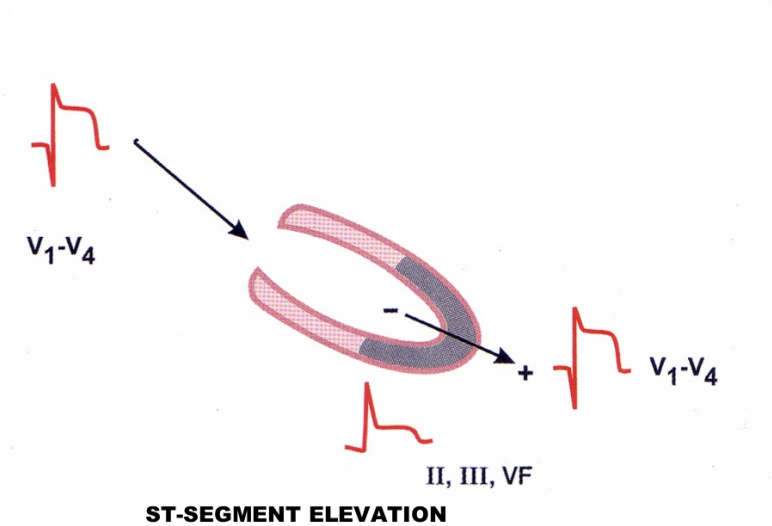
TYPICAL ECG PATTERN IN PROXIMAL OBSTRUCTION OF LADA* (HYPERACUTE PHASE)



LADA*: Left Anterior Descending Artery

Bayés de Luna A. Electrocardiografía Básica. Patrones electrocardiográficos normales y patológicos. Pg. 95. Prous Science, 2007.

TYPICAL ECG PATTERN IN DISTAL OBSTRUCTION OF LADA* (HYPERACUTE PHASE)



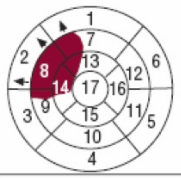
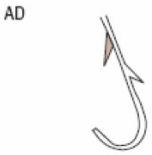
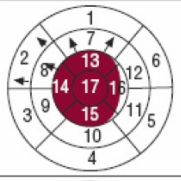
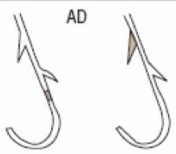
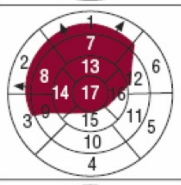
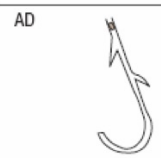
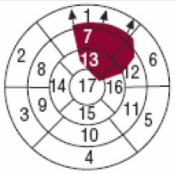
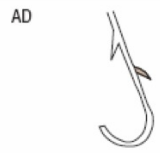
ST-SEGMENT ELEVATION

LADA*: Left **A**nterior **D**escending **A**rtery

Bayés de Luna A. Electrocardiografía Básica. Patrones electrocardiográficos normales y patológicos. Pg. 95. Prous Science, 2007.

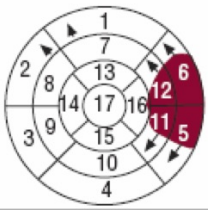
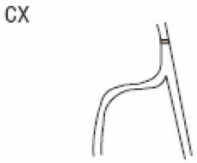
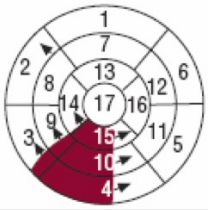
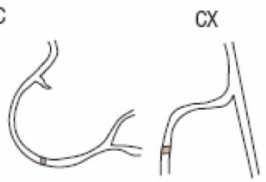
THE ECG PATTERN OF Q-WAVE MYOCARDIAL INFARCTION (MI) OR Q-WAVE EQUIVALENTS WITH THE NAMES GIVEN TO MI AND RELATED INFARCTION AREA DOCUMENTED BY CARDIAC MAGNETIC RESONANCE

ANTEROSEPTAL ZONE

Types of MI	Infart Area (MRI)	Electrocardiographic Patents	Name of the Infarct	More Probable Place of Occlusion
A1		Q in V1-2 SE: 86% ES: 98%	Septal	
A2		Q in V1-2 to V4-V6 SE: 86% ES: 98%	Apical/ Anteroseptal	
A3		Q in V1-2 to V4-V6 VL and Sometimes SE: 83% ES: 98%	Anterior Extense	
A4		Q (qr or r) in I, VL, and Sometimes I, V2-3 and/or R5 in V1 SE: 70% ES: 100%	Anterior Limited	

Bayés de Luna A. Rev Esp Cardiol. 2007;60:683-9.

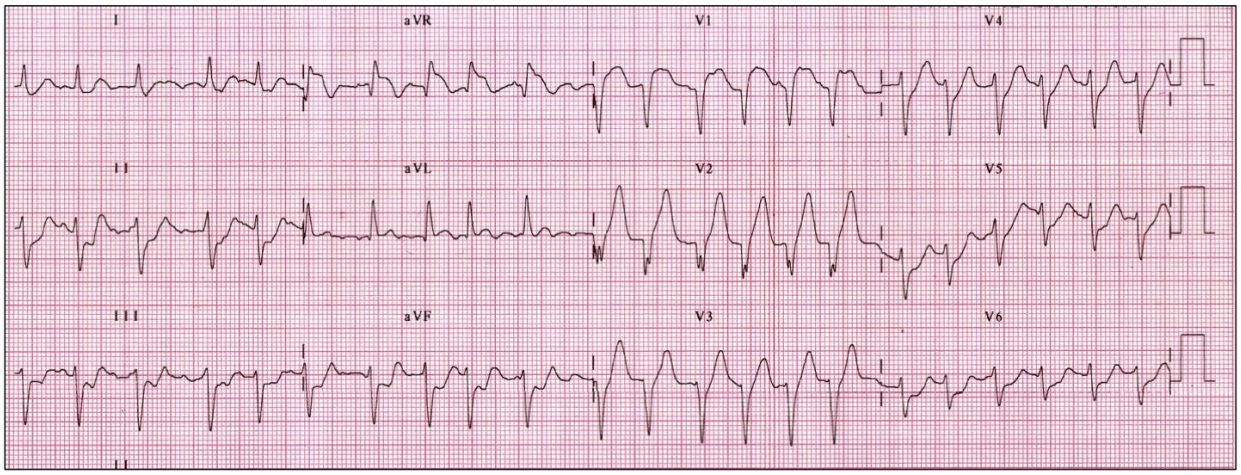
INFEROLATERAL ZONE

Types of MI	Infart Area (MRI)	Electrocardiographic Patents	Name of the Infarct	More Probable Place of Occlusion
B1		Q (qr o r) in I, VL, V5-6 and/or R5 en V1 SE: 50% ES: 100%	Lateral	
B2		Q in II, III, VF SE: 87,5% ES: 98%	Inferior	
B3		Q in II, III, VF (B2) + Q in I, VL, V5, 6 and/or RS in V1 (B1) SE: 70% ES: 100%	Inferolateral	

Bayés de Luna A. Rev Esp Cardiol. 2007;60:683-9.

Name: CF **Sex:** Male **Age:** 61 yo. **Race:** Caucasian
Weight: 82 Kg **Height:**1,72 m **Biotype:** Normoline
Medication:

Date: 05/01/2008 **Time:** 11:44AM

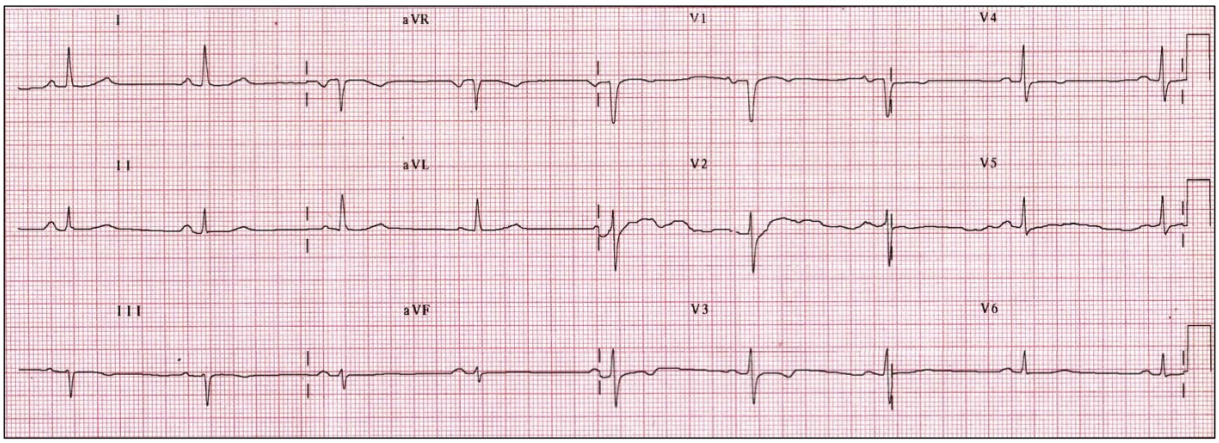


Clinical Diagnosis: Myocardial Infarction in hyper acute phase.

ECG diagnosis: Rhythm: atrial fibrillation with rapid ventricular response (134bpm average), SÂQRS: -80º, SIII > SII: Left Anterior Fascicular Block, anteroseptal infarct , QT/QTc: 324/484 ms, QT interval long for rate.
Angiography: RCA: 75% proximal stenosis + Mg from Cx artery 80%.+ LDA 100% proximal obstruction

Name: CF **Sex:** Male **Age:** 61 yo. **Race:** Caucasian
Weight: 82 Kg **Height:**1,72 m **Biotype:** Normoline
Medication:

Date: 13/01/2008 **12 days after initial manifestation**
After Percutaneous Transluminal Coronary Angioplasty with 2 stent implantation in RCA and Marginal from Cx coronary artery



Clinical Diagnosis:.
ECG diagnosis: ?

Now there are not dromotropic intraventricular disorder (and return to sinus rhythm).

OPINIONES DE COLEGAS

Estimados amigos:

En el ECG observamos como imagen más llamativa ascenso del ST de V1-V4 y también en VR y VL con descenso marcado en II, III y VF. Por tanto está claro que la arteria afecta es la DA

proximal a la primera septal (ascenso en VR, V1 y descenso V6) y también a la primera diagonal (descenso en II, III y VF). El descenso profundo en cara inferior nos orienta a que estamos ante una DA que seguramente no será muy larga. La presencia de fibrilación auricular puede indicar que la isquemia también se ha propagado a territorio auricular. Por lo tanto este tipo de SCA puede evolucionar, sino es abortado, a la patente A3 de la nueva clasificación de infartos propuesta por Bayés de Luna.

Saludos,

Javier García Niebla

Saludos a todos: Con relación al excelente caso del Prof. Dr. Andrés R. Pérez R., y tratándose de la primera pregunta, opino como el Dr. García Niebla que es un A3, hasta pronto,

Dr. Ricardo Pizarro.