

Respect Biphasic T waves

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Clinical Presentation

A 44-year-old male introduced to emergency with discontinuous, exertional mid-sternal mid-section torment of one-week length assuaged with rest. He got ibuprofen and nitroglycerine. Introductory electrocardiogram (EKG) demonstrated no confirmation of ischemia. Troponin I was 0.16 ng/ml (typical <0.10 ng/ml). After three hours, he had a repeat of mid-section torment which settled suddenly. EKG in agony free period demonstrated biphasic T-waves in lead V2-V4. No extra medicines were directed. After two hours, the patient created intermittent mid-section agony and EKG showed ST-portion rise in the anterolateral leads with complementary changes in sub-par leads. Eminent coronary angiography indicated 95% stenosis of the proximal left foremost dropping coronary supply route. Effective re-vascularized with medication eluting stents was performed. The learning and acknowledgment of biphasic T-waves in foremost leads (Wellen's disorder) is basic for early heparinization and coronary revascularization to presumably forestall movement of NSTEMI to front divider ST-Elevation MI (STEMI) (Figures 1-4).

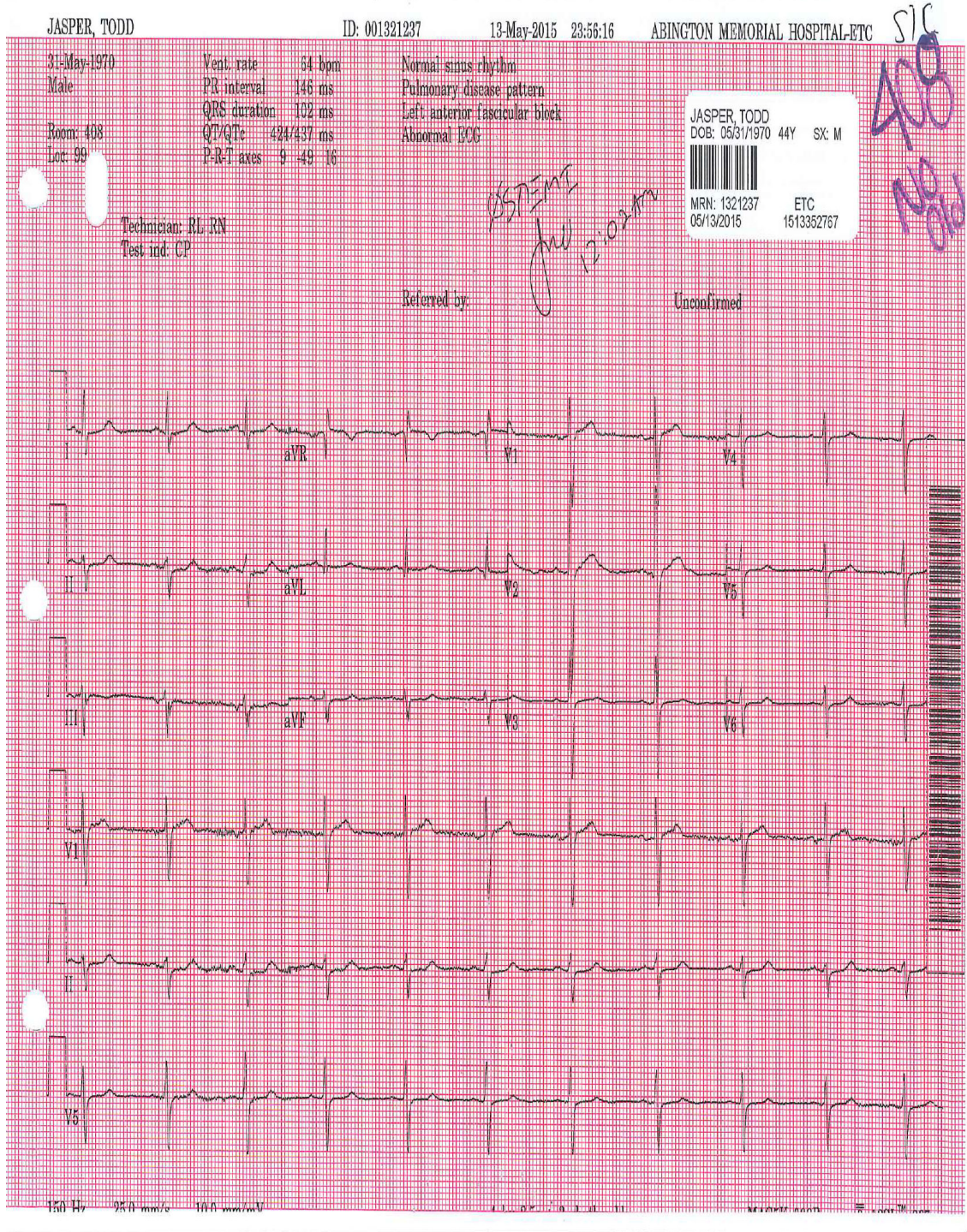


Figure 1: Baseline EKG.

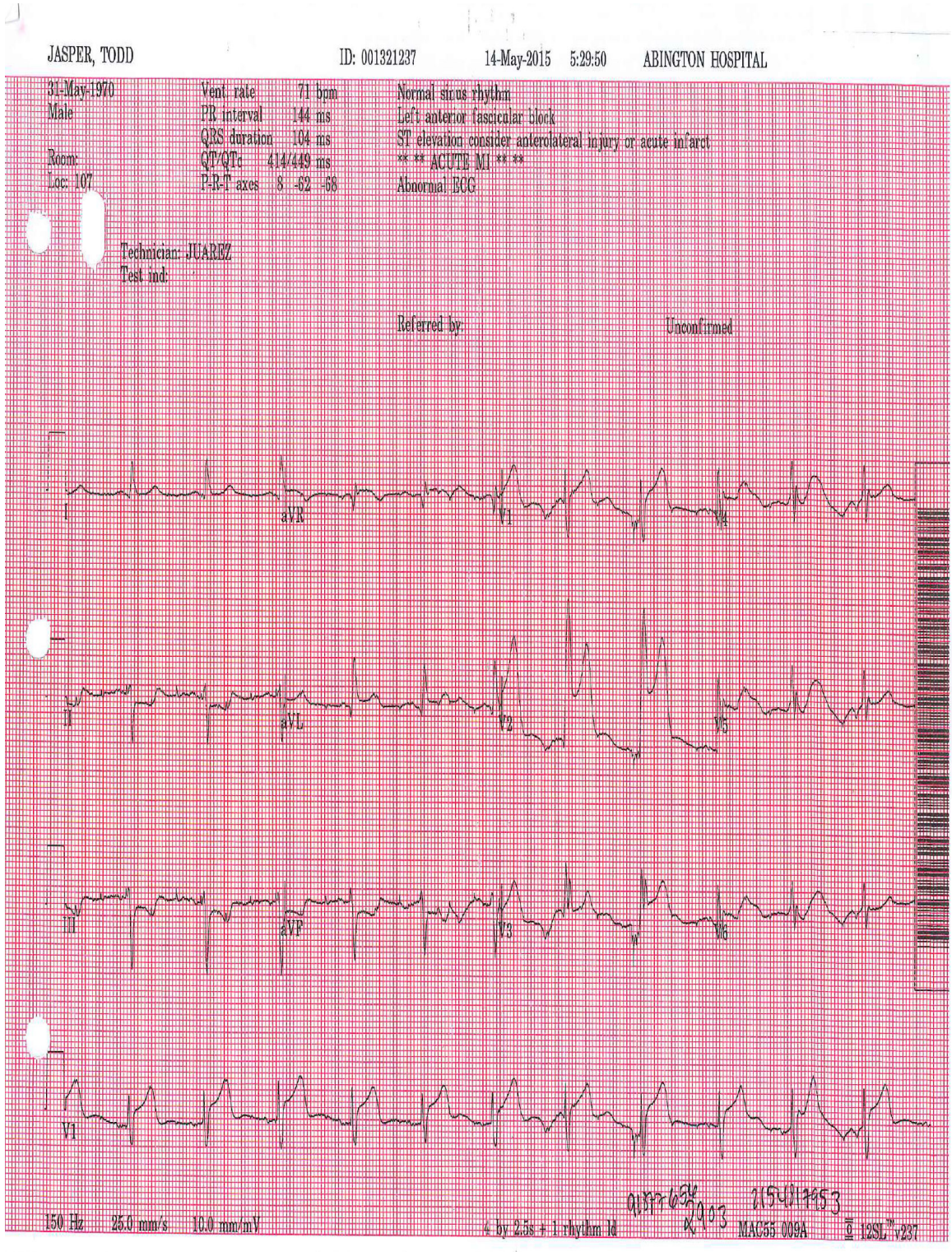


Figure 3: STEMI.

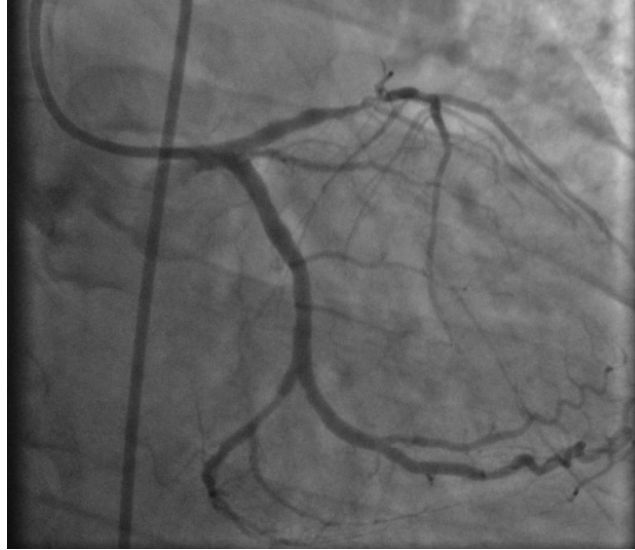


Figure 4: 95 % stenosis of the proximal left anterior descending coronary artery: Culprit of Wellen's syndrome.