

complications, and should be avoided in asymptomatic patients. The most common of these complications are inappropriate shocks, which cause pain, and can produce psychological trauma. Pulmonary vein isolation (PVI) is an effective method for controlling paroxysmal AF. The literature indicates that the success rate of PVI is 79.8% in the long term in patients with brugada syndrome.

Conclusions. According to studies, PVI has been shown to have minimal risk of complications and is considered one of the most effective long-term methods in the control of atrial fibrillation and brugada syndrome. This treatment method could be considered the first line of treatment for atrial fibrillation and in brugada syndrome.

Key words: atrial fibrillation, brugada syndrome, sudden cardiac death, implantable cardioverter-defibrillators, catheter ablation.

239. WELLENS` SYNDROME IN AN ELDERLY PATIENT

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Background. Wellens' syndrome consists of particular T-wave changes in the precordial leads on ECG accompanied by severe proximal left anterior descending artery stenosis, and is often associated with sudden cardiac death and acute myocardial infarction. It is a pre-infarction state. However, this syndrome is not always an acute process. There are two ECG patterns of Wellens syndrome. Type-A: up sloping ST waves, no or mild ST elevation at the J point and biphasic T waves, with initial positivity and terminal negativity. These T wave findings are present in about 25% of cases. Type-B: symmetrical deeply inverted T waves, in approximately 75% of cases. Both types, R waves preserved in the precordial leads

Case report. A 65-year-old male patient, was admitted in the Intensive Care Unit of MCH "Holy Trinity" with Non-STE ACS. Complaining on angina: burning chest pain felt as well in the neck and lower jaw, occurring at mild exertion lasting for ≥ 40 min and relieved by i/v nitrates. Other complains: shortness of breath at mild exertion and fatigue. History: his condition worsened for about 5 days ago while being on a ski resort in Ukraine and felt for the first time angina chest pain lasting about 1h. He was admitted in the ICU of the Regional non-PCI hospital and acute MI diagnose was established, based on a troponin I test – 3,14ng/ml. Because of high costs of the medical care he left the hospital and came back to Moldova by car. During the long trip (5h) he felt several angina episodes, the longest lasting about 40min. ECG at admission: sinus rhythm, normal axis, HR = 76 bpm, up slopping ST segment in V2-V4, ST elevation at the J point max 0,5 mm in V3, biphasic T waves in V2-V4 initially positive than negative. Echography: no wall motion abnormality revealed, EF 58%. Serum troponin T – 0.21 ng/ml (0,3ng ml reference limit), CK-MB - 17 U/l (reference limit 24 U/l). Coronary angiography: two-vessel disease, sub occlusive stenosis of proximal LAD (99%), severe on RCA (75-90%). PCI of the culprit lesion with one DES of new generation was performed successfully and the second PCI on RCA scheduled in two weeks (aiming complete revascularization). ECG on the second day following PCI showed no biphasic T-waves in the precordial leads. At 1 month after the complete revascularization, the patient has no symptoms even at intense exertion.

Conclusions. It is important to identify the ECG signs of Wellens' syndrome and provide appropriate treatment in due time, as this ECG pattern is a sign of instability which can evolve any time into an extensive MI with high mortality and disabling rates.

Key words: Wellens syndrome, myocardial infarction, sub occlusive stenosis

240. TAKOTSUBO CARDIOMYOPATHY (TTS) – A DISEASE THAT MIMICS AN ACUTE CORONARY SYNDROME

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Background. TTS, also known as stress cardiomyopathy and "Broken Heart Syndrome", is a cardiac syndrome that appears suddenly and implies transient left ventricular systolic dysfunction leading to heart failure symptoms. It frequently occurs following a significant stress. Available data report about 1.7-2.2% of patients with suspected ASC to be subsequently diagnosed with TTS. The aim is to present a TTS clinical case and the differential diagnosis with an ACS.

Case report. A 62 years old, female, presented with: compressive chest pain, lasting >6 hours without relieve at rest or on nitrates, shortness of breath at mild exertion and fatigue. Symptoms onset at 2 days following a major stress (death of the only brother). Other symptoms: palpitations, dizziness. Objective: mild uncle swelling. Cracking murmurs in the lower lung fieldson auscultation. Heart rate 86 bpm, BP- 140/80 mmHg, SaO₂ – 95%. Laboratory testing: troponin I – 4.8ng/ml (reference limit 0.3ng/ml), NT-proBNP – 10236pg/ml. ECG: Sinus rhythm, HR – 86 bpm, normal axis, inverted T-waves in I, II, aVL, V3-V6. Echocardiography: moderate LV dilatation: diastolic diameter 57mm, systolic diameter 40mm, LV apical akinesia, middle segments hypokinesia, mild concentric hypertrophy of the LV(septum 12mm, posterior wall 12mm), moderately abnormal systolic function, EF - 39%. Non-STE ACS was suspected and the patient was admitted in the CCU for 48h, and a cardiology ward for 4 days afterwards. Treated with: nitrates, heparins, β -blockers, ACE-inhibitors, aspirin and diuretics. Coronarography (performed on the 2nd day of admission): no significant lesions identified. Non-STE ACS ruled out and TTS presumed. At 4 days: troponin I –1,3ng/ml, NT-proBNP– 3455pg/ml. At discharge troponin I –0.14ng/ml, NT-proBNP- 460pg/ml. Echo: mild LV dilation: diastolic diameter 54mm, systolic diameter 37mm, LV apical hypokinesia, mildly abnormal systolic function EF – 50%, in rest – the same. At 20 days from symptoms onset: ECG: HR 74bpm, normalization of the T waves, in –rest the same. Echo: no wall motion abnormalities, EF 63%, complete recovery of the LV function. TTS confirmed.

Conclusions. TTS is a rare condition which can be suspected when ECG changes and LV wall motion abnormalities present at echo without respecting a specific coronary pool and no culprit lesion is identified at coronarography. An ACS is to be, firstly, ruled out. The diagnosis is confirmed only after the recovery of the LV function.

Key words: Stress cardiomyopathy, Takotsubo, acute coronary syndrome, hypokinesia, akinesia.