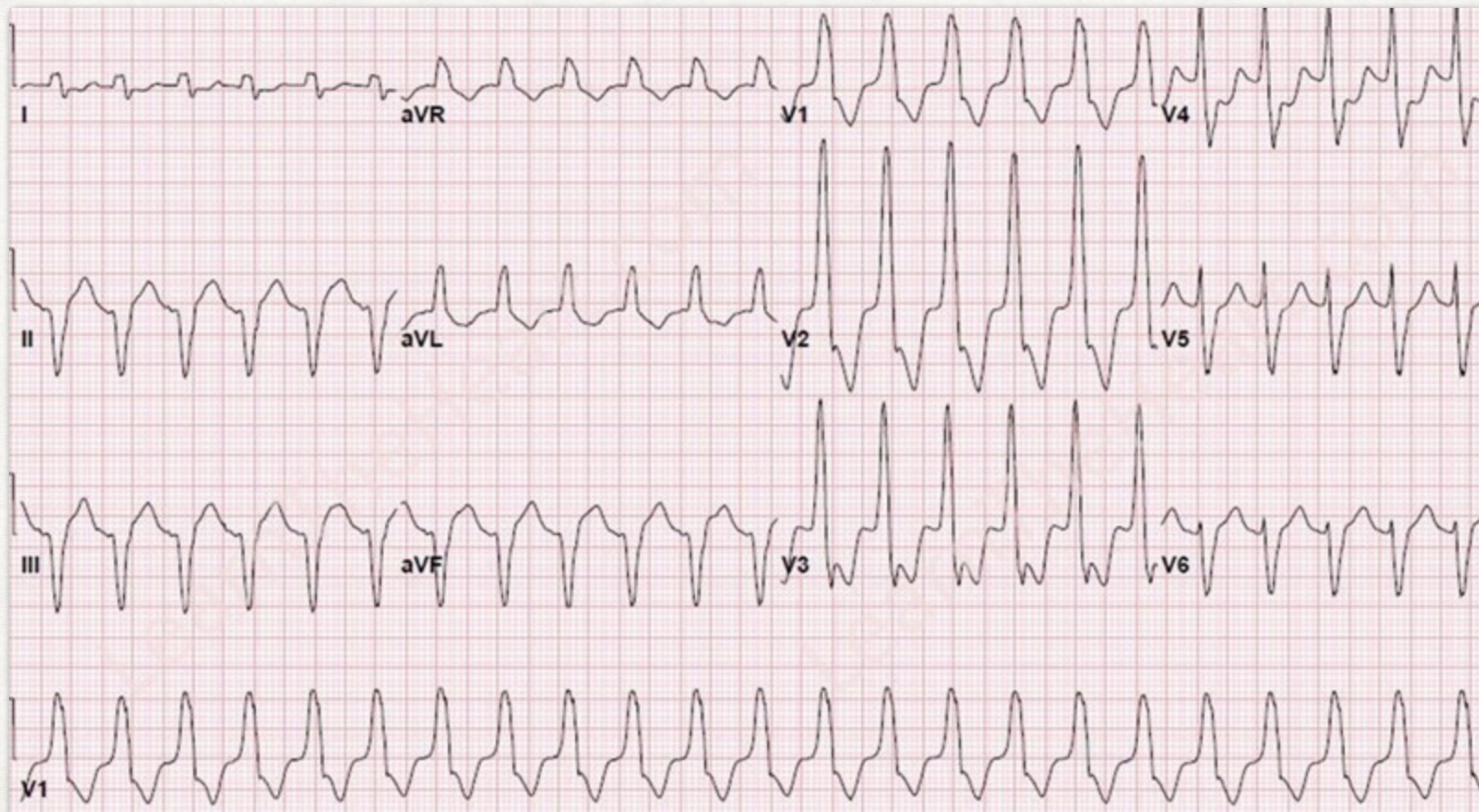


DR MAHLOW

EP EMERGENCIES

CASE 1

- 62 yo male with ischemic cardiomyopathy, EF 20%, presents after syncope, hypotensive, confused, diaphoretic

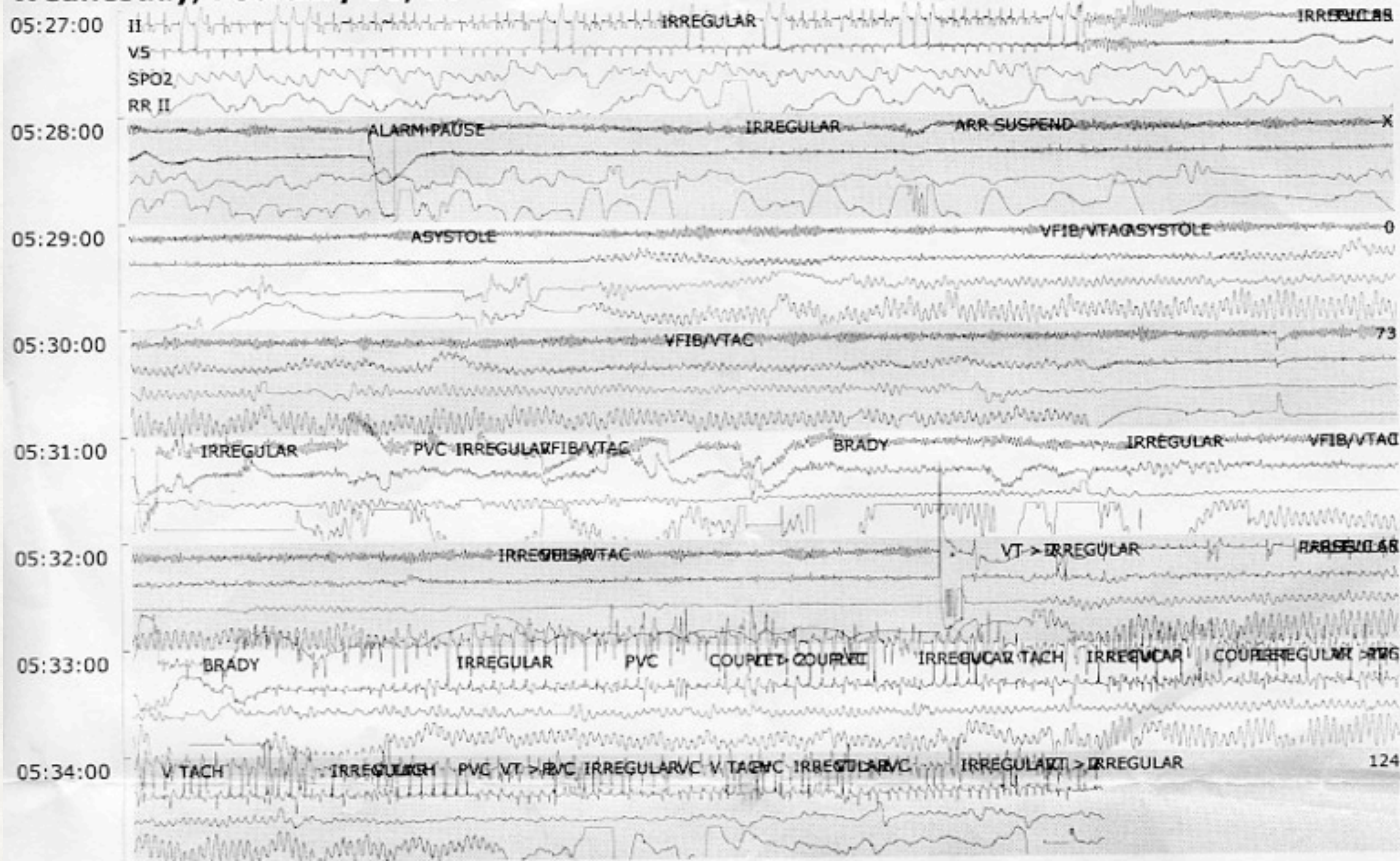


- 62 yo male with advanced ischemic cardiomyopathy presents after syncope, found to be in unstable ventricular tachycardia, hypotensive, confused, diaphoretic
- Cardioverted successfully with 50 J. Now what?

- 62 yo male with advanced ischemic cardiomyopathy presents after syncope, found to be in unstable ventricular tachycardia, hypotensive, confused, diaphoretic
- Cardioverted successfully with 50 J.
- Continues to have episodes of VT/VF requiring several cardioversions in ED.

- 62 yo male with advanced ischemic cardiomyopathy presents after syncope, found to be in unstable ventricular tachycardia, hypotensive, confused, diaphoretic
- Cardioverted successfully with 50 J.
- Continues to have episodes of VT/VF requiring several cardioversions in ED.
- Amiodarone iv bolus and drip started, Lidocaine iv drip started, continues to have refractory VT/VF requiring more cardioversion/defibrillation

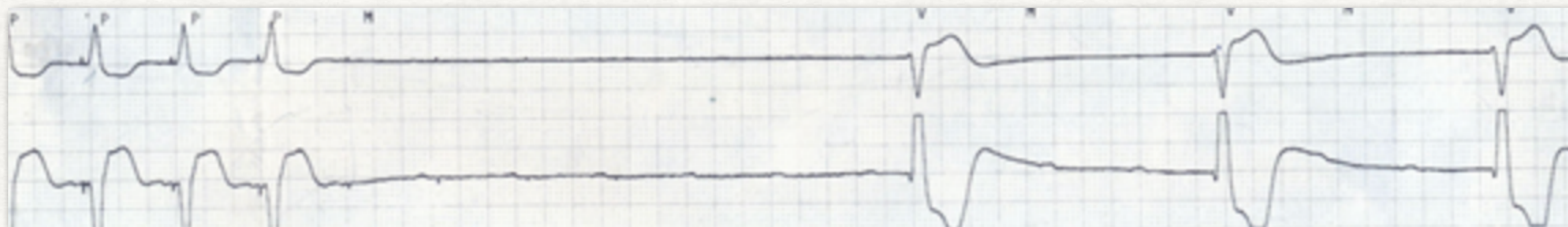
Wednesday, February 08, 2012



Reason for consult: "ICD didn't work"

CASE 2

- 82 yo female admitted after syncopal spell, normotensive but confused



- 82 yo female admitted after syncopal spell, presents in complete heart block with ventricular escape rhythm at 30 BPM, normotensive but confused
- Transcutaneous pacing initiated but is not capturing, patient now appears uncomfortable

- 82 yo female admitted after syncopal spell, presents in complete heart block with ventricular escape rhythm at 30 BPM, normotensive but confused
- Transcutaneous pacing initiated but is not capturing, patient now appears uncomfortable
- Family informs you that patient had a pacemaker placed 23 years ago with subsequent generator changes and is 1 week s/p attempted lead revision

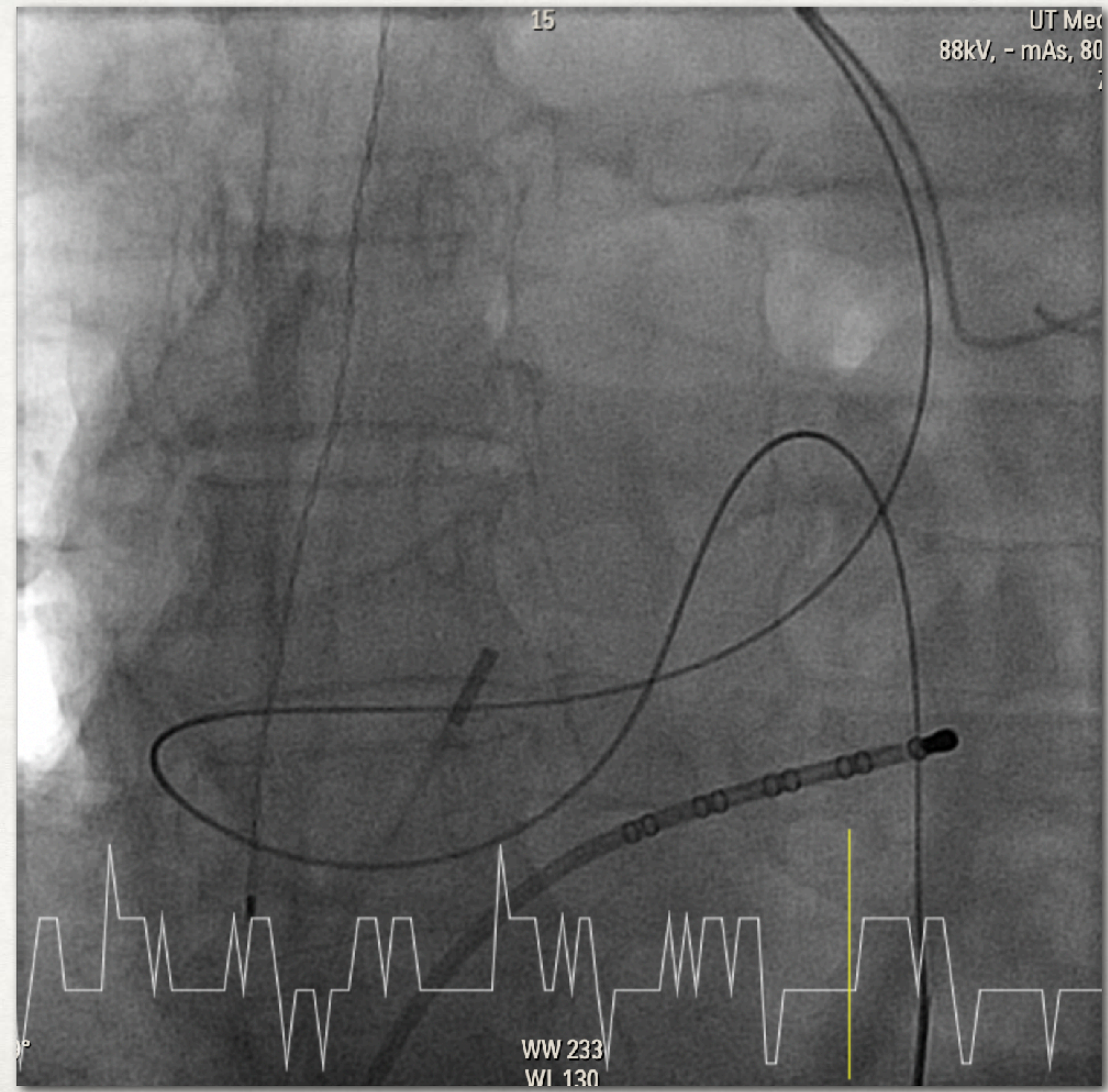
- 82 yo female admitted after syncopal spell, presents in complete heart block with ventricular escape rhythm at 30 BPM, normotensive but confused
- Transcutaneous pacing initiated but is not capturing, patient now appears uncomfortable
- Family informs you that patient had a pacemaker placed 23 years ago with subsequent generator changes and is 1 week s/p attempted lead revision
- Magnet is applied and ventricular pacing is noted. She complains of swelling at the site and mild erythema along the incision, with a small amount of pus at one corner of the incision

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- Magnet is applied and ventricular pacing is noted. She complains of swelling at the site and mild erythema along the incision, with a small amount of pus at one corner of the incision
- With palpation of the pacemaker pocked, copious amounts of pus are expressed from the incision
- Patient is also noted to be hypotensive and dyspneic

15

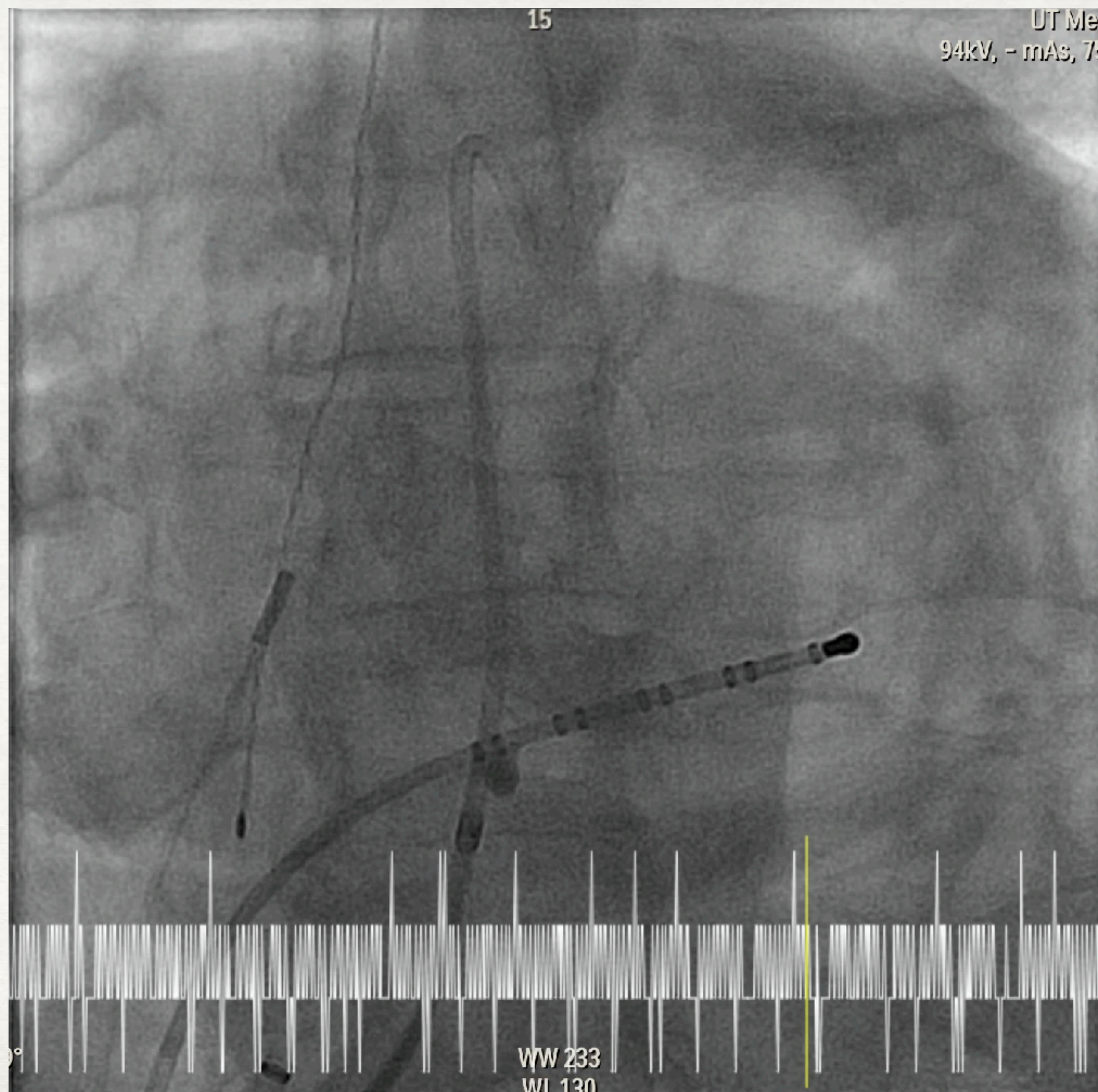
UT Med
88kV, - mAs, 80



WW 233
WI 130

15

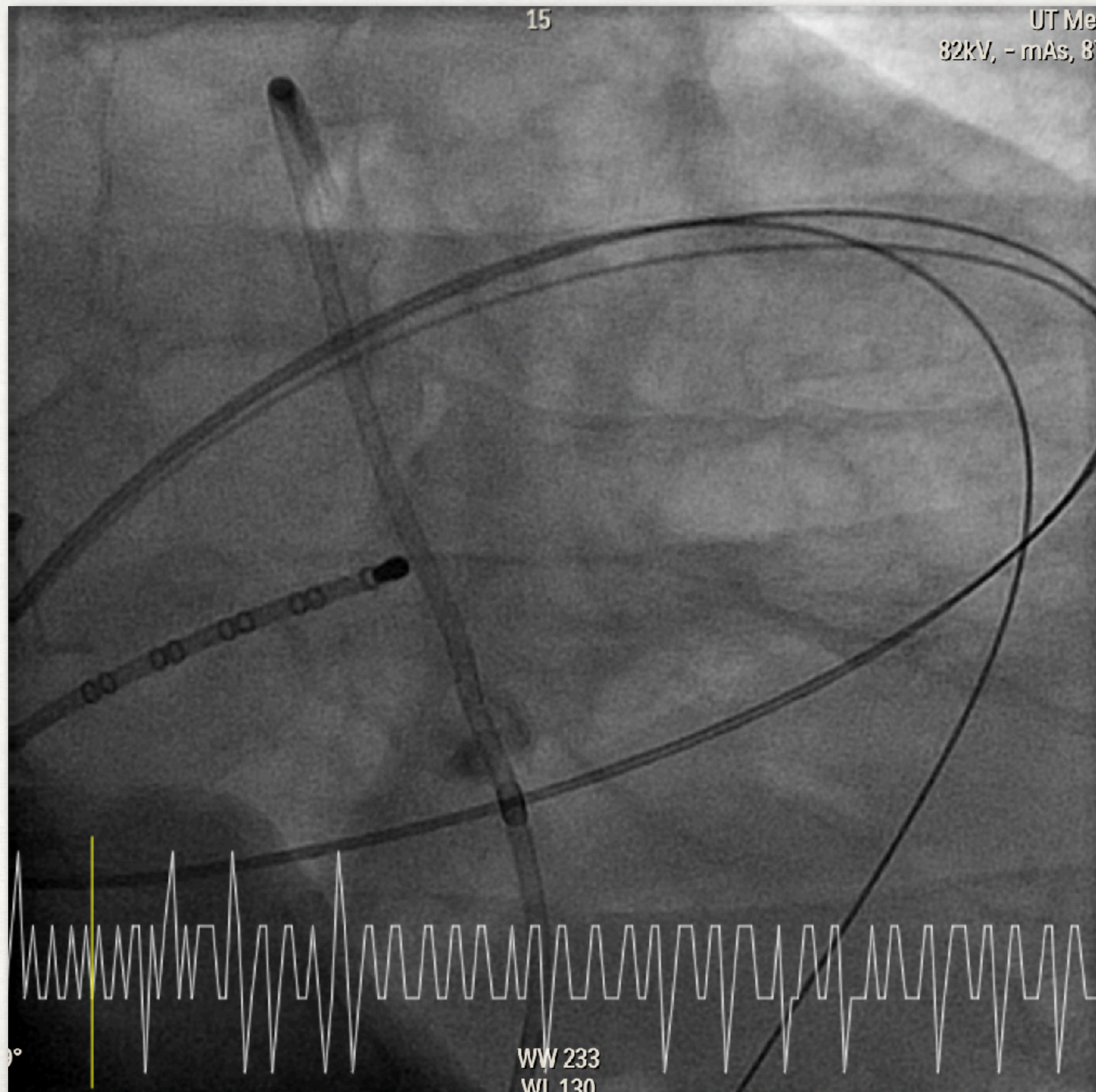
UT Med
94kV, - mAs, 75



WW 233
WI 130

15

UT Med
82kV, - mAs, 87



WW 233
WI 130

CASE 3

- 45 yo female with ESRD, noncompliant with dialysis, presents with severe bradycardia, confused.

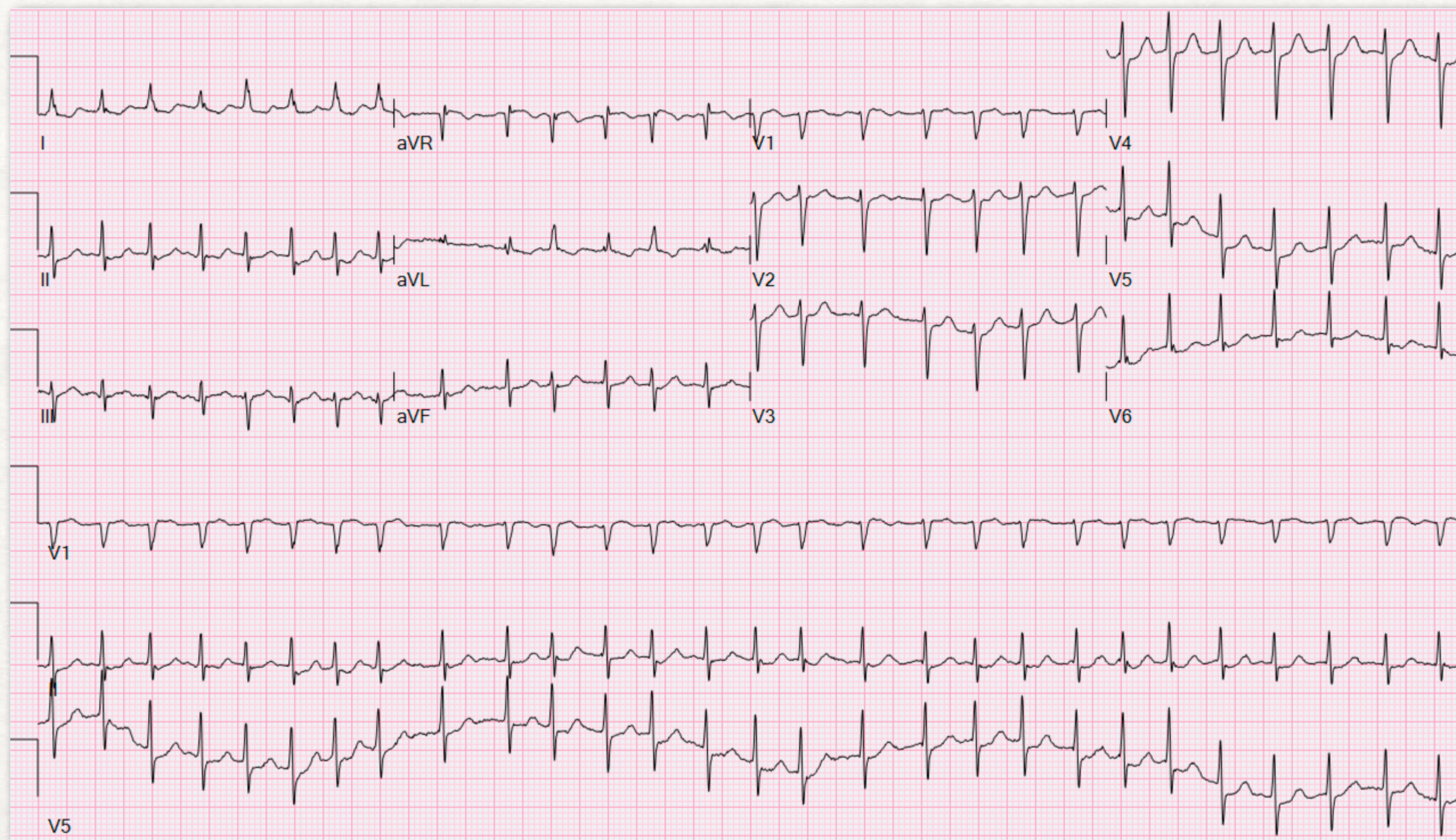


- 45 yo female with ESRD, noncompliant with dialysis, presents with severe bradycardia, confused.
- Transcutaneous pacemaker not capturing

- 45 yo female with ESRD, noncompliant with dialysis, presents with severe bradycardia, confused.
- Transcutaneous pacemaker not capturing
- Receives calcium gluconate, insulin, D50, bicarbonate, heart block resolves but patient is now severely nauseated with sinus bradycardia at 30 BPM, hypotensive

CASE 4

- 54 yo male s/p MVC with multiple traumatic injuries, subarachnoid hemorrhage, aspiration pneumonitis, hypotensive, in respiratory distress, Pulse ox 81% on high flow oxygen
- Cardiology consulted stat



- 54 yo male s/p MVC with multiple traumatic injuries, subarachnoid hemorrhage, aspiration pneumonitis, has AF-RVR and is hypotensive, in respiratory distress, Pulse ox 81% on high flow oxygen
- Cardiology consulted stat
- Trauma service called to intubate patient; patient remains tachycardic at 120-130 BPM in AF and mildly hypotensive

- 54 yo male s/p MVC with multiple traumatic injuries, subarachnoid hemorrhage, aspiration pneumonitis, has AF-RVR and is hypotensive, in respiratory distress, Pulse ox 81% on high flow oxygen
- Cardiology consulted stat
- Trauma service called to intubate patient; patient remains tachycardic at 120-130 BPM in AF and mildly hypotensive
- Upon further questioning, patient has a history of persistent AF and is on flecainide

CASE 5

- 76 yo male 1 week s/p recent PVI presents to the ED with recurrent AF

- 76 yo male 1 week s/p recent PVI presents to the ED with recurrent AF and groin pain
- Also complains of hypotension, dysphagia, fever

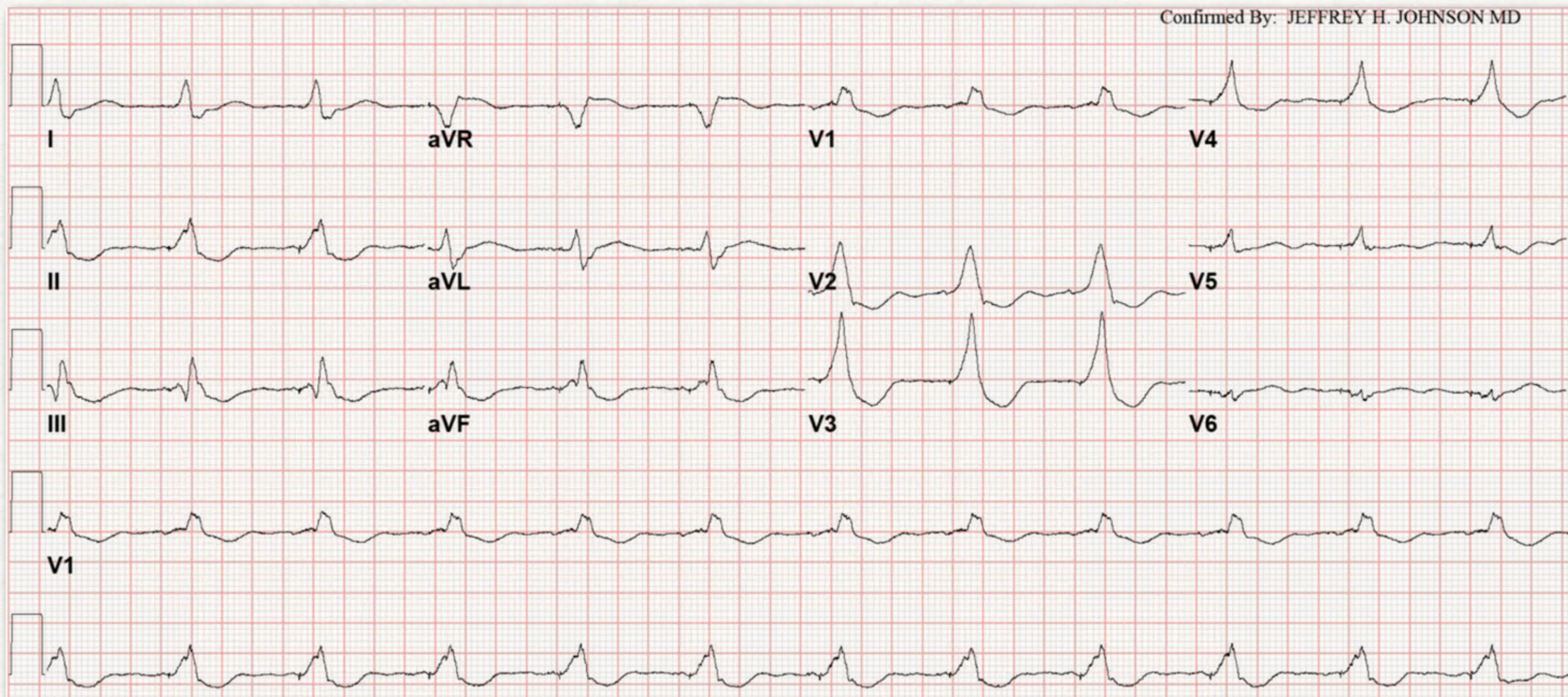
- 76 yo male 1 week s/p recent PVI presents to the ED with recurrent AF and groin pain
- Also complains of hypotension, dysphagia, fever
- He is treated and eventually discharged. Several months later, his dyspnea returns. He calls the answering service after having an episode of hemoptysis.



CASE 6

- 76 yo female admitted after syncopal spell resulting in cervical fracture and subarachnoid hemorrhage

Confirmed By: JEFFREY H. JOHNSON MD

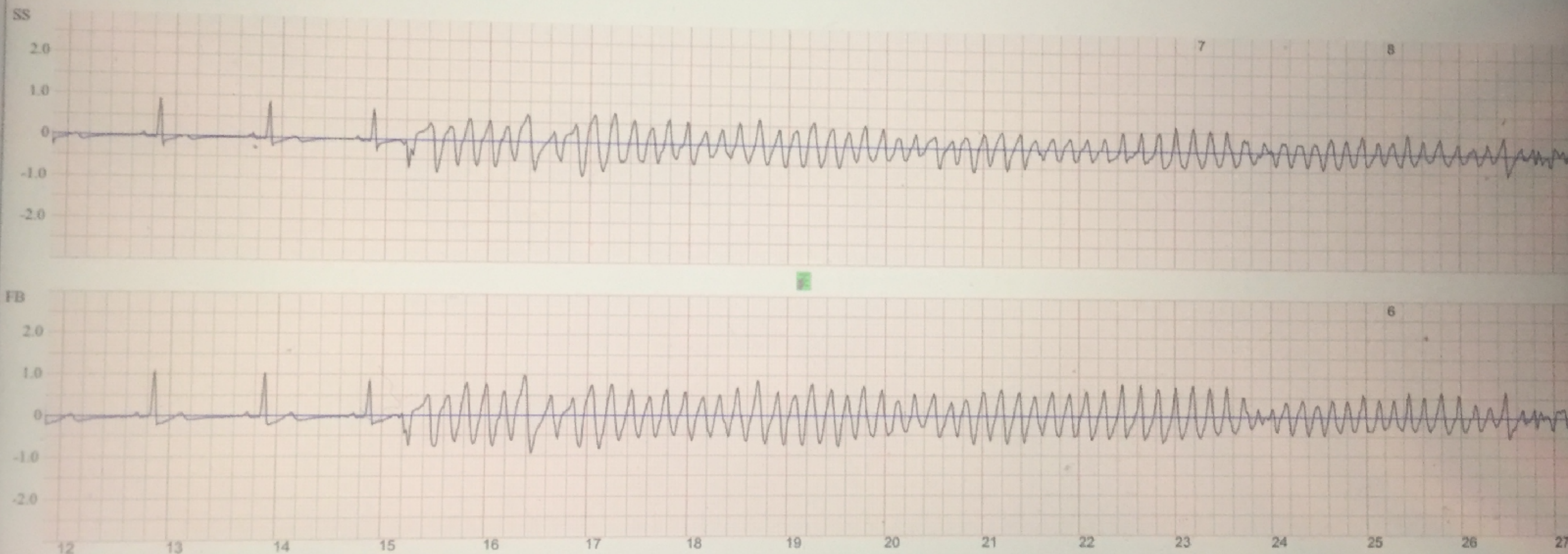


- 76 yo female admitted after syncopal spell resulting in cervical fracture and subarachnoid hemorrhage
- S/p CRT-D at OSH.

Select any point on the ECG to enable calipers

Plotting at: 1 MV/10 MM

Recording Speed: 25 MM/S



- 76 yo female admitted after syncopal spell resulting in cervical fracture and subarachnoid hemorrhage
- S/p CRT-D at OSH. Interrogation reveals multiple episodes of VF
- Coronary angiography normal. Options?

- 76 yo female admitted after syncopal spell resulting in cervical fracture and subarachnoid hemorrhage
- S/p CRT-D at OSH. Interrogation reveals multiple episodes of VF
- Coronary angiography normal. Options?
 - iv amiodarone
 - iv lidocaine
 - iv procainamide
 - iv esmolol
 - Raise LRL
 - Stellate ganglion block

CASE 7

- 36 yo female POD #1 s/p lap CCY with syncope

09-AUG-1960 (61 yr)
Male Caucasian
Room:NCC6
Loc:8

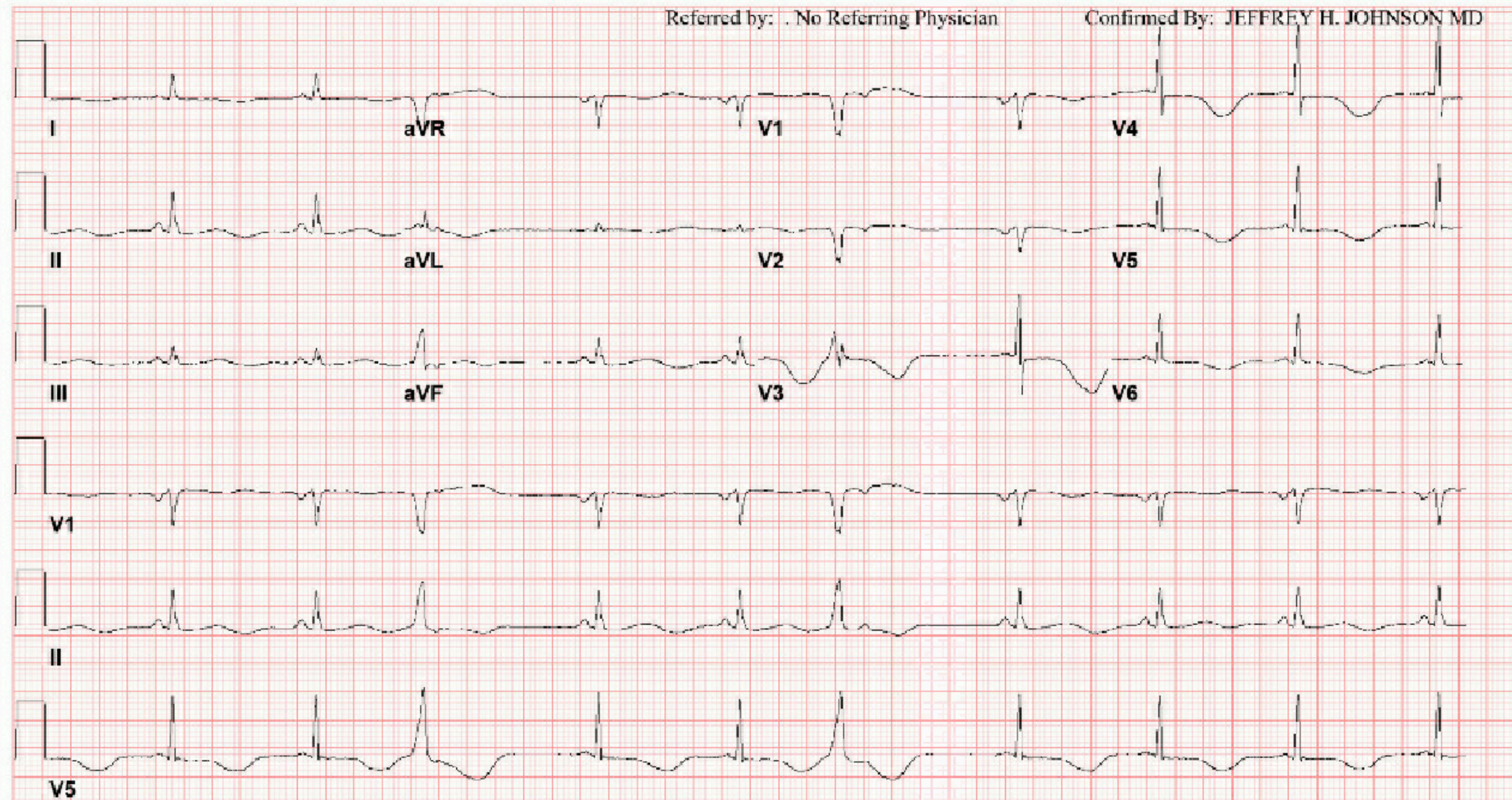
Vent. rate 60 BPM
PR interval 114 ms
QRS duration 82 ms
QT/QTc 666/666 ms
P-R-T axes 65 53 172

Sinus rhythm with occasional Premature ventricular complexes
ST & T wave abnormality, consider anterolateral ischemia
Prolonged QT
Abnormal ECG
When compared with ECG of 14-MAY-2022 08:35,
Premature ventricular complexes are now Present
Non-specific change in ST segment in Anterior leads
Nonspecific T wave abnormality now evident in Inferior leads
T wave inversion now evident in Anterolateral leads
QT has lengthened
Confirmed by JOHNSON MD, JEFFREY H. (50) on 5/15/2022 12:14:57 PM

Technician:SHIRLEY SMITH
Test ind:STAT

Referred by: . No Referring Physician

Confirmed By: JEFFREY H. JOHNSON MD



25mm/s 10mm/mV 150Hz 8.0 SP2 12SL 241 CID: 9

EID:50 EDT: 12:14 15-MAY-2022 ORDER:5320124789 ACCOUNT: 22608250001

Page 1 of 1

09-AUG-1960 (61 yr)
Male Caucasian

Room: NCC6
Loc: 8

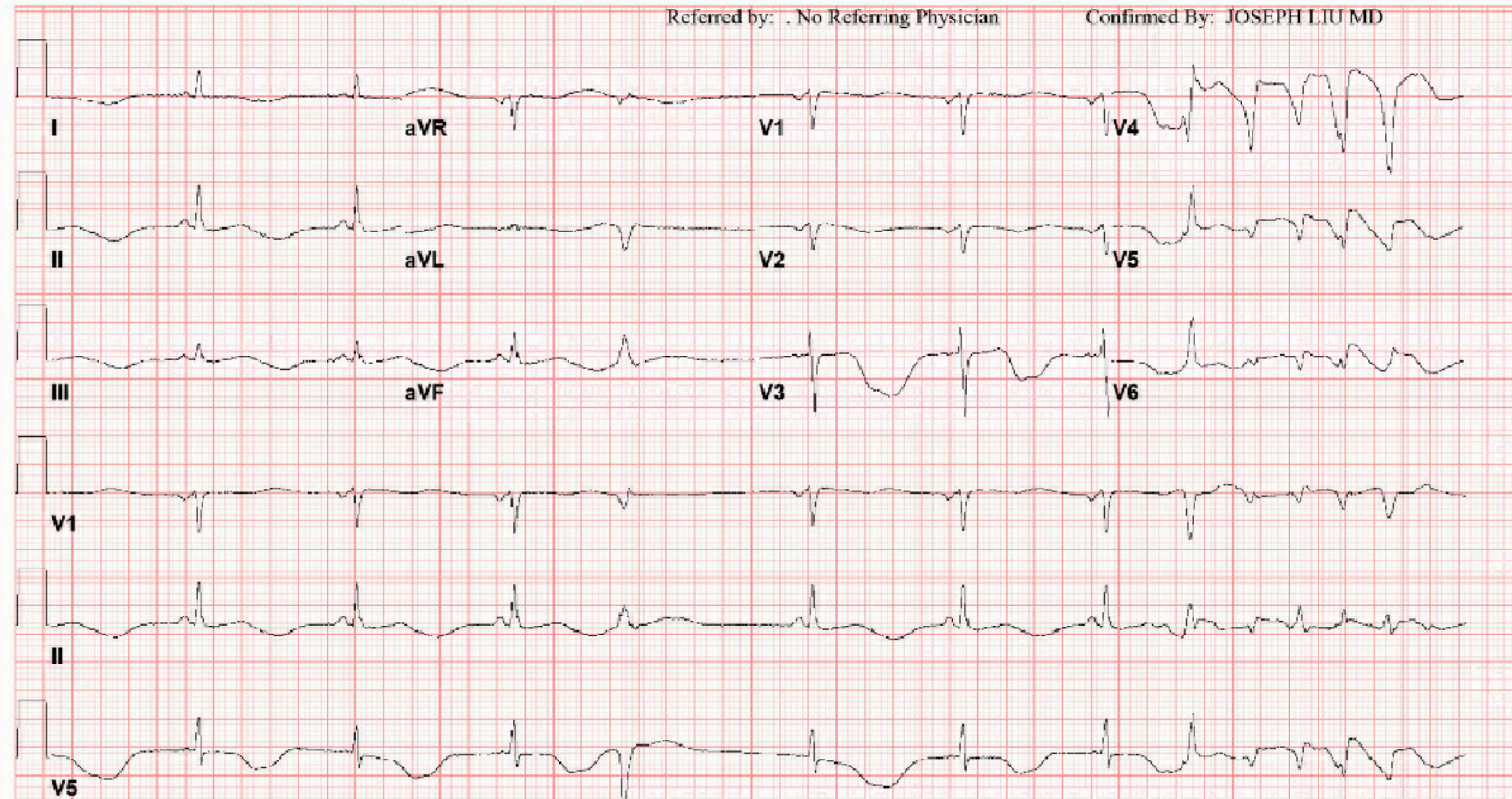
Vent. rate 64 BPM
PR interval 114 ms
QRS duration 84 ms
QT/QTc 722/744 ms
P-R-T axes 71 57 231

*** Poor data quality, interpretation may be adversely affected
Baseline artifact
Sinus bradycardia with occasional Premature ventricular complexes
Nonspecific T wave abnormality
Prolonged QT
Abnormal ECG
When compared with ECG of 15-MAY-2022 14:58,
QT has lengthened
Confirmed by LIU MD, JOSEPH (49) on 5/15/2022 10:04:19 PM

Technician: SHIRLEY SMITH
Test ind: STAT

Referred by: . No Referring Physician

Confirmed By: JOSEPH LIU MD



25mm/s 10mm/mV 150Hz 8.0 SP2 12SL 241 CID: 9

EID:49 EDT: 22:04 15-MAY-2022 ORDER:5320648303 ACCOUNT: 22608250001

Page 1 of 1



CASE 8

- 86 yo with Parkinson's disease POD 1 from ORIF right hip
- Asymptomatic

