Prikaz dva atipična slučaja bolesnica s kliničkom slikom akutnog infarkta miokarda s elevacijom ST-segmenta i potpuno urednim koronarogramom

Two atypical cases of ST segment elevation myocardial infarction and normal coronary arteries

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UVOD: Klinička slika akutnog infarkta miokarda s elevacijom ST-segmenta (STEMI) i potpuno urednim koronarogramom ne susreće se tako rijetko u intenzivnoj kardiologiji. Uglavnom se može objasniti sindromom apikalnog baloniranja miokarda – potpuno reverzibilnoj Takotsubo kardiomiopatiji koja je gotovo uvijek praćena s akutnom elevacijom ST-segmenta u prekordijalnim odvodima.

PRIKAZ SLUČAJA: Ovdje prikazujemo dva atipična slučaja sindroma apikalnog baloniranja miokarda u dvije bolesnice koje su liječene s kliničkom slikom akutnog infarkta miokarda bez elevacije ST-segmenta (NSTEMI) i akutnog STEMI. Prva bolesnica se prezentirala u suradnoj ustanovi sa slikom NSTEMI nakon udara groma, s pozitivnim nalazom kardiosepcifičnih enzima i razvojem vrlo diskretnih nespecifičnih elektrokardiografskih promjena u lateralnim odvodima. Na koronarografiji je nađen uredan nalaz, uz diskretnu apikalnu diskineziju koja se potpuno oporavila do kraja liječenja. Druga bolesnica je upućena na urgentnu koronarografiju iz suradne ustanove s tipičnom kliničkom slikom akutnog STEMI inferiorne stijenke. Nalaz koronarografije bio je potpuno uredan, a nalaz ventrikulografije pokazao je jasan ispad kontraktilnosti apikalno, iako su promjene ST-segmenta bile jasno izražene u inferiornim odvodima i potpuno reverzibilne do kraja hospitalizacije.

ZAKLJUČAK: Na Takotsubo kardiomiopatiju trebalo bi se posumanjati i u atipičnim slučajevima akutnog STEMI inferiorne regije s urednim koronarogramom.

INTRODUCTION: Normal coronary arteries found in patients with clinical signs of acute ST-segment elevation myocardial infarction are mostly found within the reversible apical ballooning syndrome, also known as Takotsubo cardiomyopathy. It almost always affects the left ventricular apex and is associated with ST-segment elevation in the precordial leads.

CASE REPORT: We present two cases. First case is a female patient with non-ST-segment myocardial infarction who was scheduled for coronary angiography because she had chest discomfort with nonspecific ECG changes in lateral leads and small rise in troponin T levels after she experienced mild thunderbolt. Her coronary angiogram was normal, however the left ventriculography showed apical dyskinesia. Second case is a woman who was sent for a primary percutaneous coronary intervention because of a typical clinical presentation of an acute inferior ST-segment elevation myocardial infarction. Her coronary arteries were normal, but she had apical wall akinesia, that recovered within a week.

CONCLUSION: Takotsubo cardiomyopathy should be considered even in the atypical cases of myocardial infarction with normal coronary arteries, such as inferior localization or non-specific ECG changes.

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LITERATURE

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