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Case report

Unusual electrocardiographic changes during acute pancreatitis

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ABSTRACT

A 46-year-old man suffered from mild upper abdominal pain radiating to the back and nausea; after a week he began to complain also of chest discomfort radiating to the neck and presented to the emergency room. A 12 leads electrocardiogram showed large peaked T waves in leads II-III-AVF and giant T waves inversion in AVL, V₁ through V₆; half an hour later the chest discomfort and the electrocardiographic changes resolved. Serum biochemistry results showed elevated serum pancreatic enzymes; electrolytes, creatinine kinase and troponin T serum values remained normal. Coronary angiography showed normal coronary arteries. The patient was conservatively managed.

Electrocardiographic abnormalities were reported in patients with acute pancreatitis but broad, tall and peaked T waves, as found in our patient electrocardiogram, have not been yet reported.

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Introduction

Acute pancreatitis presents with abdominal pain and elevated pancreatic enzymes in serum. It is associated with variable involvement not only of pancreatic tissue but also of other organs. Alcohol abuse and gallstones are its two most common etiological factors [1].

Case report

A 46-year-old man suffered from mild upper abdominal pain radiating to the back and nausea. After a week he began to complain also of chest discomfort radiating to the neck and

presented to the emergency room. He had no known cardiac disease or cardiovascular risk factors. The patient had no previous attacks of pancreatitis or cholecystitis and he was hospitalized for the first complaints; he had no history of immoderate alcohol consumption.

On physical examination the patient was afebrile, had a Body Mass Index of 30.1, blood pressure 141/90 mmHg, pulse 72 beats/min., oxygen saturation 94% on air, and cardiac and pulmonary examination were unremarkable; abdominal palpation disclosed mild diffuse tenderness, worse in the epigastrium; bowel sounds were normal.

A 12 leads electrocardiogram (ECG), taken at his arrival to the emergency room, showed sinus rhythm 60 beats/min, large peaked T waves in leads II-III-AVF and giant T waves inversion in AVL, V₁ through V₆ (Fig. 1A); about half an hour

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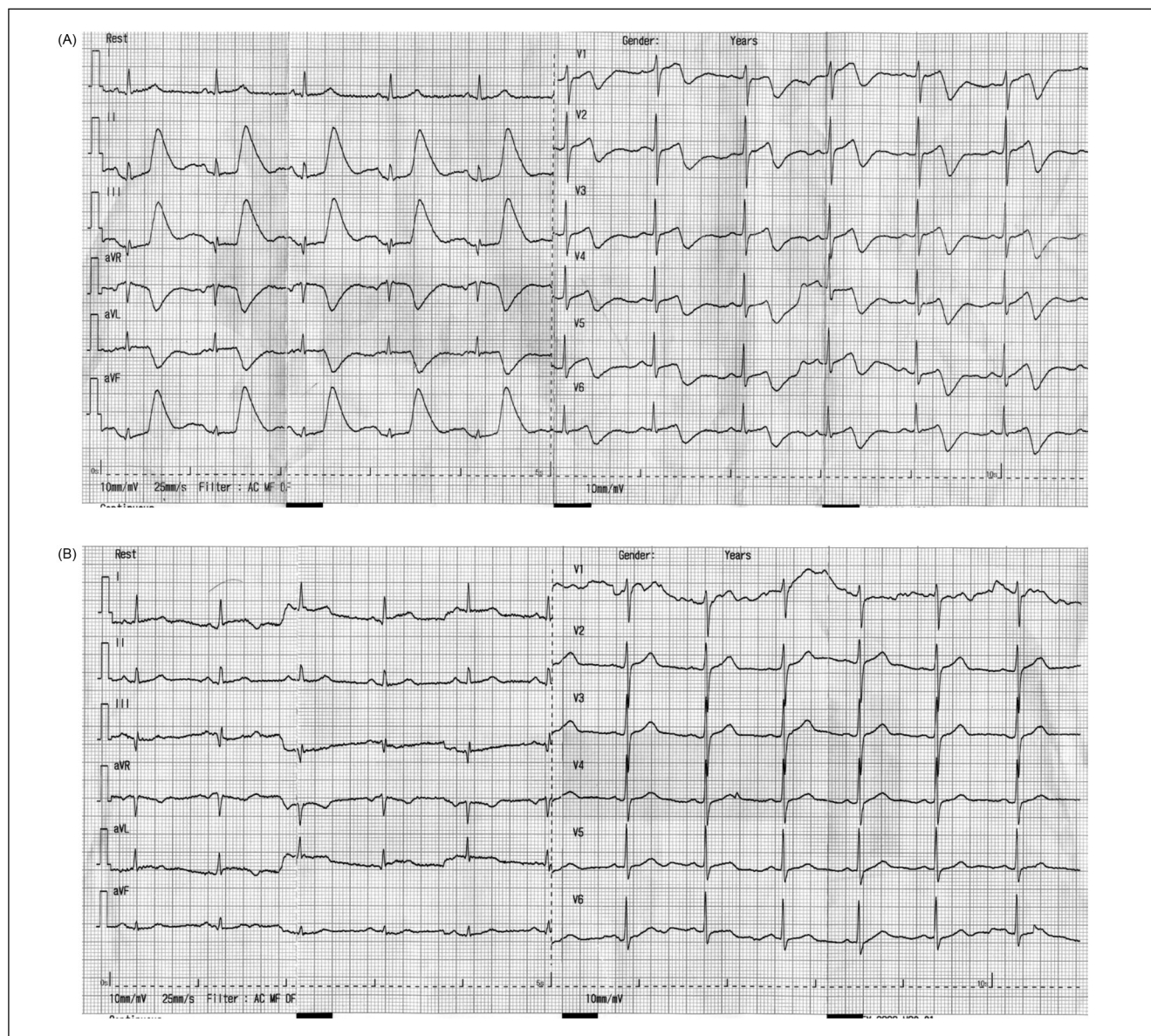


Fig. 1 – (A) Electrocardiogram on admission showing sinus rhythm 60 beats/min, large peaked T waves in leads II-III-AVF and giant T waves inversion in aVL, V₁ through V₆. (B) Electrocardiogram obtained half an hour after the initial one revealing resolution of the ischemic changes.

later the chest discomfort resolved and a repeat ECG revealed resolution of the ischemic changes (Fig. 1B).

Serum biochemistry results are shown in Table 1. Transthoracic echocardiography, performed when the ECG changes resolved, found normal left ventricular function with no wall motion abnormalities and no pericardial effusion.

An upper abdomen ultrasound examination revealed multiple small gallstones in the gallbladder.

Coronary angiography performed on the following day showed normal coronary arteries (Fig. 2A and B).

The patient was conservatively managed. He no further complained of chest discomfort; the abdominal symptoms improved and his ECG remained normal for the course of hospital stay. During outpatient clinic follow-up gradually

his chemistries returned to normal levels. The patient underwent laparoscopic cholecystectomy 6 months after hospital discharge. One year follow-up was uneventful regarding cardiac symptoms and pancreatitis.

Discussion

The abdominal pain, pathological values of serum pancreatic enzymes and ultrasound evidence of gallstones are suggestive of acute pancreatitis. Chest pain and tall peaked T waves on ECG are suggestive of myocardial ischemia; however, in our patient cardiac catheterization excluded presence of coronary artery disease.

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