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Case Report

Adenosine induced coronary spasm – A rare presentation

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ABSTRACT

Adenosine is commonly used as a pharmacological agent in myocardial perfusion imaging, as an antiarrhythmic agent, and in Cath Lab. during PCI for treating no reflow phenomenon. Coronary spasm has been reported following adenosine injection during stress imaging. We report a rare complication with ST segment elevation, following adenosine injection, given for treatment of supraventricular tachycardia.

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1. Introduction

Adenosine is widely used as a pharmacological agent for stress myocardial perfusion imaging as it is a potent coronary vasodilator¹ as well as treatment of supraventricular tachycardia.² It is also used for treatment of no reflow phenomenon during PCI.³ Coronary vasospasm leading to ST elevation during MPI has been reported rarely^{4,5} which resolved spontaneously on discontinuation of infusion. Isolated case reports of transient ST elevation following adenosine injection, given for treatment of SVT are there,⁶ but to our knowledge no cases have been reported from the Indian subcontinent.

2. Case report

A 39-year-old female presented to emergency with complaint of sudden onset palpitation, 2 h prior to admission. There was

no history of chest discomfort or syncope accompanying palpitations. She did not have any history of previous such episodes. On examination pulse rate was rapid with a systemic blood pressure of 100/80 mmHg. Rest of clinical examination was unremarkable. ECG was done and it revealed SVT with heart rate of 200 BPM (Fig. 1A). Vagal maneuvers were unsuccessful in terminating the tachycardia. Intravenous adenosine bolus of 6.0 mg was planned and given through large bore cubital vein. The tachycardia terminated following adenosine injection, however upon cessation of tachycardia, patient started developing ST segment elevation noted on monitor. ECG done revealed ST elevation in inferior leads, consistent with inferior wall myocardial infarction (Fig. 1B). Patient developed hypotension and started gasping. She was immediately intubated. Echocardiography revealed regional wall motion abnormality in inferior wall. ST segment started settling after 4–5 min. Patient was started on inotropes and taken to Cath Lab with intent to perform primary PTCA.

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