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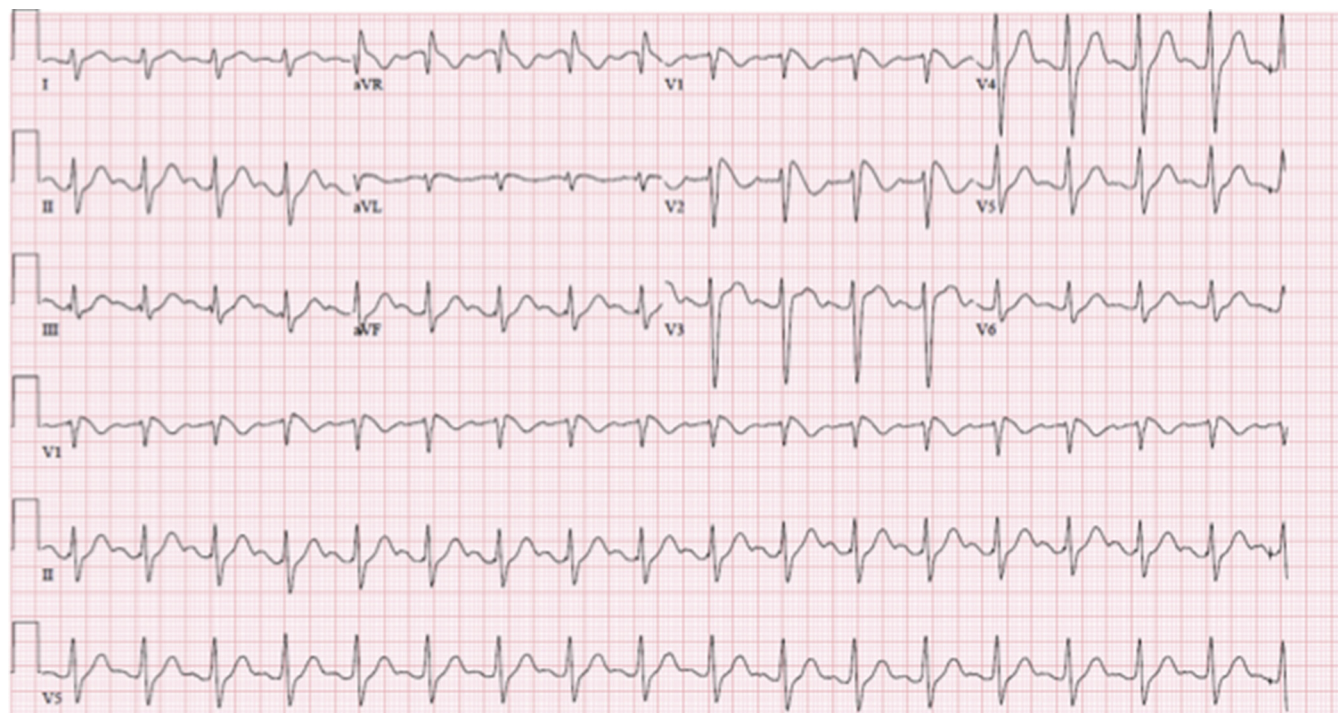
<http://dx.doi.org/10.1016/j.annemergmed.2016.03.022>

Figure 1. Initial electrocardiogram.

[Ann Emerg Med. 2017;69:552-553.]

CASE PRESENTATION

A 47-year-old white man was brought to the emergency department (ED) by ambulance after being found unresponsive by his wife. He was accompanied by empty bottles of amitriptyline and cyclobenzaprine.

On physical examination, the patient's vital signs were remarkable for a blood pressure of 94/55 mm HG, pulse rate of 105 beats/min, respiratory rate of 18 breaths/min, and temperature of 35.7°C (96.3°F). Physical examination revealed an obtunded mental status, normal cardiopulmonary examination, and dry skin. Laboratory study results were normal: glucose 117 mg/dL; negative salicylate, acetaminophen, and ethanol concentrations; and a negative urine toxicology screen. An initial ECG (Figure 1) was obtained.

What is the diagnosis?

For the diagnosis and teaching points, see page 560.

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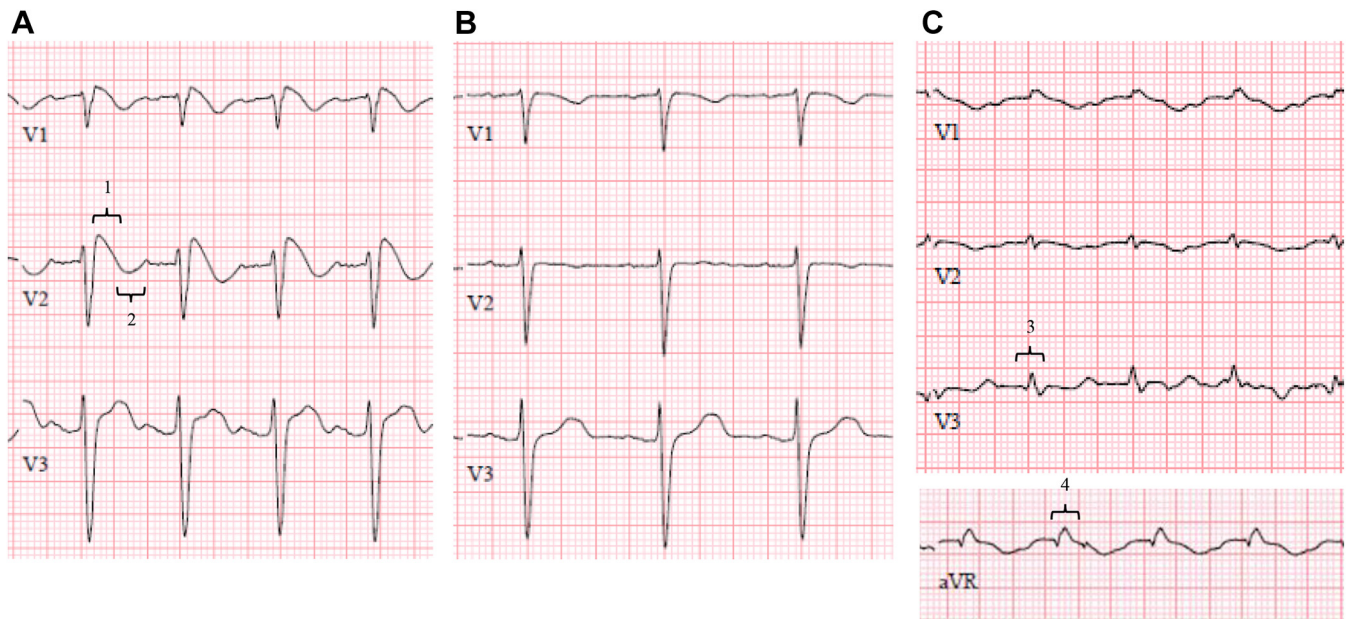


Figure 2. A, Initial ECG demonstrating a type 1 Brugada pattern. This pattern is defined by ¹coved ST-segment elevation greater than or equal to 2 mm, followed by ²T-wave inversion in greater than 1 of the right precordial leads (V1 to V3). B, Repeat ECG obtained after 300 mEq total of sodium bicarbonate. Note the disappearance of the coved ST segments in V1 and V2, as well as subtle QRS-interval shortening. C, Representative ECG from tricyclic antidepressant overdose without induced type 1 Brugada pattern. This ECG was obtained from a separate patient also presenting with tricyclic antidepressant overdose. Note the sinus tachycardia, ³QRS prolongation, and ⁴prominent R wave in aVR that are typical ECG features of tricyclic antidepressant overdose. Compared with B, this ECG does not demonstrate coved ST-segment elevation followed by T-wave inversion in the right precordial leads, which are typical of the type 1 Brugada pattern.

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