Case report: Shorter-than-normal QT interval and provicable right precordial ST segment elevation in three patients with suspicious arrhythmogenic right ventricular cardiomyopathy

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Shorter-than-normal QT interval and provokable right precordial ST segment elevation in three patients with suspicious arrhythmogenic right ventricular cardiomyopathy

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Abstract

According to an American Heart Association Scientific Statement of the contemporary definition and classification of cardiomyopathies, suspicious arrhythmogenic right ventricular cardiomyopathy is demonstrated in 3 cases of typical Brugada syndrome with a shorter-than-normal QTc interval. The history and the findings of electrocardiology, echocardiography, right ventricular angiography and electrophysiology are described in detail.

Introduction

An American Heart Association Scientific Statement of contemporary definition and classification of cardiomyopathies describes arrhythmogenic right ventricular cardiomyopathy, Brugada syndrome and short QT syndrome as classical genetic diseases [1]. Three cases of variants of Brugada syndrome with a shorter-than-normal QTc interval of < 360 ms in males and of < 370 ms in females [2] were associated with suspicious arrhythmogenic right ventricular cardiomyopathy.

Case Reports

Case 1: A 36-year-old male presented as an out-patient because of non-exertional chest pain, no syncope, no history of sudden cardiac death in the family. In the 12-lead ECG (amplitude 10 mV, paper speed 50 mm/s) a prolonged QRS interval in right precordial leads of more than 110 ms and a saddle-back ST-segment elevation in lead V2 with a small epsilon potential was found. QTc interval measured in lead II and lead V5 according to Bazett formula was at mean 340 ms before ajmaline administration (Fig. 1). Echocardiography revealed normal left ventricular function, no valve abnormalities and a right ventricle with normal dimensions, normal global function and contraction abnormalities of the apex and dilation of the right ventricular outflow tract. Coronary artery disease could be excluded by coronary angiography; right ventricular angiography in 30°RAO and 60°LAO projection could confirm echocardiographic findings. Ajmaline challenge disclosed type 1 ST-segment elevation in V1 and V2 with the development of right bundle branch block and negative T
waves in V1 (Fig. 1). The patient refused programmed ventricular stimulation and was free of symptoms in a 6 years’ follow-up.

**Case 2:** A 29-year old male with an inborn brain damage and known epileptia in the childhood was admitted to the hospital because of syncope without any medication. There is no history of sudden cardiac death in the family. Standard 12-lead ECG showed a QTc interval measured in lead II and in lead V5 according to Bazett formula of at mean 340 ms before ajmaline administration, prominent U waves in V2 and V3 and right precordial QRS prolongation of 110 ms. Small epsilon potentials were present in V1 and V3 (Fig. 2). Echocardiography revealed a localised apical akinesia of the right ventricle with a prominent moderator band. During the electrophysiologic study no sustained ventricular arrhythmias were inducible. Right ventricular angiography confirmed major apical dilatation and akinesia in 30°RAO and 60°LAO projection. Ajmaline challenge demonstrated significant type 1 ST-segment elevation in V1 with typical right bundle branch block and negative T waves in V1 (Fig. 2). Antiepileptic therapy was restarted; syncopes do not appear in a 5 years’ follow-up.

**Case 3:** A 54-year-old female was admitted to hospital because of recurrent syncopes. No history of familial disease. In the 12-lead standard ECG right precordial QRS prolongation of 110 msec with T wave inversions in V1 and V2 and a QTc interval measured in lead II and lead V5 according to Bazett formula of at mean 360 ms before ajmaline administration was striking (Fig. 3). Coronary artery disease could be excluded by coronary angiography. Biplane right ventricular angiography could demonstrate major apical and inferior akinesia. Programmed ventricular stimulation could not induce sustained ventricular arrhythmias. Ajmaline challenge could provoke significant type 1 ST elevation in V1 and V2 with typical right bundle branch block and negative T waves in V1 and V2 (Fig. 3).

Because of recurrent syncopes and the result of the ajmaline challenge with negative T waves in V1 and V2 an ICD was implanted without documentation of ventricular arrhythmias in the holter of the ICD and recurrent holter monitorings despite recurrent syncopes in a 4 years’ follow-up. After a lead fracture of the ICD and because a repeated electrophysiologic study was again negative, the ICD was explanted.

## Molecular Genetics

In patient no. 2 a mutation screening of the laboratory of Prof. C. Antzelevitch in Utica, USA, was conducted. A mutation of SCN5A gene (P2006A) was detected. Patient 1 lived in abroad and missed the screening. In patient no. 3 there are up to now no mutations found.

## Discussion

These 3 cases reported present for the first time the possible coincidence of shorter-than-normal QTc interval and provokable right precordial ST-segment elevation by ajmaline challenge and right ventricular abnormalities suspicious of arrhythmogenic right ventricular cardiomyopathy [3].

With regard to ECG features the three patients revealed coved-type ST segment elevation after ajmaline administration in two patients in two right precordial leads [4] and in one patient in only one right precordial lead. A similar clinical and arrhythmic profile has been described in typical Brugada patients with type 1 ST-segment elevation in a single right precordial lead [5]. In all three reported cases ajmaline led to typical right bundle branch block. This special ECG feature can be found in a certain percentage of cases [6]. Nevertheless, ECG findings after ajmaline challenge are striking in all three cases with a mixture of depolarisation and repolarization abnormalities discussed in Brugada syndrome [7]. Case no. 3 demonstrated type 1 ST segment elevation and negative T waves in V1 and V2 which is a major risk factor for the development of ventricular fibrillation in typical Brugada patients [8].

Shorter-than-normal QTc interval seen in all three cases is very similar to what has been found in mutations of the alpha1- and beta 2b-subunit of the L-type calcium channel gene in patients with Brugada syndrome [2]. These mutations were tested in two patients and were negative. The difference was that typical ST-segment elevation was only provolvable by ajmaline testing.

The finding of a mutation encoding the SCN5A (P2006A) gene in patient 2 is a very rare finding in a case of sudden infant death syndrome [9] and is expressed at the low rate in a general population of less than 0.4%. This polymorphism has
no diagnostic specificity [10]. Recently, P2006A was the only finding in a case of Brugada syndrome and recurrent ventricular fibrillation in case of acute tomb-stone like myocardial infarction (unpublished data Prof. Antzelevitch, Utica, USA). Right ventricular abnormalities based on echocardiographic and angiographic examinations could be found in all three cases in the so-called “triangle of dysplasia” [11]. Whether these three cases really represent arrhythmogenic right ventricular cardiomyopathy is difficult to decide as all patients only demonstrate with a maximum of one major and one minor diagnostic criteria according to modified Task Force criteria [12] and represent borderline ARVD/C patients. Endomyocardial biopsies were not taken and magnetic resonance imaging was not done. According to right ventricular angiography two patients had major diagnostic criteria with akinesia of the apex and in the other patient akinesia of the inferior and apical region of the modified Task Force criteria.

Two of 3 patients had a history of syncope leading to the question whether ICD implantation was absolutely necessary [13]. In case no. 2 syncope did not appear after initiation of antiepileptic therapy in a five year’s follow-up. In case no. 3 ICD implantation was performed, but a lead fracture made a revision necessary. Multiple holter monitorings showed no ventricular tachycardia and no ventricular fibrillation despite recurrent syncope in a 4 years’ follow-up. A tilt table testing after four years revealed a positive result and electrophysiologic testing was again negative. In borderline cases of arrhythmogenic right ventricular cardiomyopathy the value of ICD implantation in cases with syncope is still under debate [14]. In typical Brugada syndrome event rates in asymptomatic patients were low. Inducibility of ventricular tachyarrhythmias and family history of sudden cardiac death were not predictors of cardiac events [15]. The report of these three cases demonstrate a mixture of puzzling electrocardiographic and angio- and echocardiographic findings suggestive of ion channelopathies and cardiomyopathies supporting the attempt of the American Heart Association to define ion channelopathies as primary cardiomyopathies [1].

The dilemma is that all cases do not represent up to now a relevant phenotype of arrhythmogenic right ventricular cardiomyopathy, short QT syndrome and Brugada syndrome. The fact that in all these patients no arrhythmias appeared in a 4 to 6 years’ follow-up is striking; a longer follow-up is needed.

References:

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