

I pitfalls nelle SCA

Quando l'ST sopra è un grande
simulatore

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9.5.8
SANTERO
9.5.8
SANTERO

TUTTOSPORT

80 ANNI

9.5.8
SANTERO
9.5.8
SANTERO

Fondatore RENATO CASALBORE

15 febbraio 2026 ANNO LXXI N. 40 € 1,50* IN ITALIA WWW.TUTTOSPORT.COM

PERI NIENTE MEDAGLIE, MA OGGI BRIGNONE (CON GOGGIA) CI RIPROVA: LE MANCA SOLO L'ORO IN GIGANTE

ABBIAMO SEMPRE FEDE

tre minuti per dare tutto quello che ho». Scommessa Compagnoni: «Ora è libera, può volare. E ha l'arma segreta...»
ramma D'Antonio, storico trionfo olimpico del brasiliano Pinheiro che si commuove con Tomba. Delusione Sighe



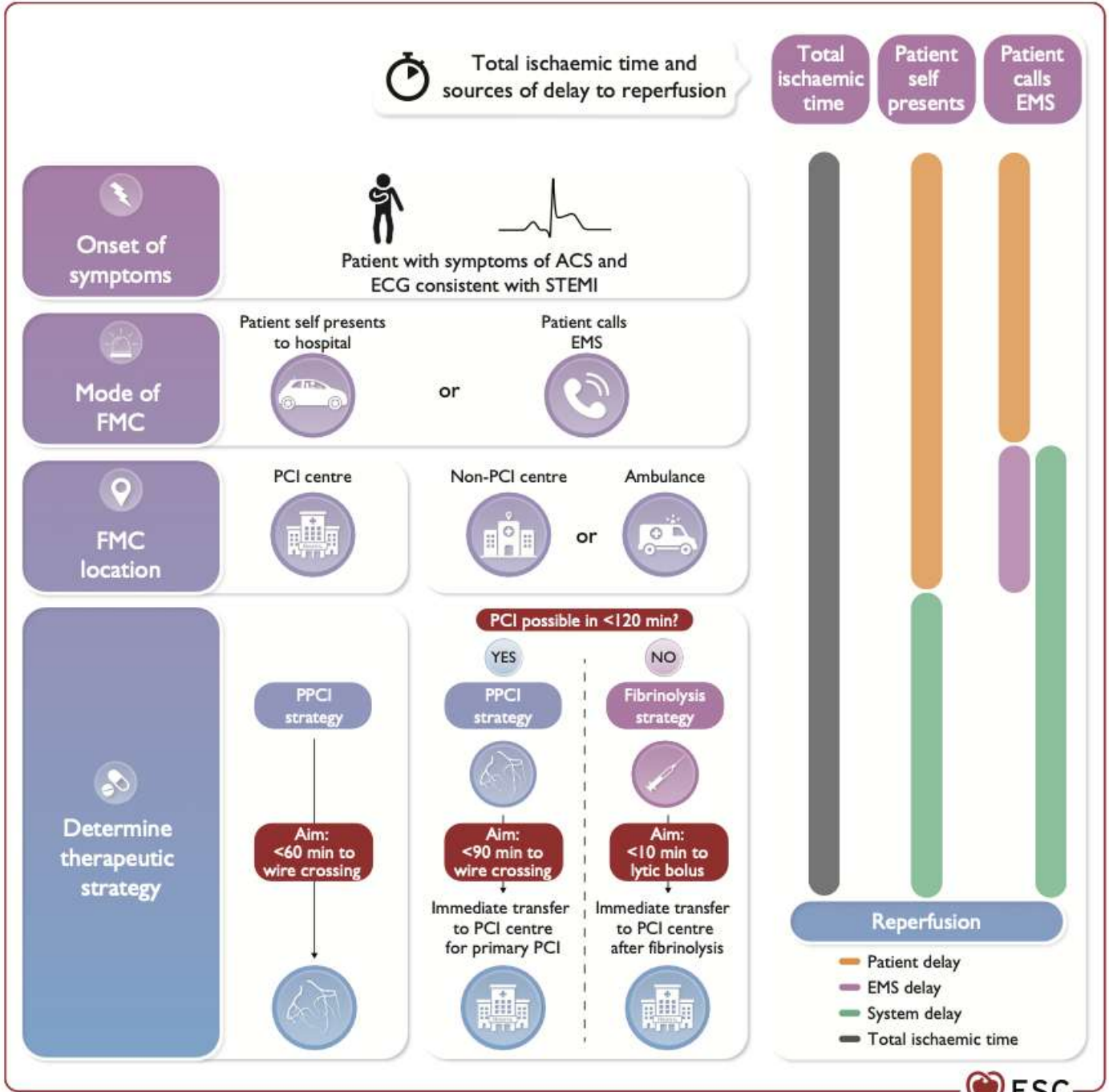
Facile, così!

3-2



2023 ESC Guidelines for the management of acute coronary syndromes

Developed by the task force on the management of acute coronary syndromes of the European Society of Cardiology (ESC)



SPECIAL FORMS ST ELEVATION



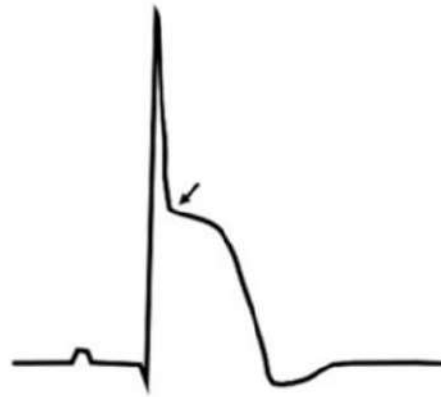
TOMBSTONE PATTERN



- Short duration R wave
- Convex ST-segment $\geq R$
- Merge of ST-segment and ascending limb of the T-wave



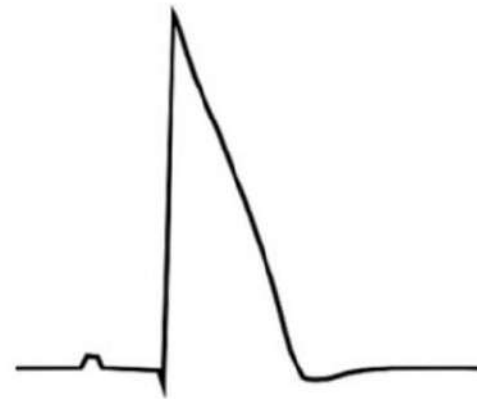
LAMBDA PATTERN



- Giant R wave amplitude ≥ 1 mV
- J-wave amplitude $\geq \frac{1}{4}R$ and $\leq R$ (arrow)
- Steep down-sloping ST-segment
- Merge of QRS and inverted T-wave



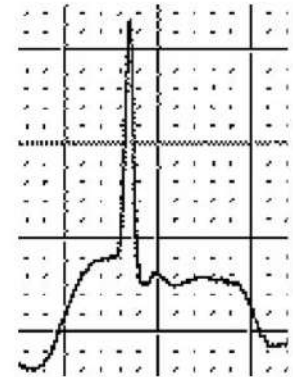
GIANT R WAVE
SHARK FIN PATTERN
TRIANGULAR PATTERN



- Giant R wave amplitude ≥ 1 mV
- Steep down-sloping ST-segment
- Merge of QRS and T-wave



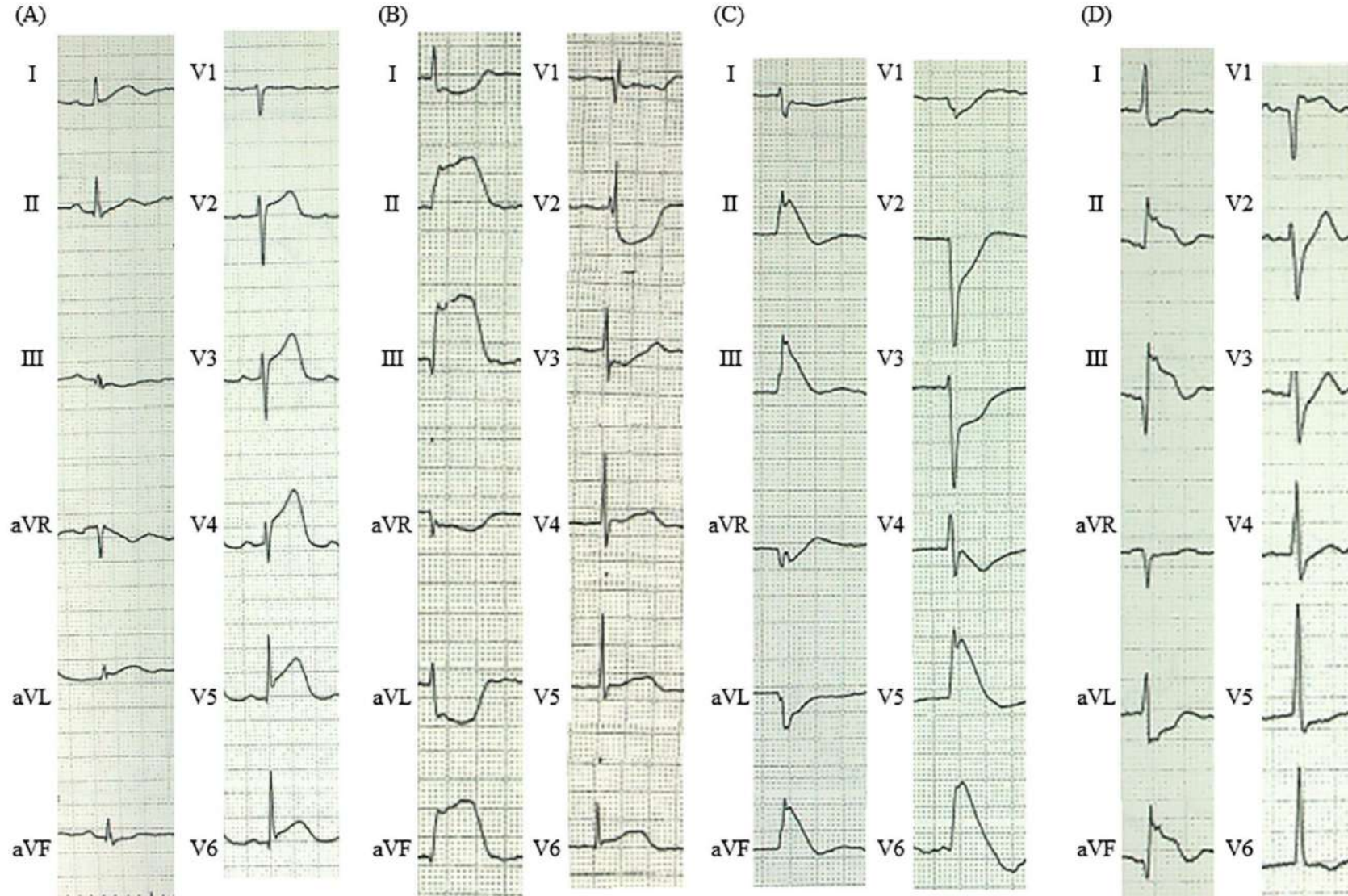
SPIKED HELMET PATTERN



- Upsloping elevation of isoelectric line starting before and ending after R wave

Clinical outcomes of ST-elevation myocardial infarction patients who present special forms of ST-segment elevation

Toshiharu Fujii, M.D. Ph.D. *, Yuji Ikari, M.D.Ph.D.



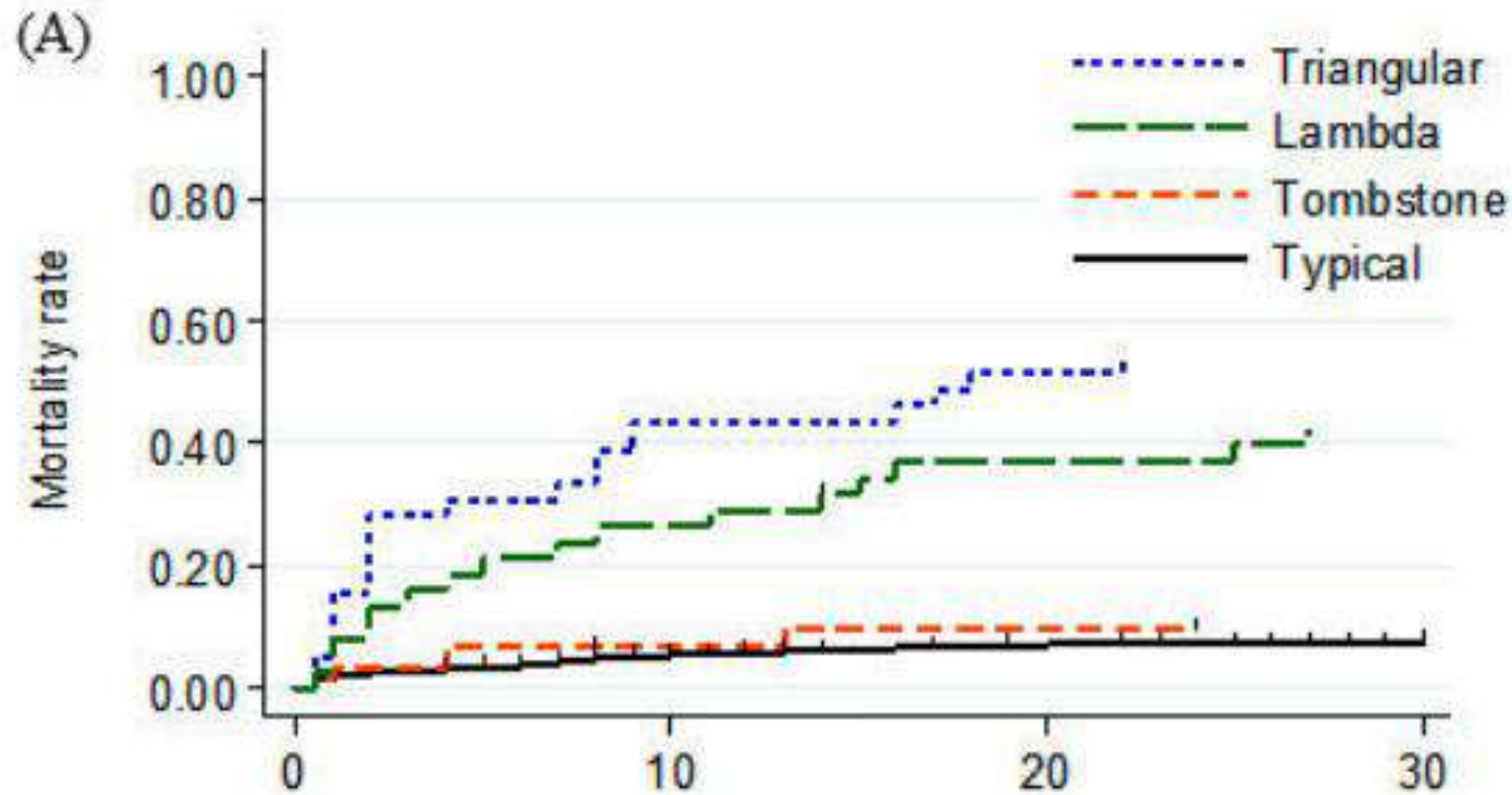
- A Typical
- B Tombstone
- C Triangular, Shark Fin
- D Lambda

**Special Forms 10%
degli STEMI**

1277 pz

Clinical outcomes of ST-elevation myocardial infarction patients who present special forms of ST-segment elevation

Toshiharu Fujii, M.D. Ph.D. *, Yuji Ikari, M.D.Ph.D.



Triangular/Lambda wave

- Shock
- OHCA
- LMT - MVD

Table 1. ST-Segment Elevation in Normal Circumstances and in Various

- Juvenile ST pattern
- Pericardial disease (pericarditis, pericardial cyst, pericardial tumor)
- Hypothermia
- Hyperthermia
- Myocardial tumor (lipoma)
- Hypertensive heart disease
- Athlete's heart
- Myocardial ischemia
- STEMI (i.e., anteroseptal myocardial infarction)
- Fragmented QRS (terminal notching)
- Hypocalcemia
- Hyperpotassemia
- Thymoma
- Aortic dissection
- Arrhythmogenic right ventricular cardiomyopathy
- Takotsubo cardiomyopathy
- Neurologic causes (intracerebral bleeding, acute brain injury)
- Myocarditis
- Chagas disease
- Cocaine use

approximately 90 percent of healthy
; therefore, normal
-3 mm
in V₂

in V₄, with notching at J point
waves
depression in aVR, not in
limb leads are involved
ough V₅ with inverted T waves
QRS voltage

: of left ventricular
ly

eviation discordant from the

;ment elevation
segment depression in aVR,

om >5 mm
epression

: of hyperkalemia present:
>RS and tall, peaked, tented
s
tude or absent P waves
it usually downsloping

V₂
evation in V₁ and V₂, typically
ng

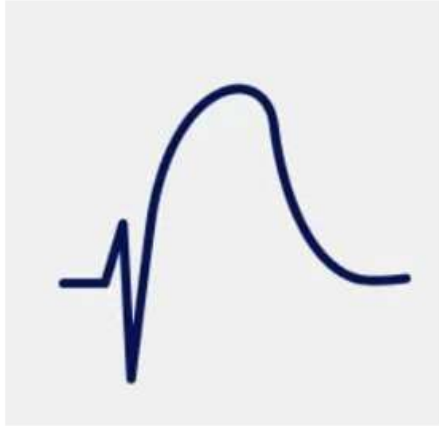
lating myocardial infarction
in both inferior and antero-
s

gment elevation, often
ut lasting only a minute or
diately after direct-current

gment elevation in
but transient

with a plateau or shoulder or

Reciprocal behavior between aVL and III



STEMI

ST-S

Kyuhyun V

ECG Ca

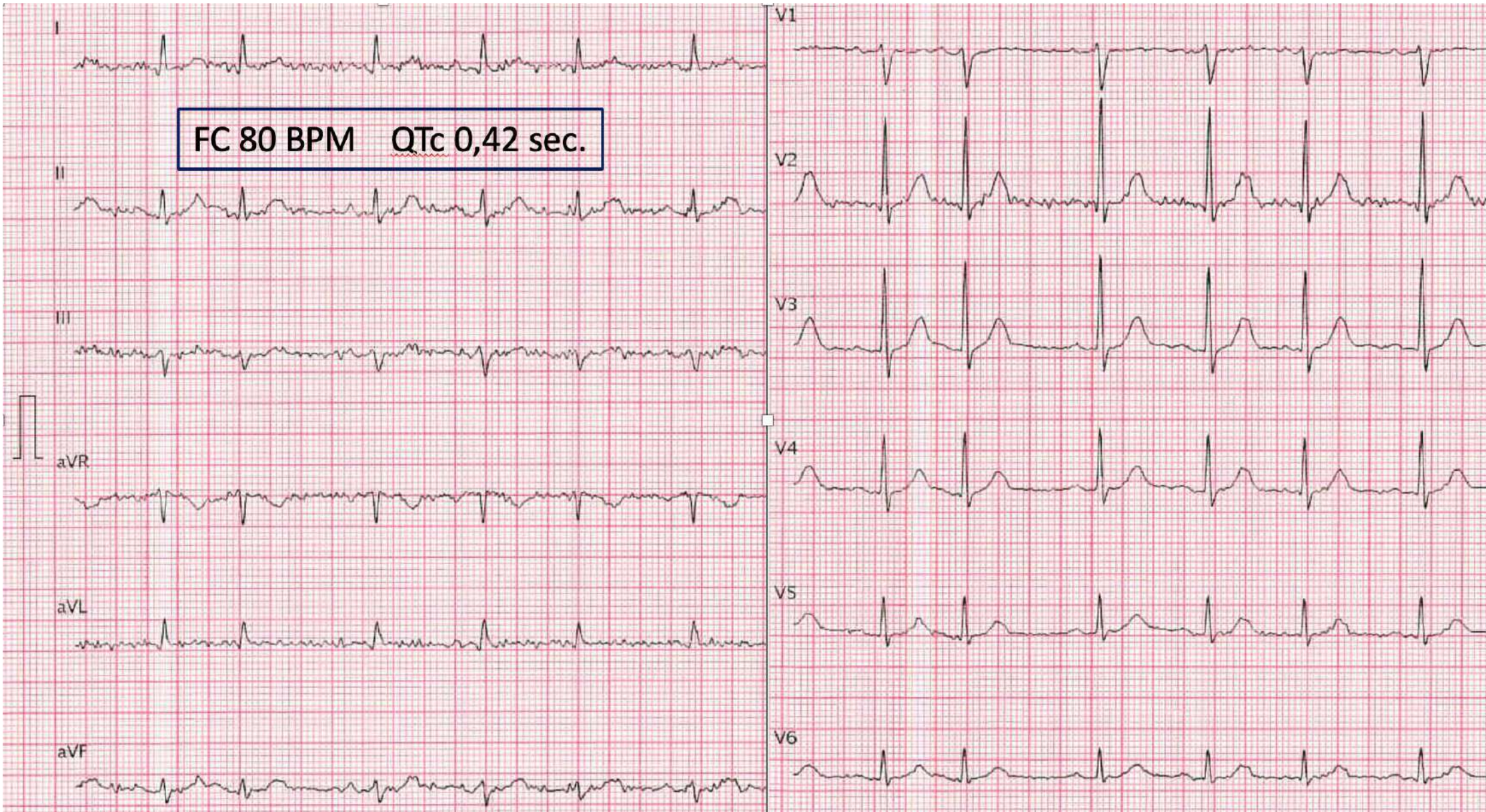


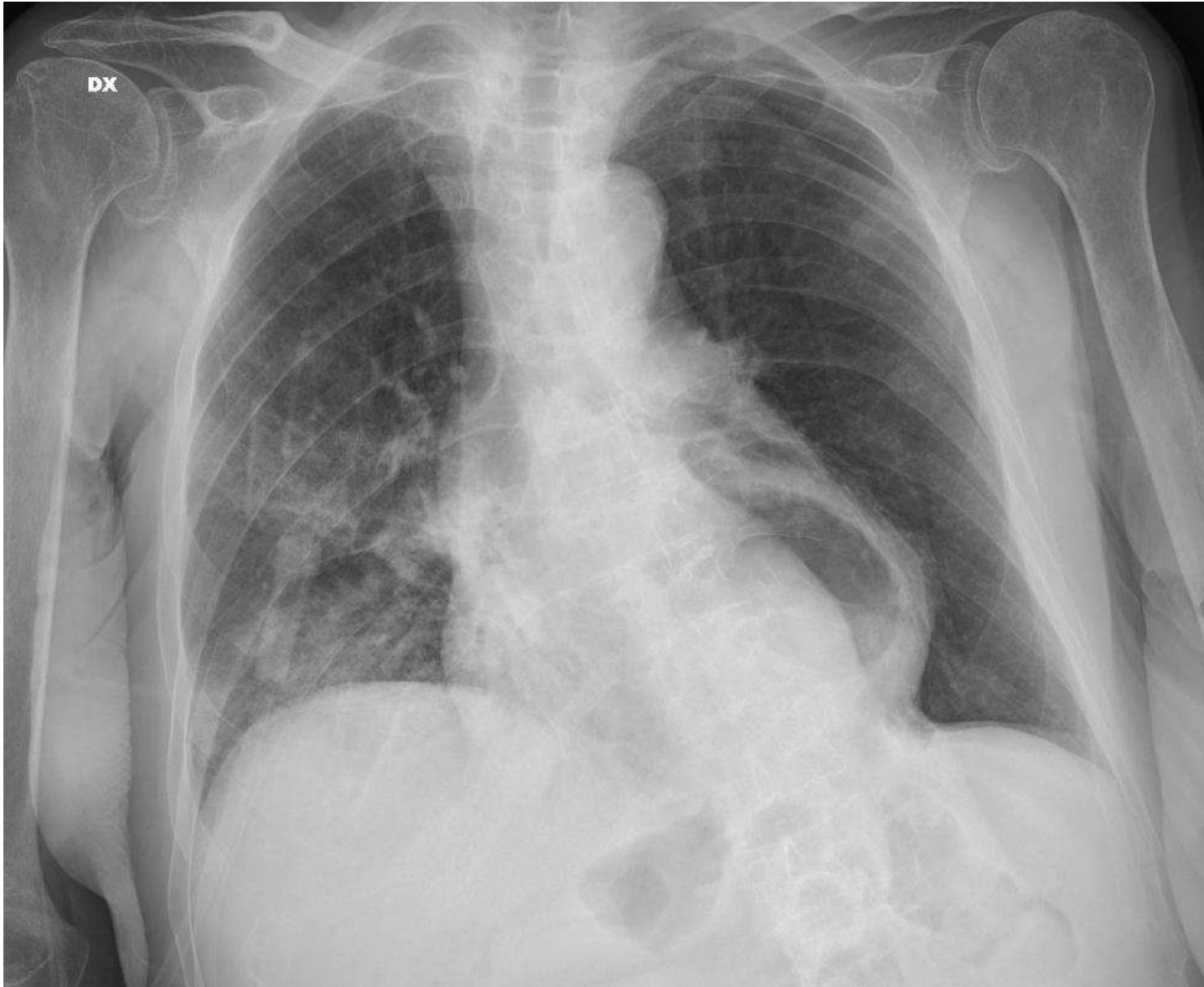
CASO CLINICO 1

- 84 anni - maschio
- Non precedenti C.V.
- Ipertensione arteriosa in terapia con Amlodipina, Furosemide, Spironolattone
- S.A.D. in terapia con Quetiapina, Sertralina, Alprazolam, Zolpidem
- Ernia Jatale con RGE in terapia con Pantoprazolo
- Dispnea e astenia da alcuni giorni, ipertermia sino a 38 °C

- Sofferente, lievemente obnubilato, polipnoico.
- PA 90/60. FC 90 bpm. **Sat O2 88%**. T 37.3 °C
- EGA pH 7.4 **PO2 63** PCO2 34 Lac 2.0
- Glicemia 125, **Creatinina 1.36**, **GFR 44**, Na⁺ 137, K⁺ 4.1, Hb 14, **G.B. 13.1**, **PCR 136**, **PCT 3.6**, **Troponina I 13** (V.N. < 35)
- TC encefalo: regolare

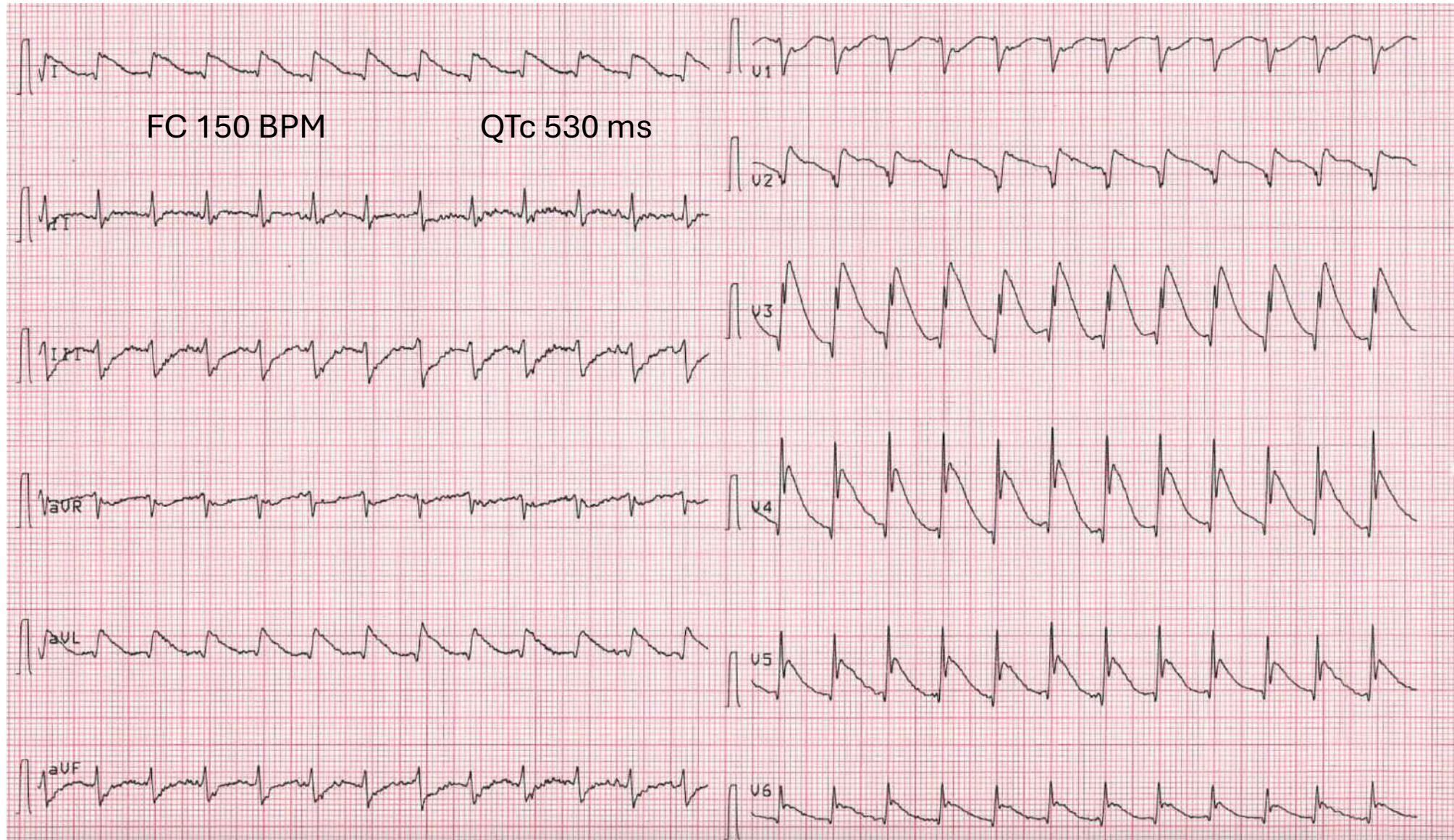
FC 80 BPM QTc 0,42 sec.





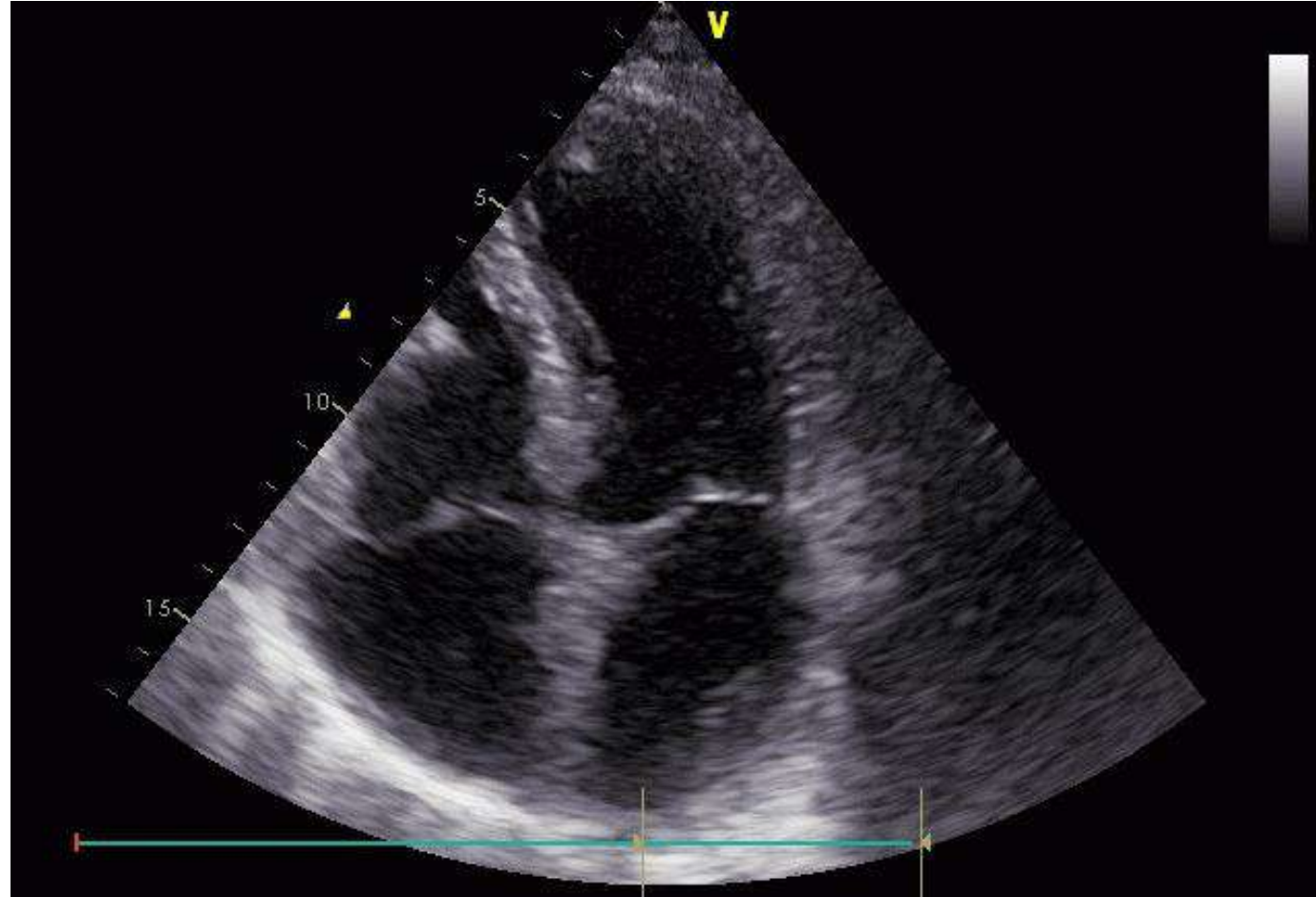
- Diagnosi: Polmonite con I.R. tipo 1
- O2 Terapia con M.V.
- Piperacillina/Tazobactam, Linezolid, Enoxaparina 4000 u. s.c., sol. Fisiologica, Furosemide 25 mg i.v., Quetiapina 50 mg, Pantoprazolo 40 mg, Beclometasone + Salbutamolo (inal.)

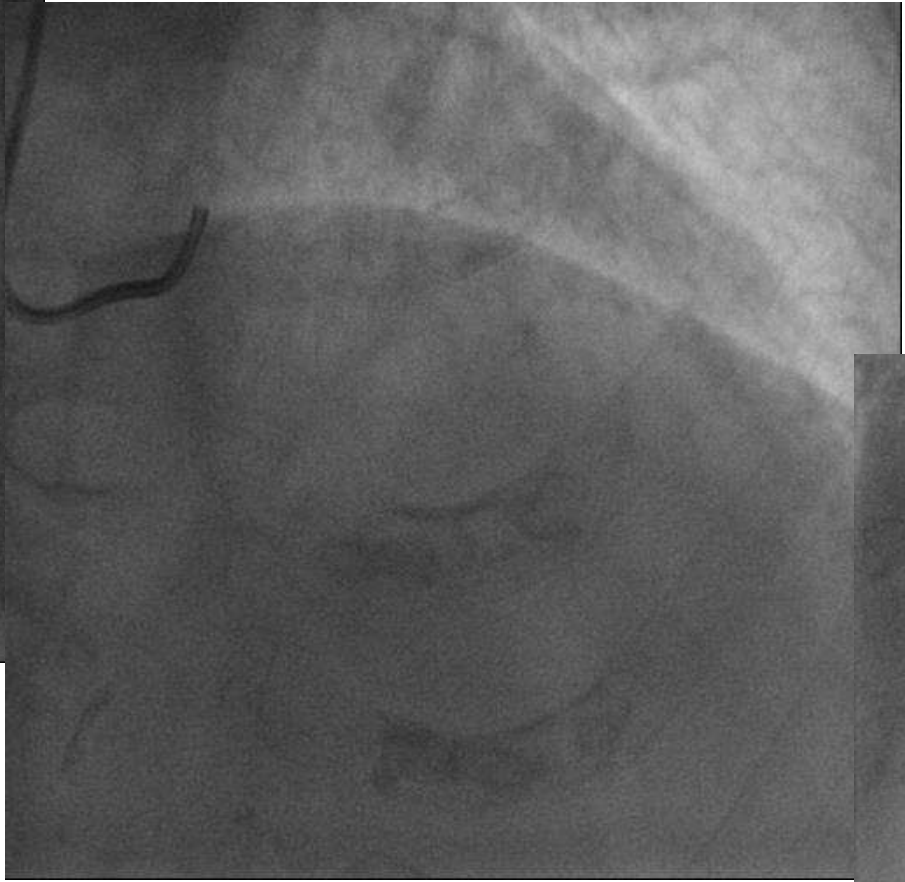
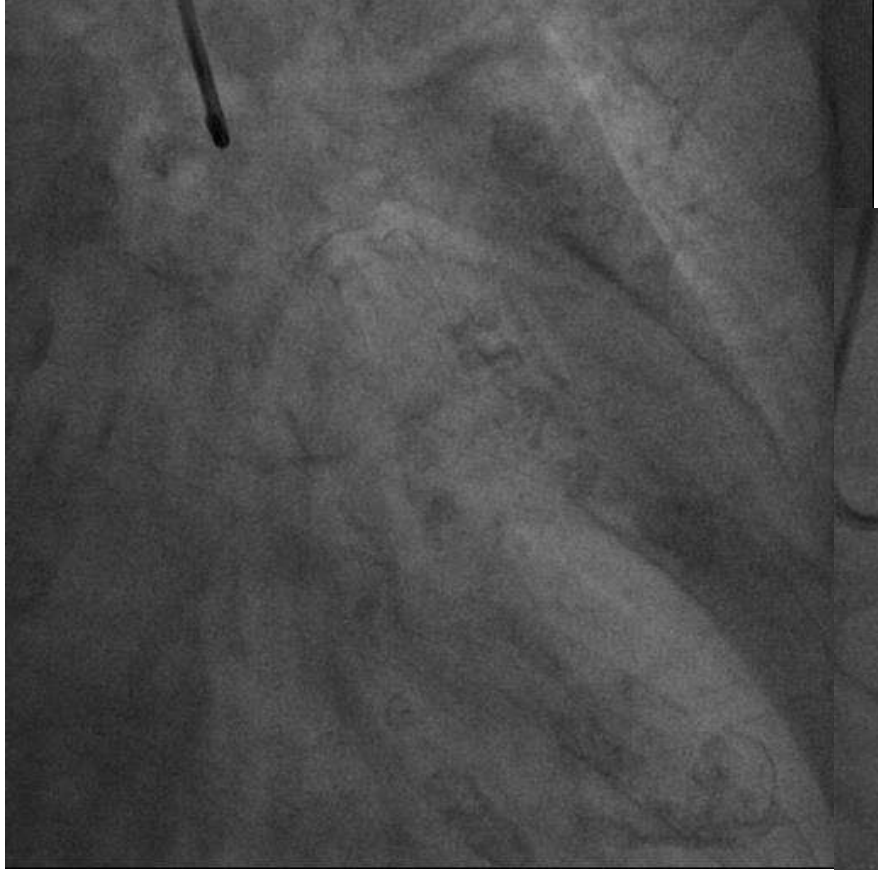
Dopo 2 giorni.....dolore toracico

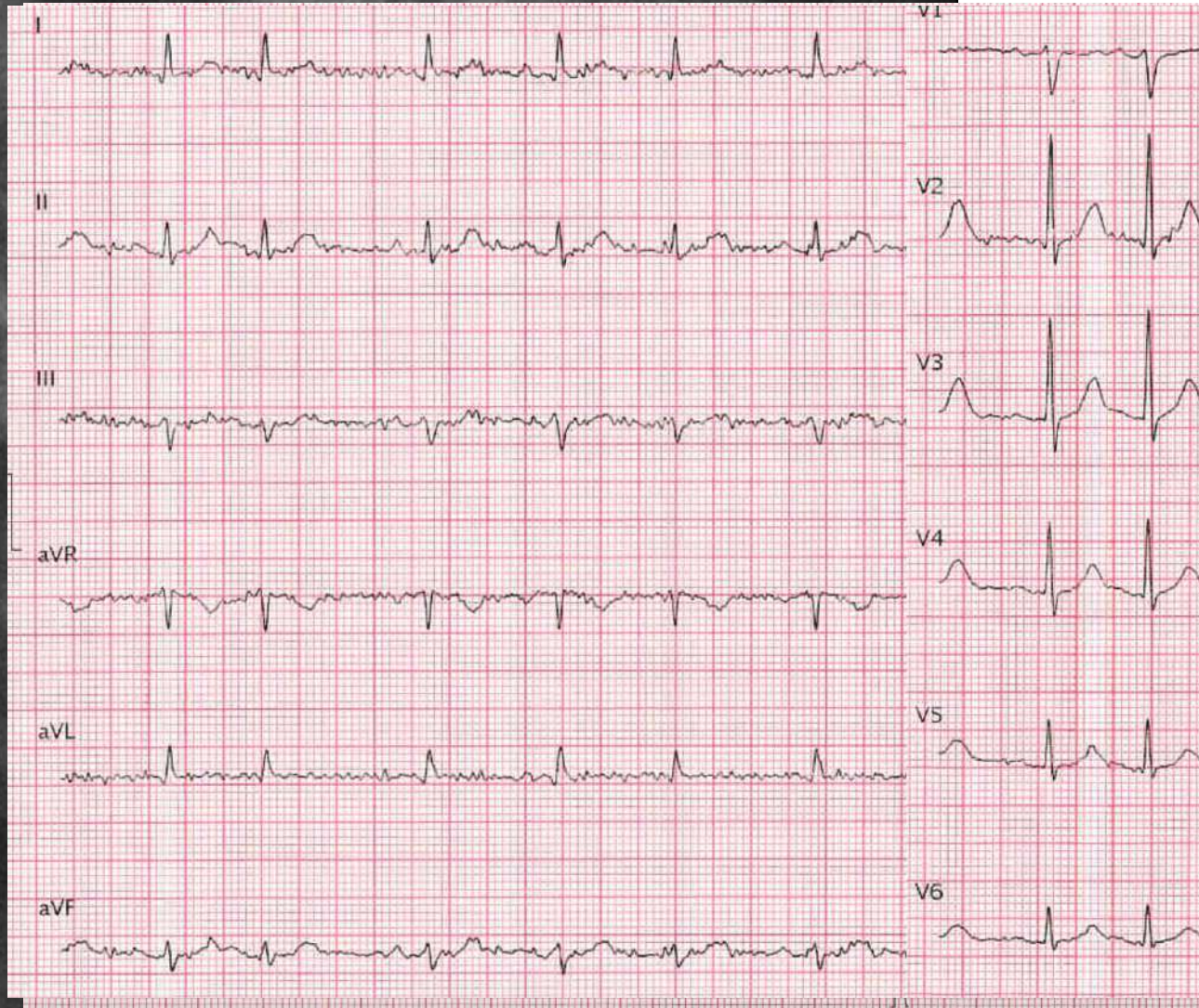


Ematochimici

- Creatinina 1.03, GFR 62
- **K⁺ 2.5**, Mg⁺⁺ 2.1, Ca⁺⁺ 9.2
- Hb 12.2, GB 10.5,
- **Troponina I 2700** (VN < 35 ng/l)
- **BNP 1230** (VN < 100 ng/l)







Emotional triggers

- ☹️ • depression
- illness of a close person
- suicide attempt
- divorce
- posttraumatic stress disorder

- 😱 • fear of speech
- robbery/burglary
- fear of surgery / hospitalization
- move to another city

- 😞 • new job
- job loss
- bankruptcy
- retirement
- bulging at work

- 💰 • debt
- huge loss of money

- ☠️ • death of a family member
- death of partner
- euthanasia of the pet

- 😡 • argument with the partner / family
- argument with the landlord

- 🌪️ • flooding
- earthquake
- storm

- 🤕 • car accident without injury
- downfall without fracture

- 😊 • Happy heart syndrome
- winning a jackpot
- birthday party
- birth of grandchild
- wedding
- visiting the opera
- positive job interview

Physical triggers

- cerebral bleeding
- stroke, TIA
- epilepsy, seizure
- migraine
- PRES
- concussion
- aneurysm rupture

- exacerbation COPD
- asthma attack
- pneumonia
- bronchitis
- pulmonary embolism
- larynx spasm

- gastrointestinal bleeding
- Crohn's disease exacerbation
- hernia incarceration

- pheochromocytoma
- urosepsis
- urolithiasis

- giving birth
- vaginal bleeding

- cancer
- chemotherapy

- influenza
- sepsis
- peritonitis
- wound infection

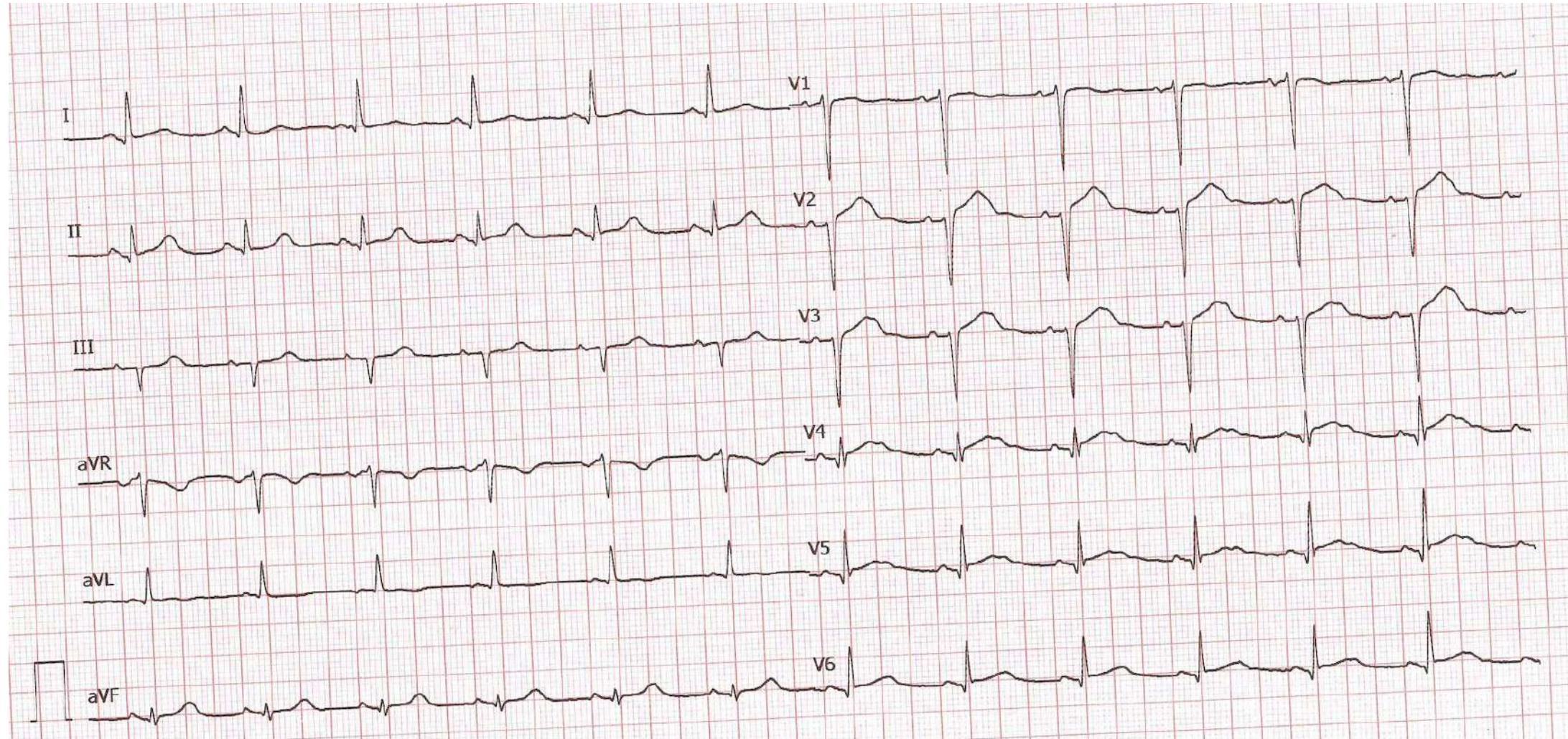
- fracture

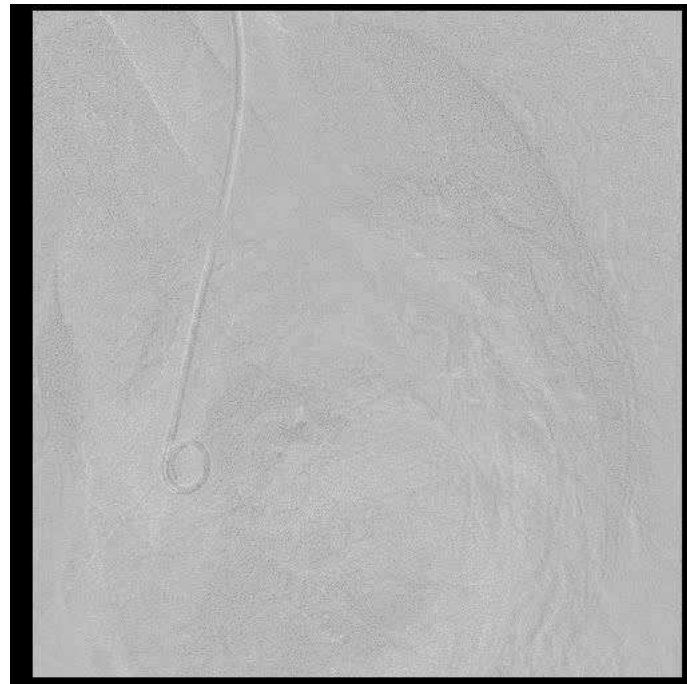
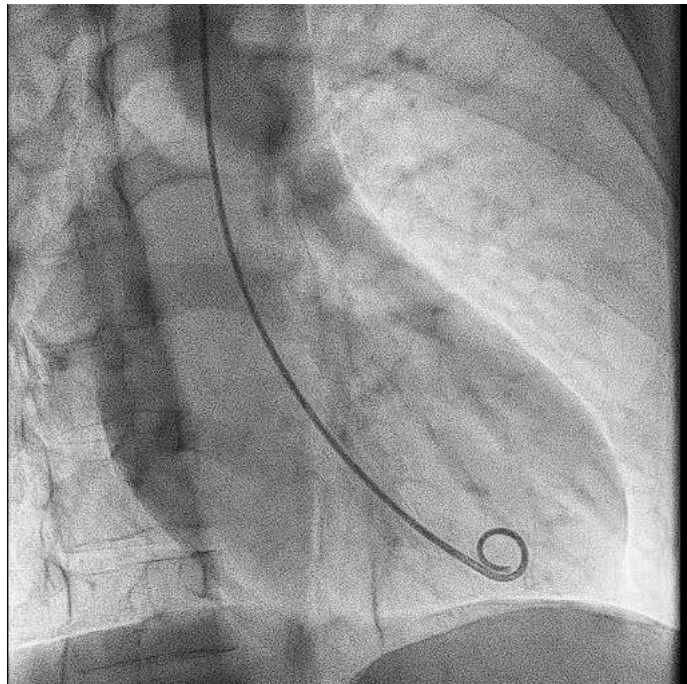
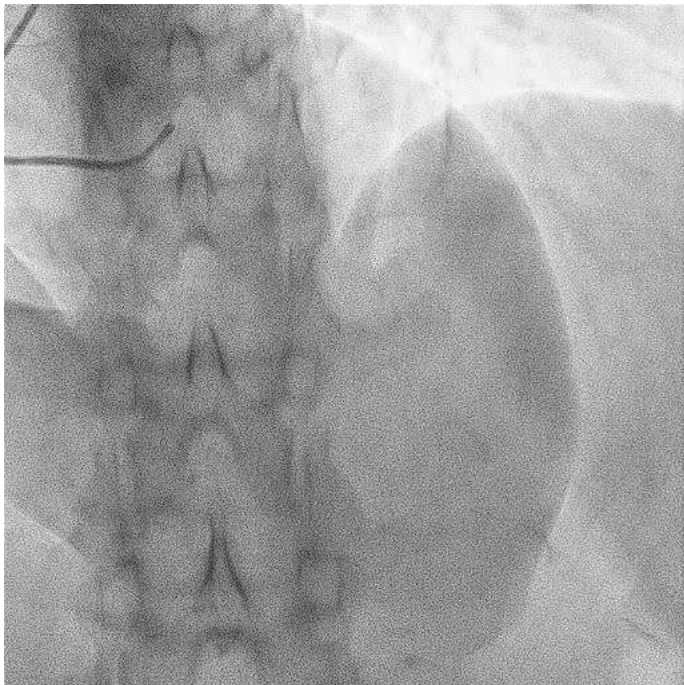
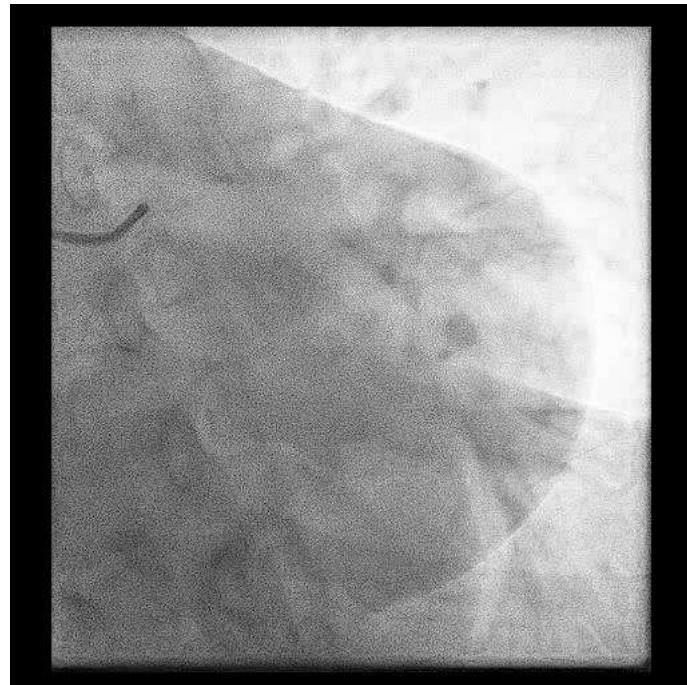
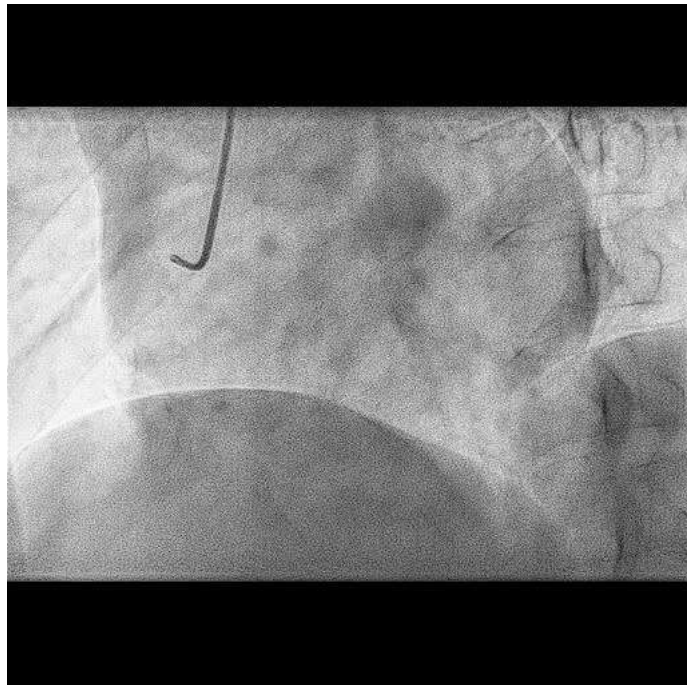
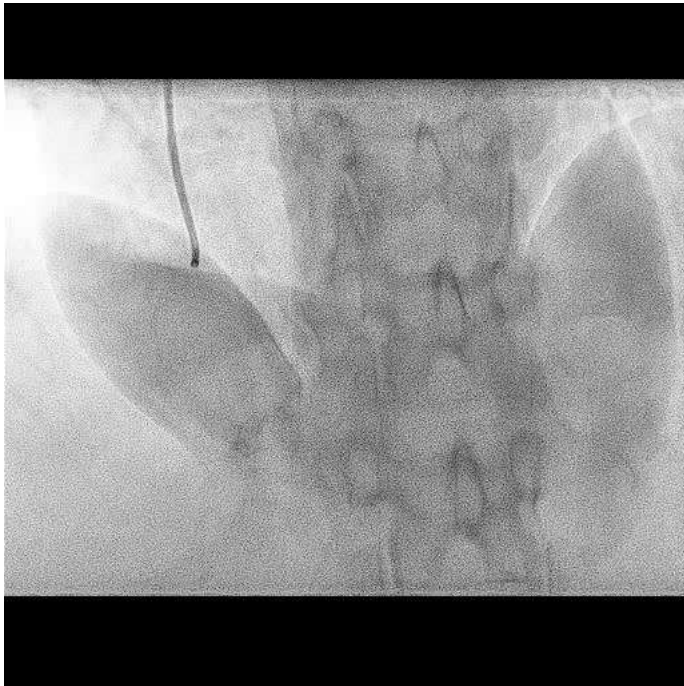
- operation

- anesthesia
- administration of catecholamines



CASO CLINICO 2- 70 anni, donna





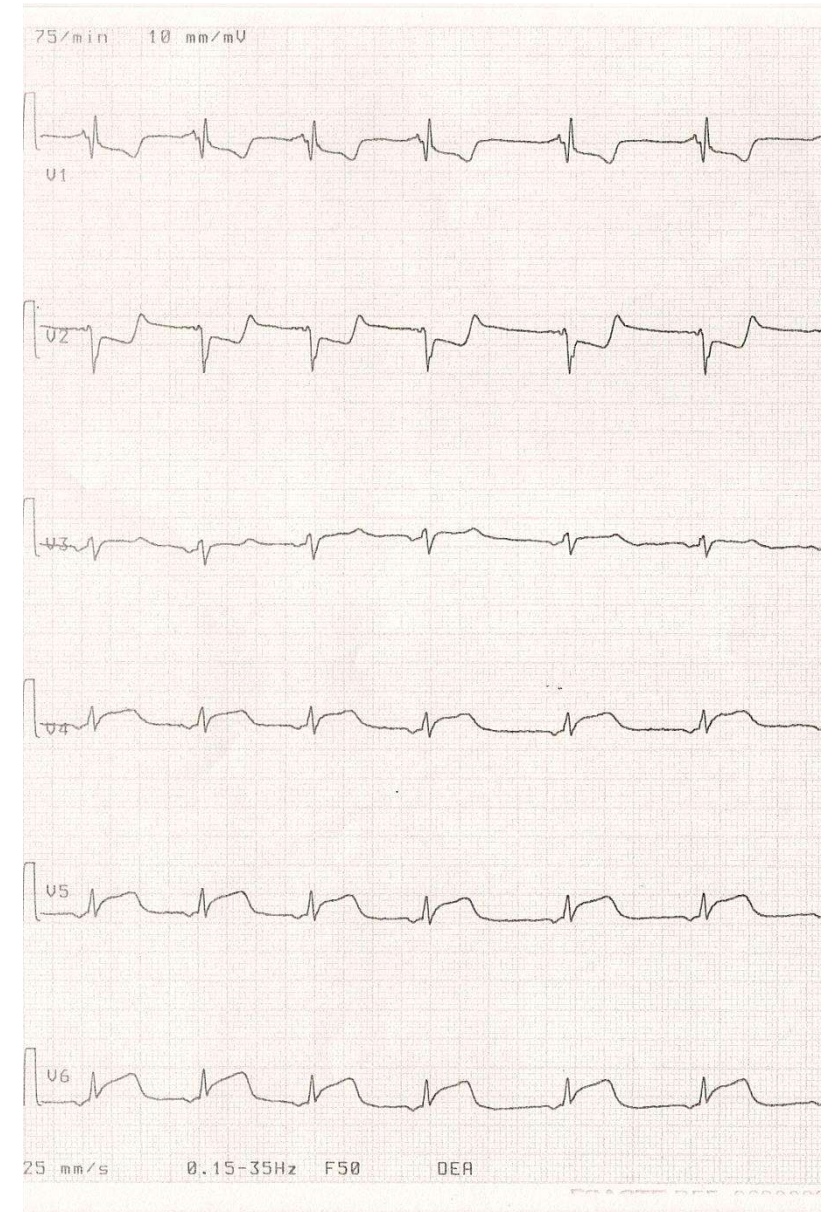
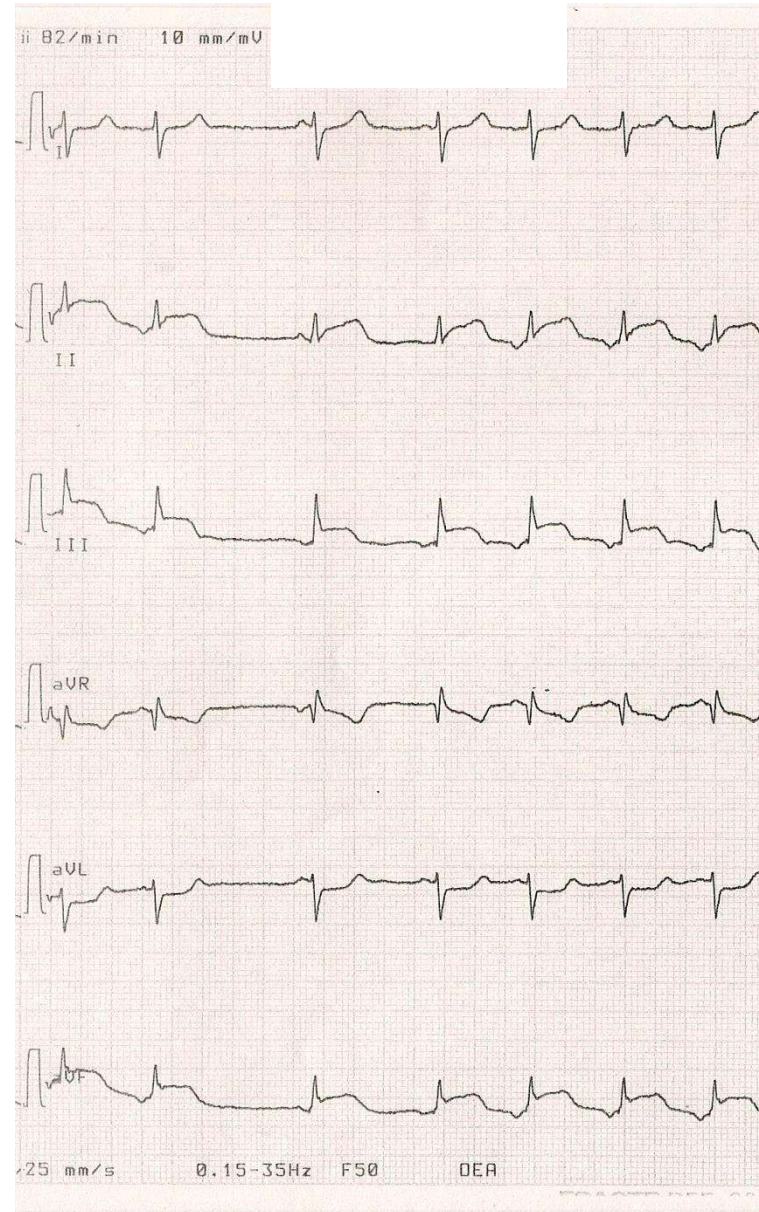
TakoTsubo ST vs STEMI

- ST Tako Tsubo presente nel 30-50 % delle presentazioni
- Non ha morfologia peculiare
- ST meno diffuso nelle derivazioni ECG
- ST Minor ampiezza
- Raramente presente in V1
- Spesso non presente ST speculare
- Minor evoluzione con onde Q e più rapida scomparsa

ECG NON E' SPECIFICO

CASO CLINICO 3

**CM, 24 aa, puerpera
(nessun frc)**



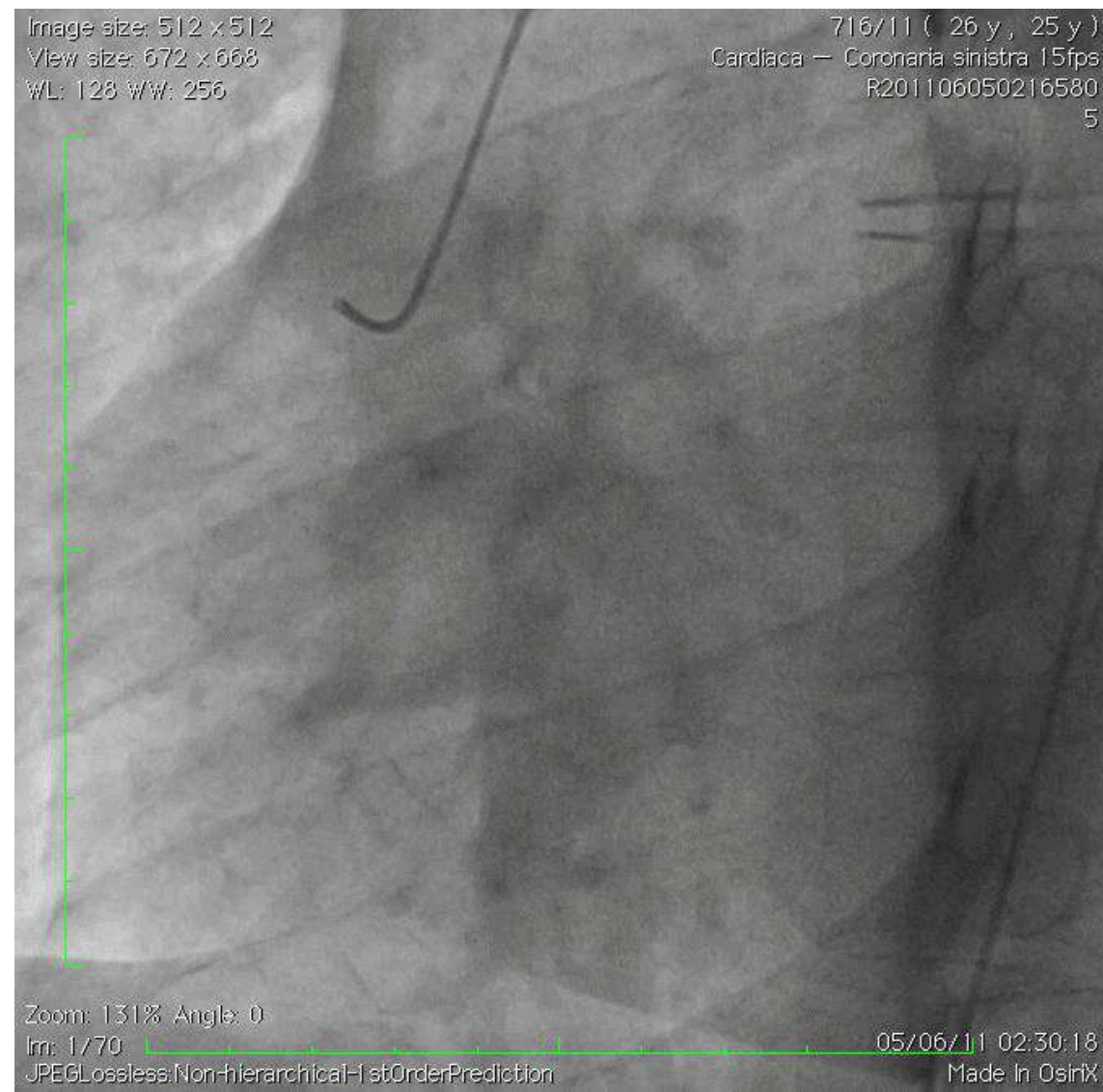
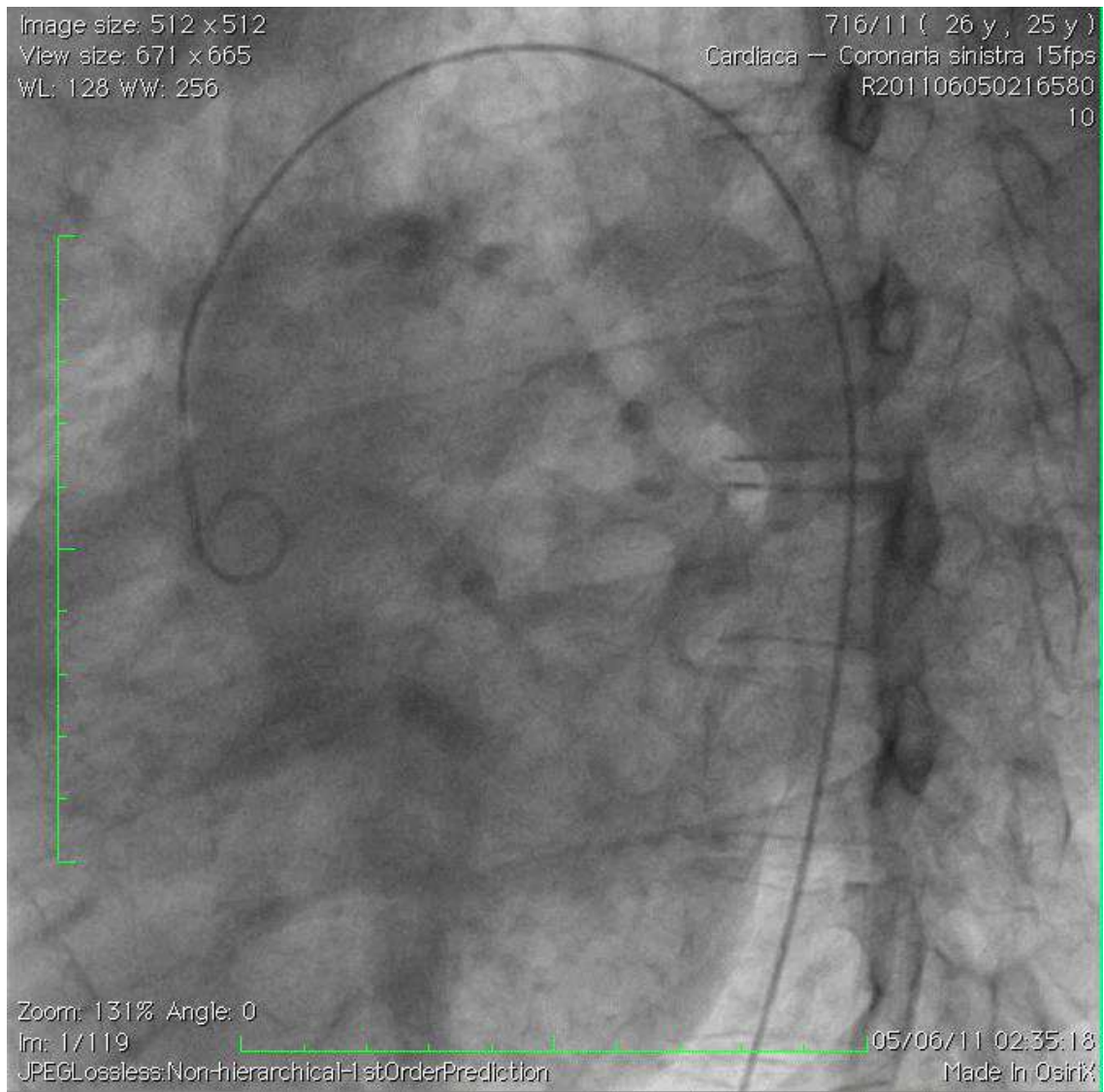
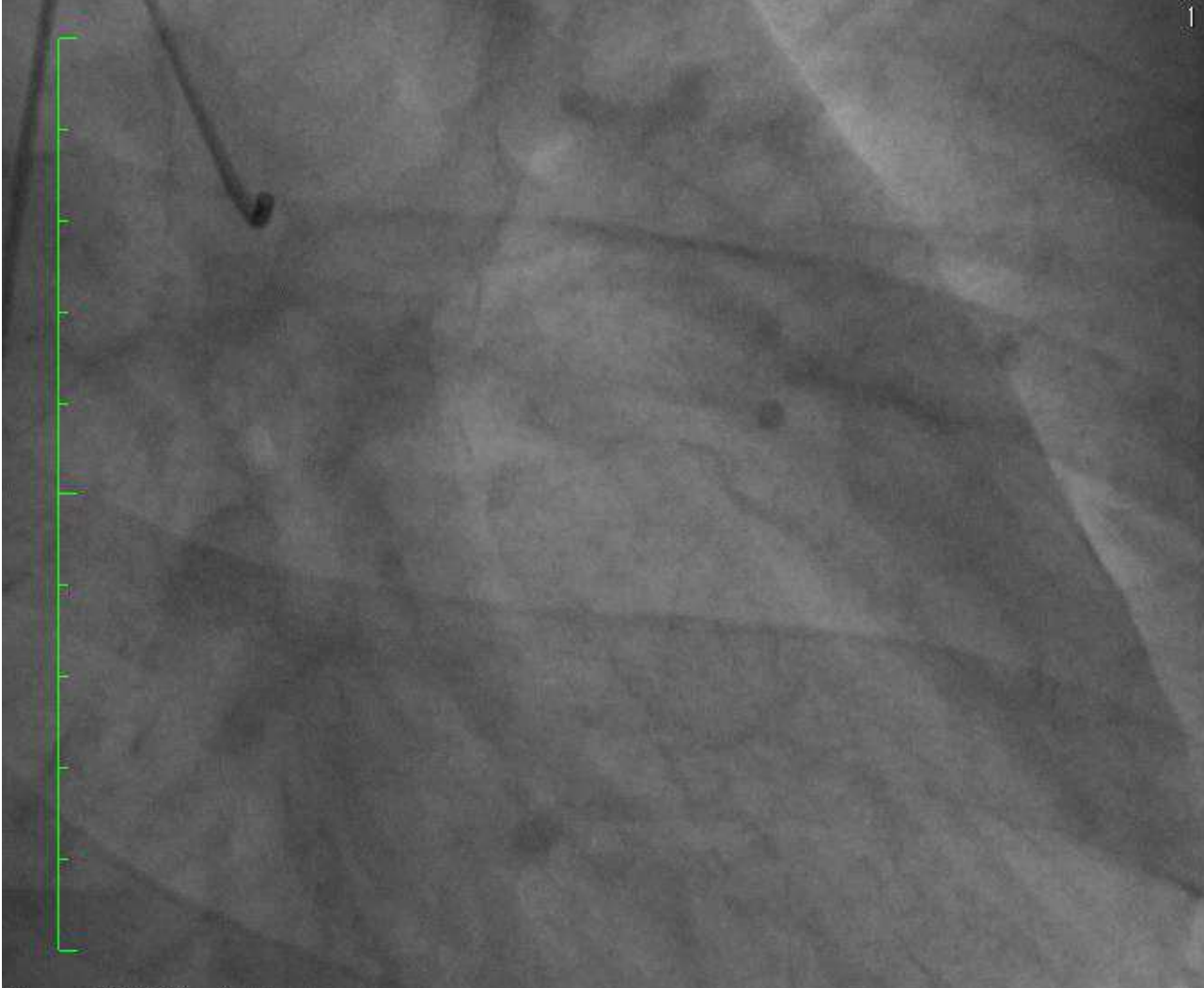


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View size: 672 x 668
WL: 128 WW: 256

716/11 (26 y , 25 y)
Cardiaca — Coronaria sinistra 15fps
R201106050216580
1

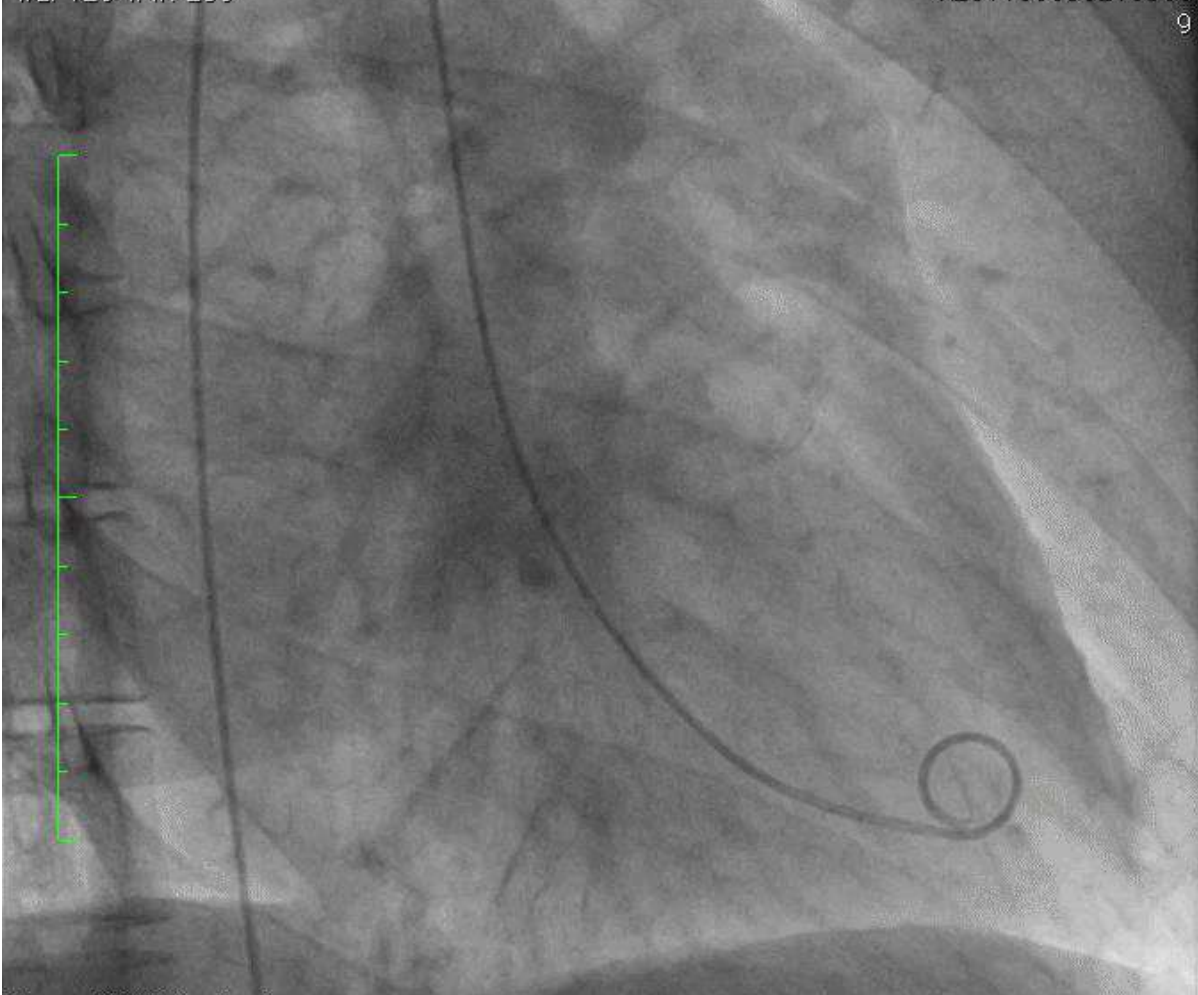


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Im: 1/80
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Made In OsiriX

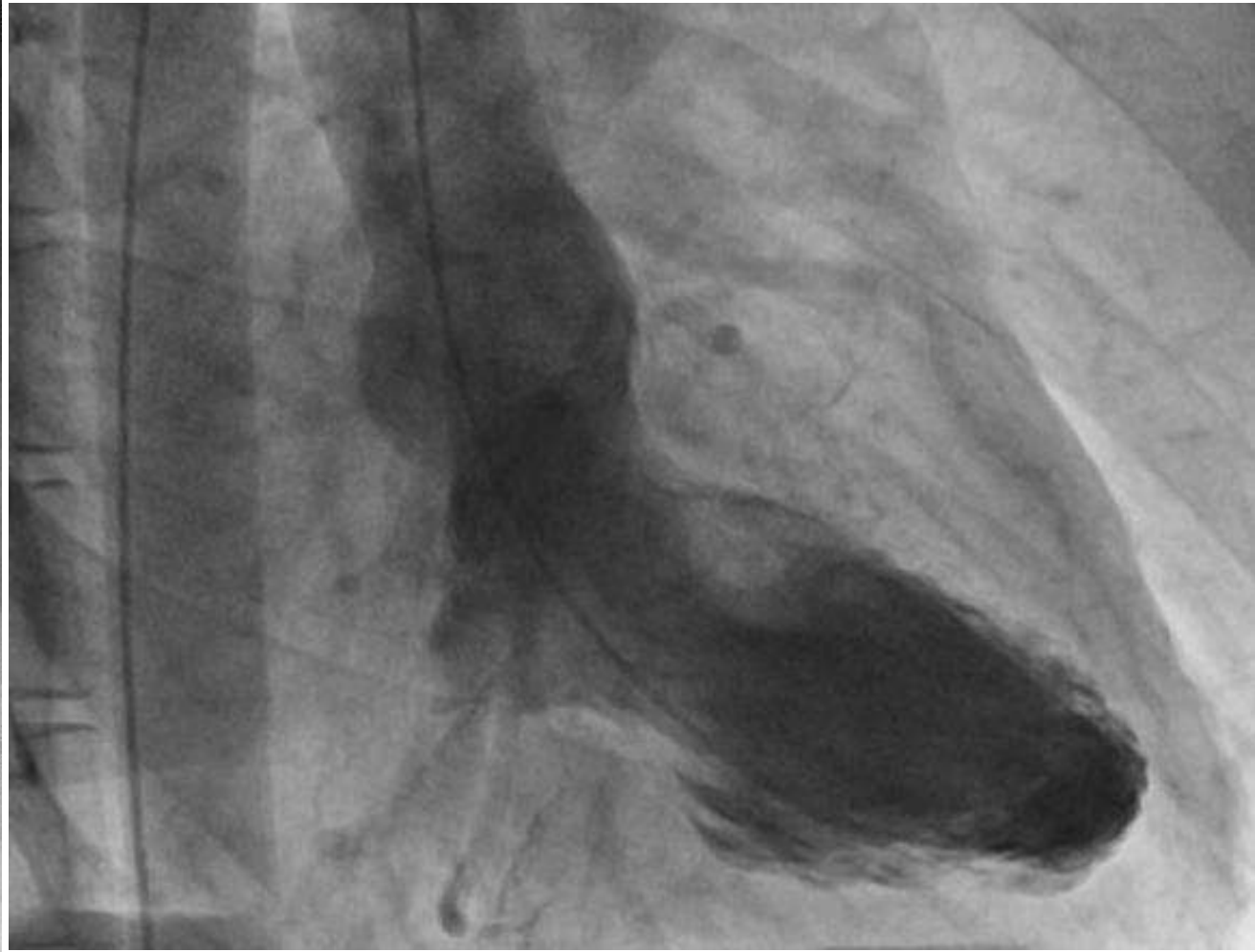


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WL: 128 WW: 256

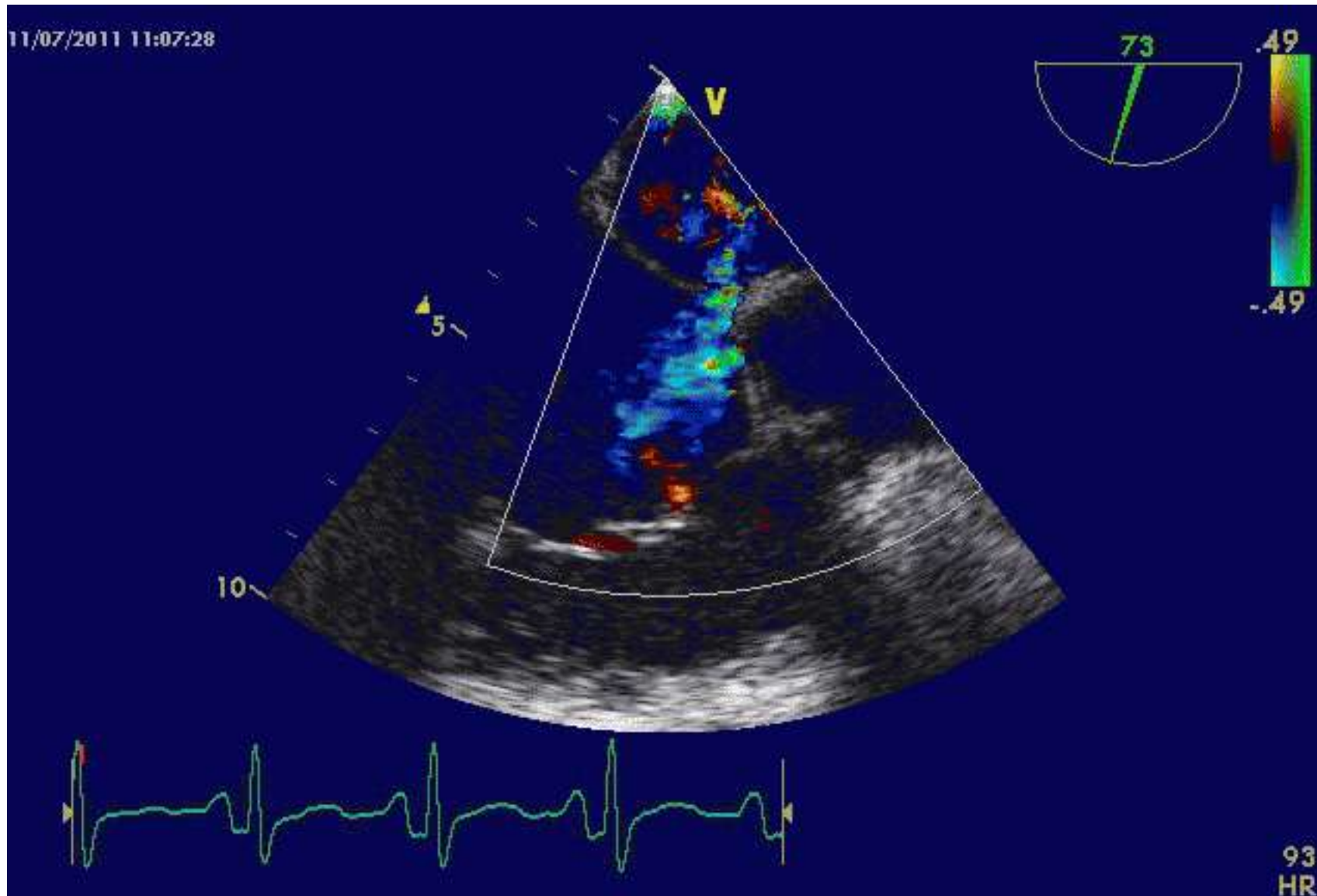
716/11 (26 y, 25 y)
Cardiaca — Coronaria sinistra 15fps
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9



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Im: 1/136
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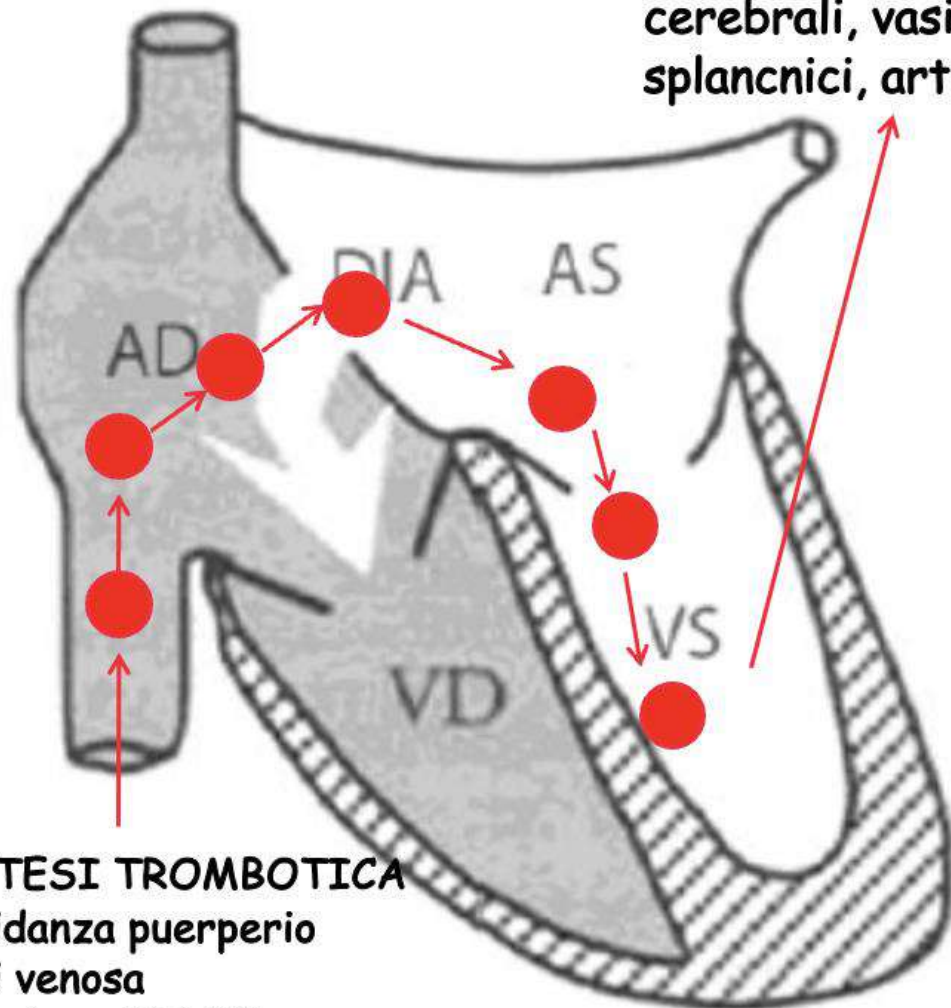


ECOCARDIO TRANS ESOFAGEO: DIFETTO INTERATRIALE >>> VEROSIMILE EMBOLO PARADOSSO



EMBOLO PARADOSSO

Coronarie, vasi
cerebrali, vasi
splancnici, arti...



DIATESI TROMBOTICA

- Gravidanza puerperio
- Stasi venosa
- Mutazione MTHFR
- iperomocisteinemia

Image size: 512 x 512
View size: 671 x 671
WL: 128 WW: 256

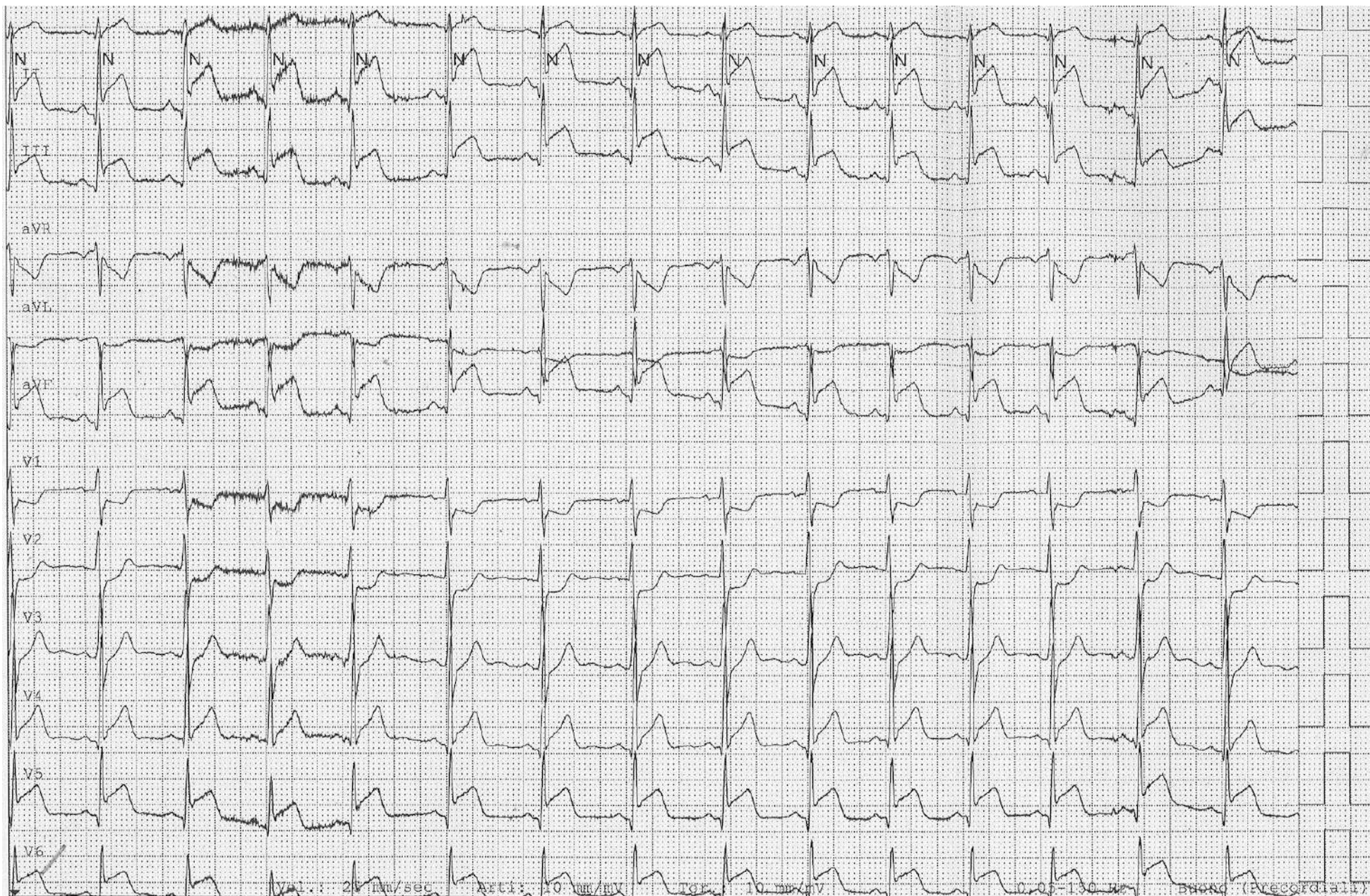
1081 (26 y, 26 y)
12.5 FPS Coronary — unnamed
02092011072103
1

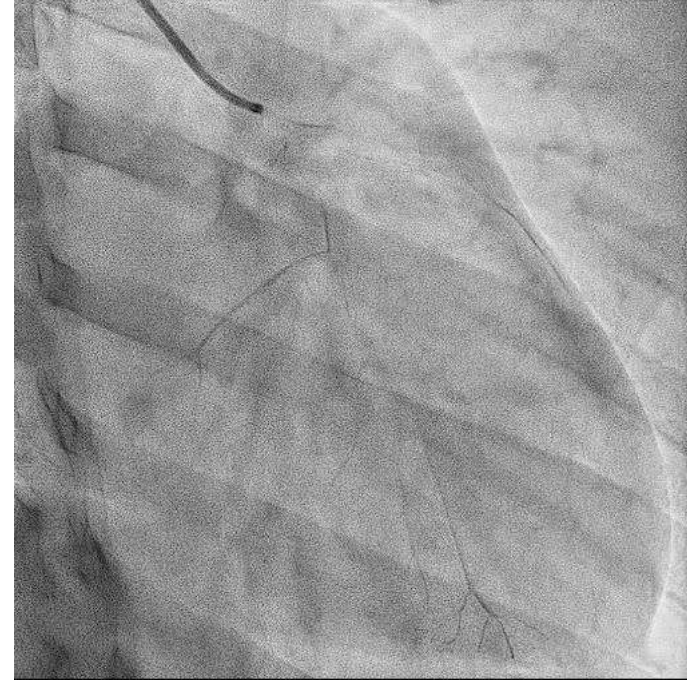
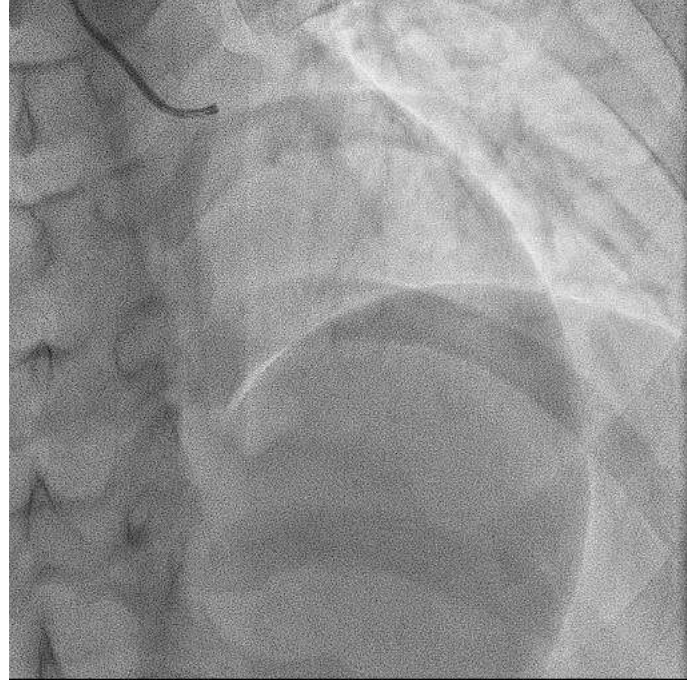
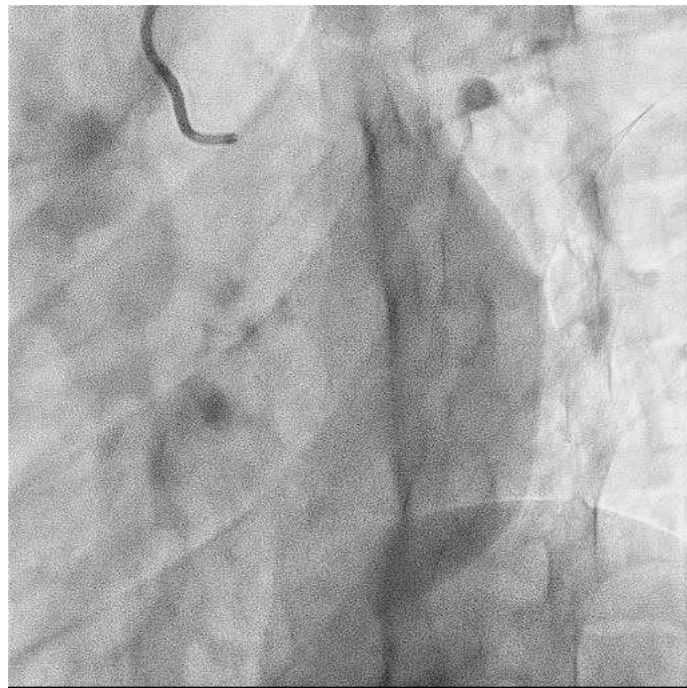
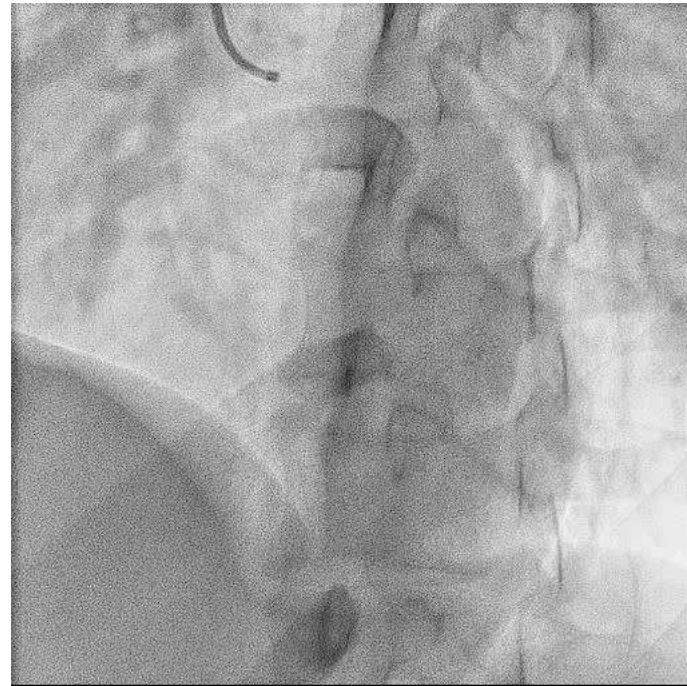
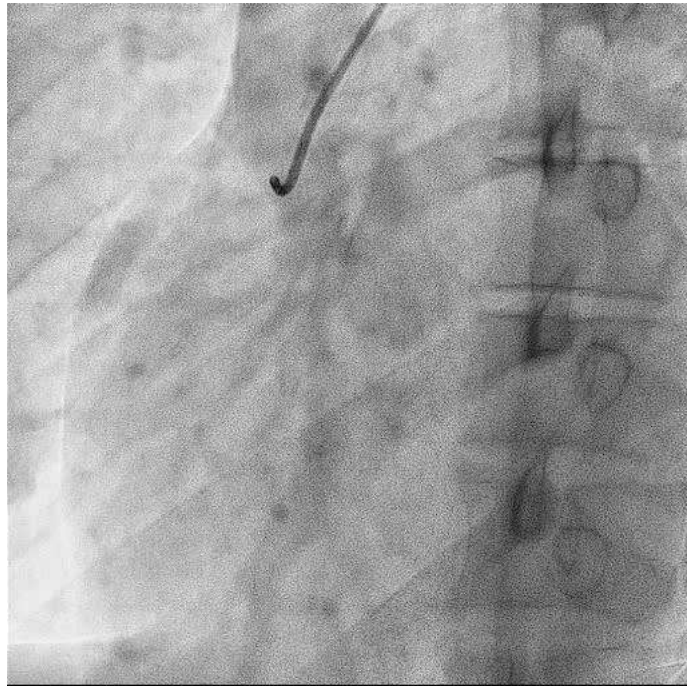
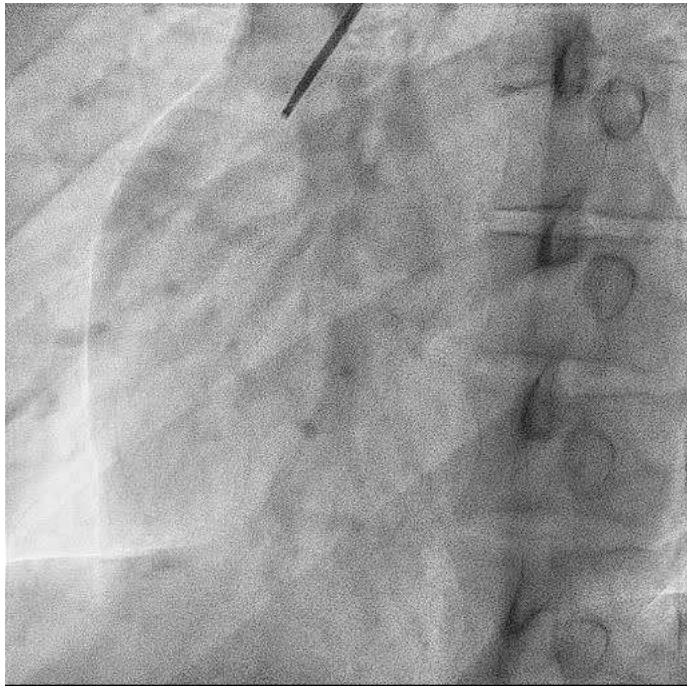
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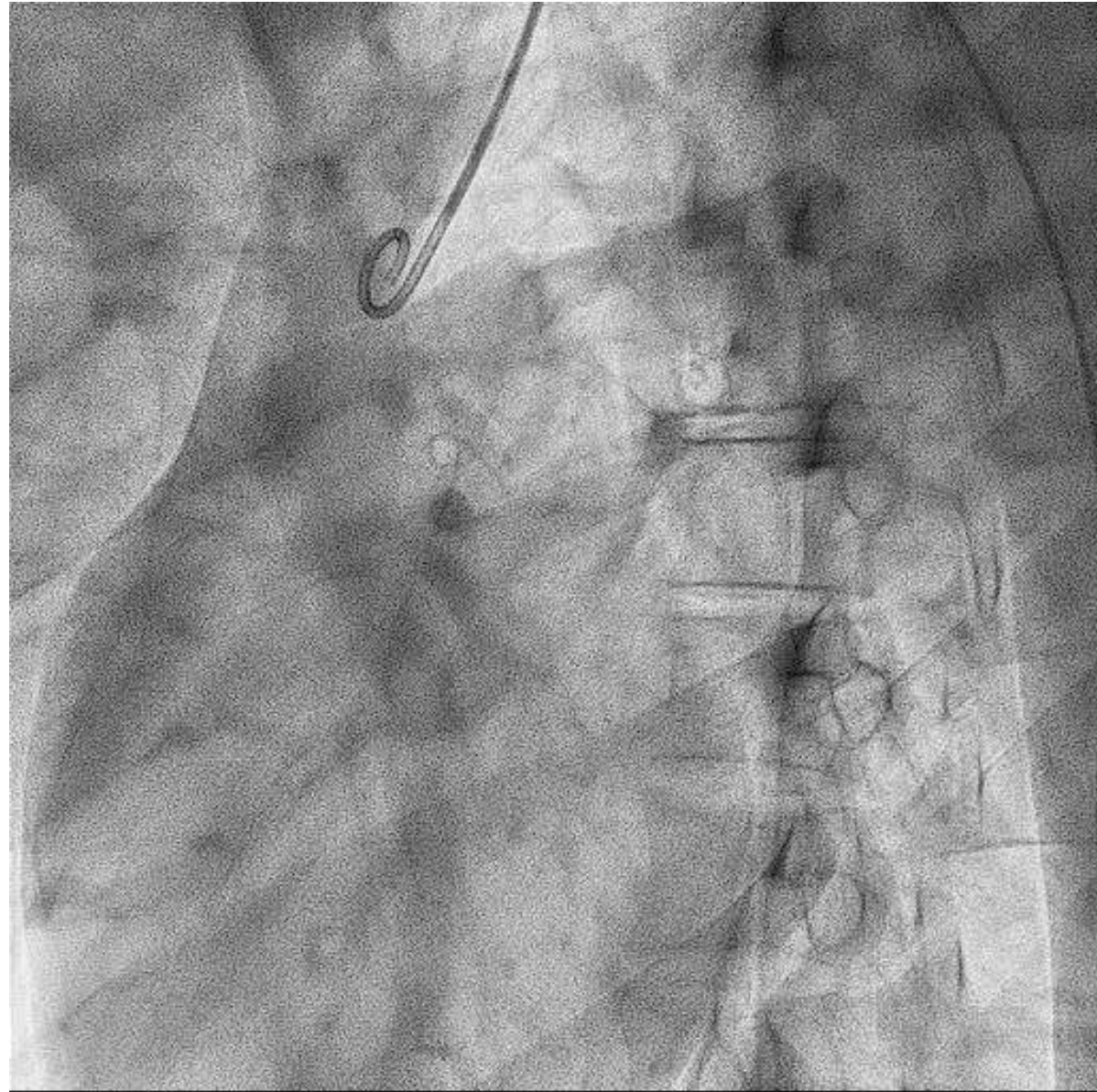
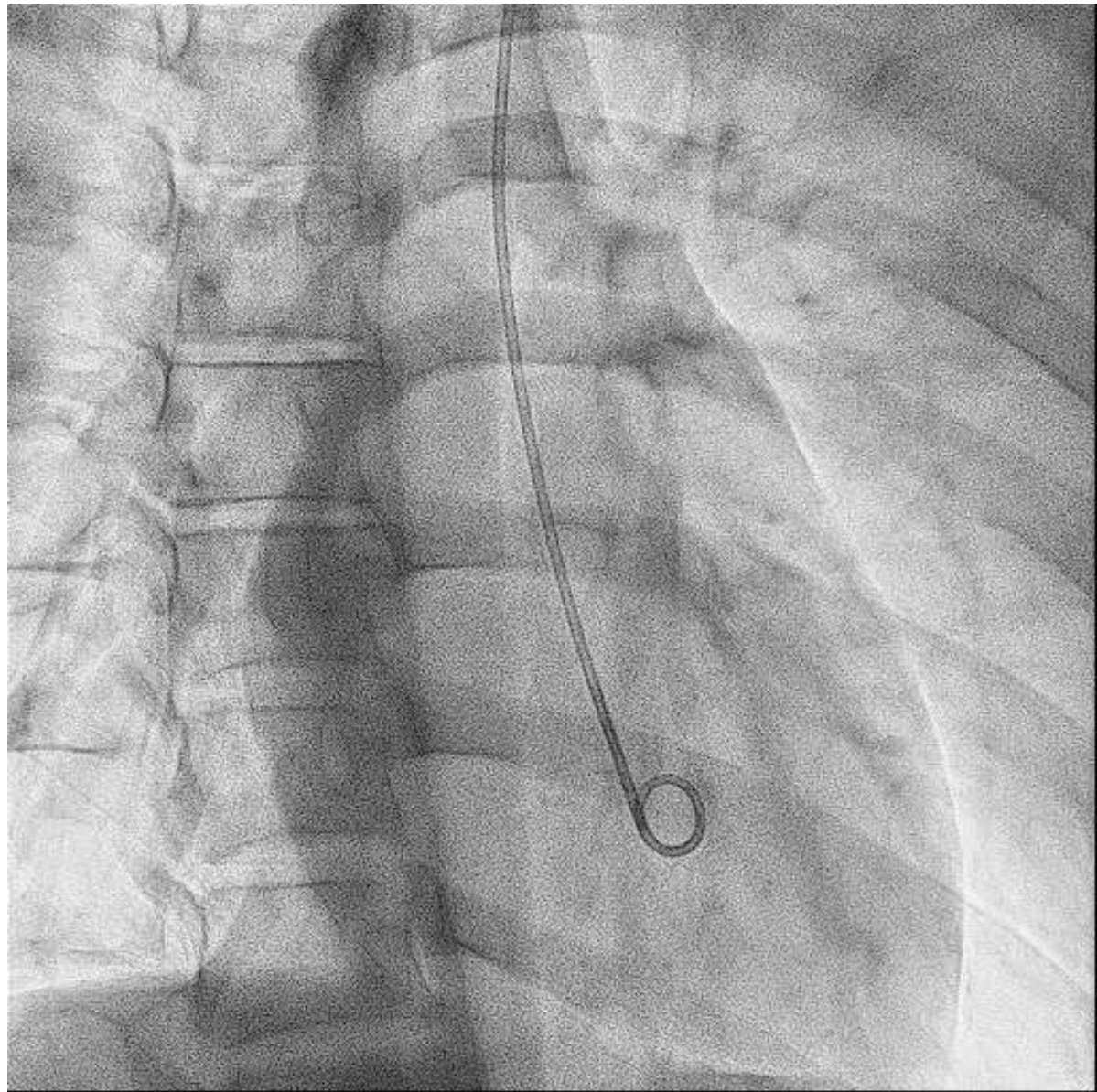
JPEGLossless.Non-hierarchical-1stOrderPrediction

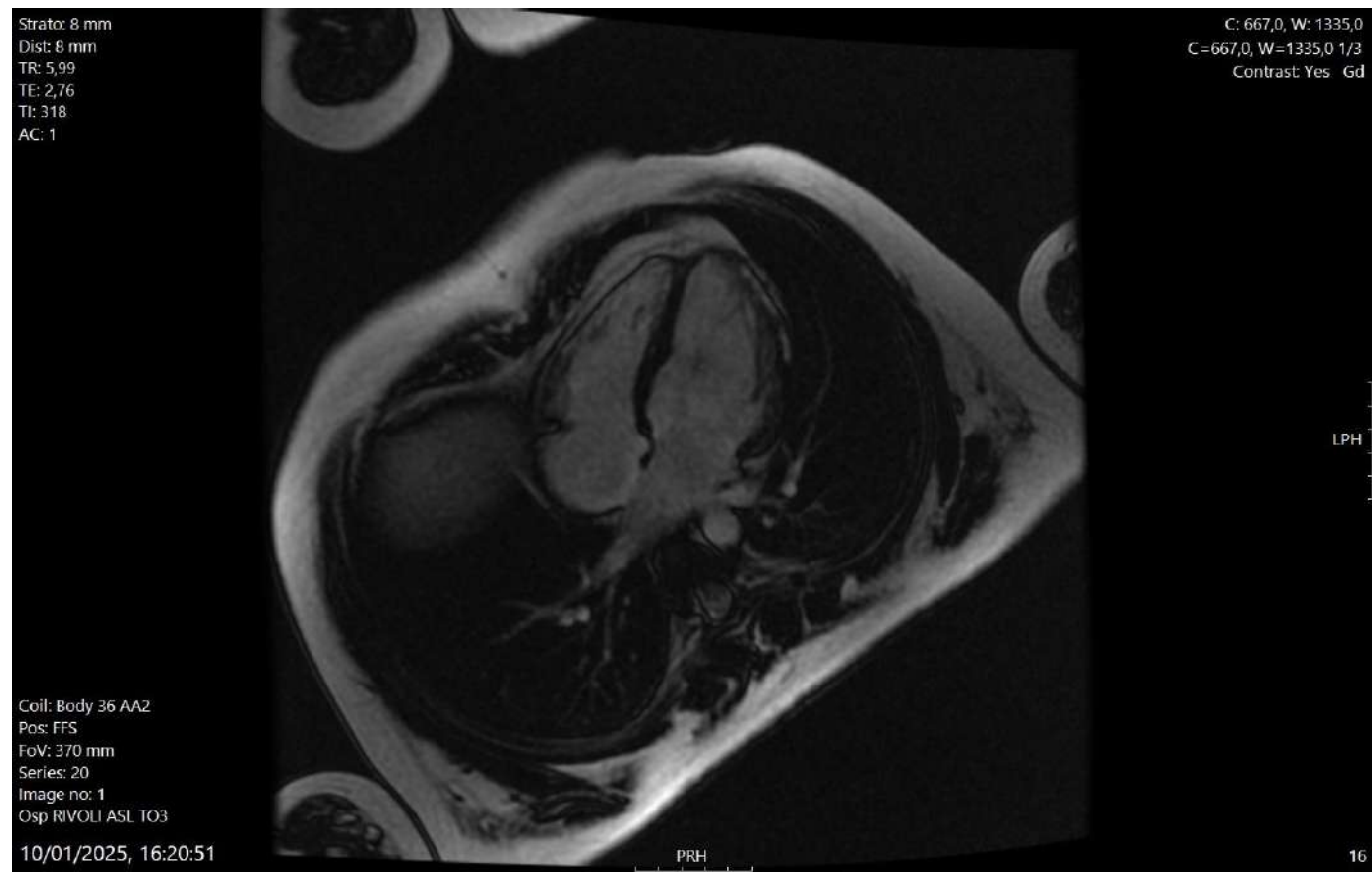
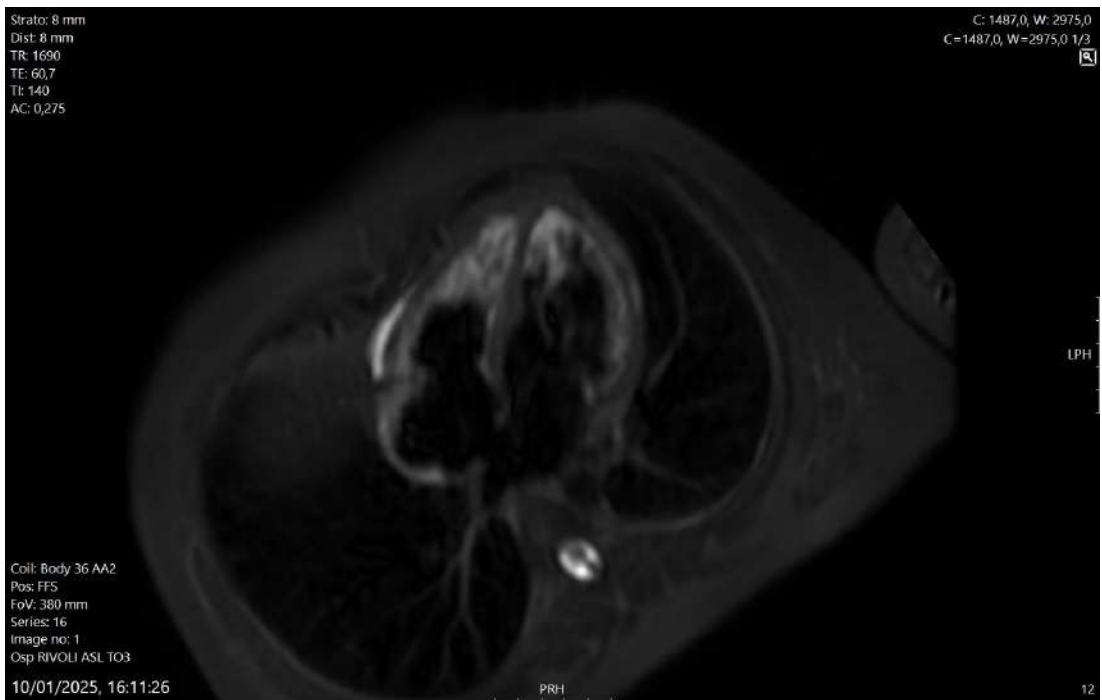
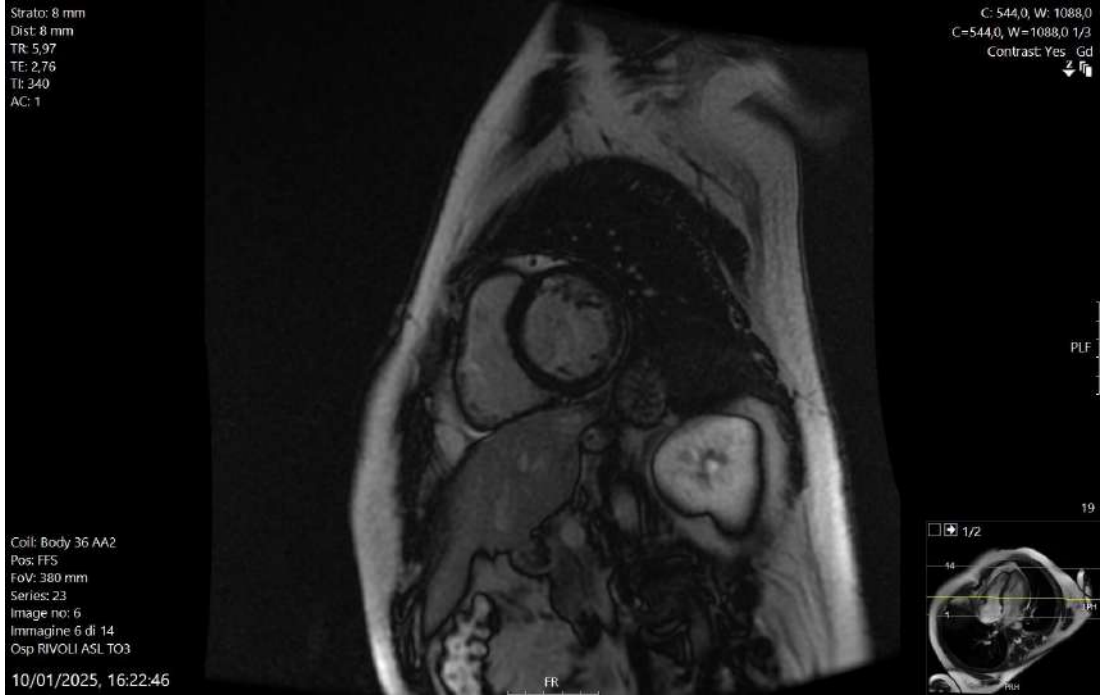
02/09/11 09:03:28
Made In OsiriX

CASO CLINICO 4 – uomo 52 anni, forte fumatore









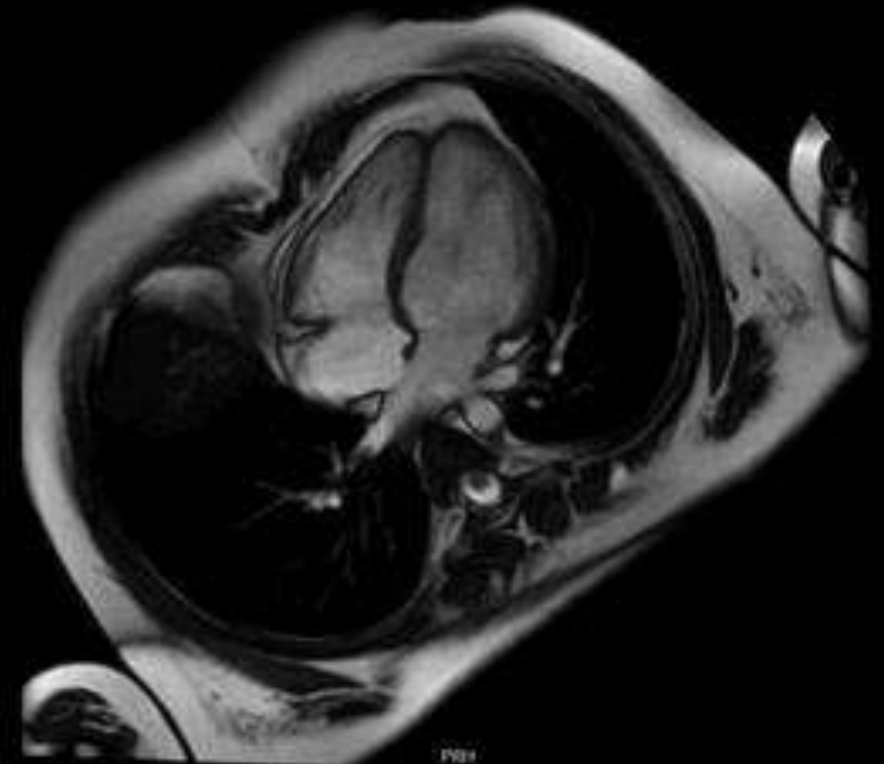
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Dist: 8 mm
TR: 4.15
TE: 1.45
AC: 1

C: 1004.0, W: 2008.0
C: 1004.0, W: 2008.0, 1/1



Strat: 8 mm
Dist: 8 mm
TR: 4.00
TE: 1.40
AC: 1

C: 1100.0, W: 2200.0
C: 1100.0, W: 2200.0, 1/0



Coil: Body 36 AAJ
Pos: RFS
FoV: 370 mm
Series: 6
Image no: 2
Imagine 2 of 30
Op: RVOLU ASL T03

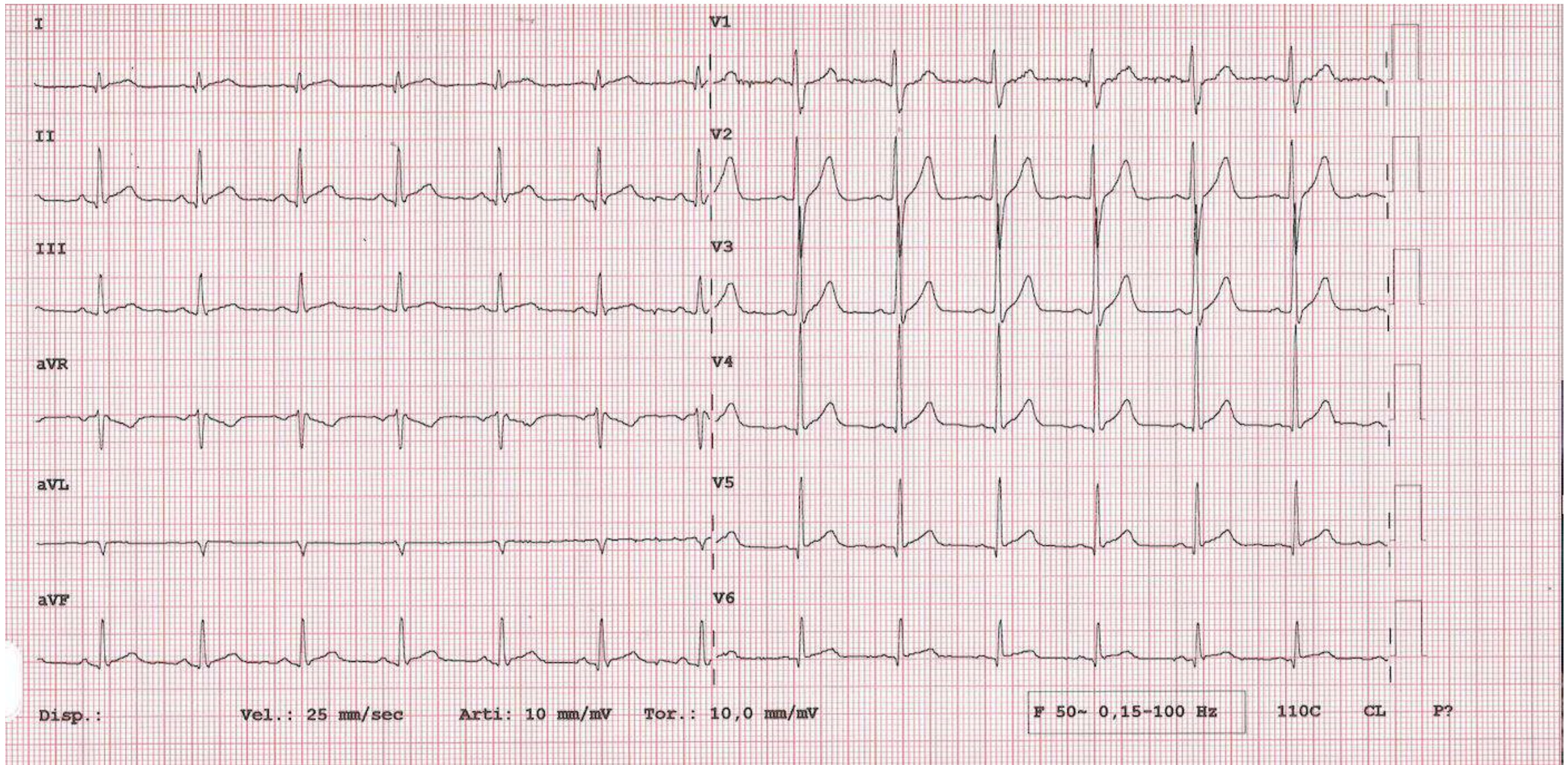
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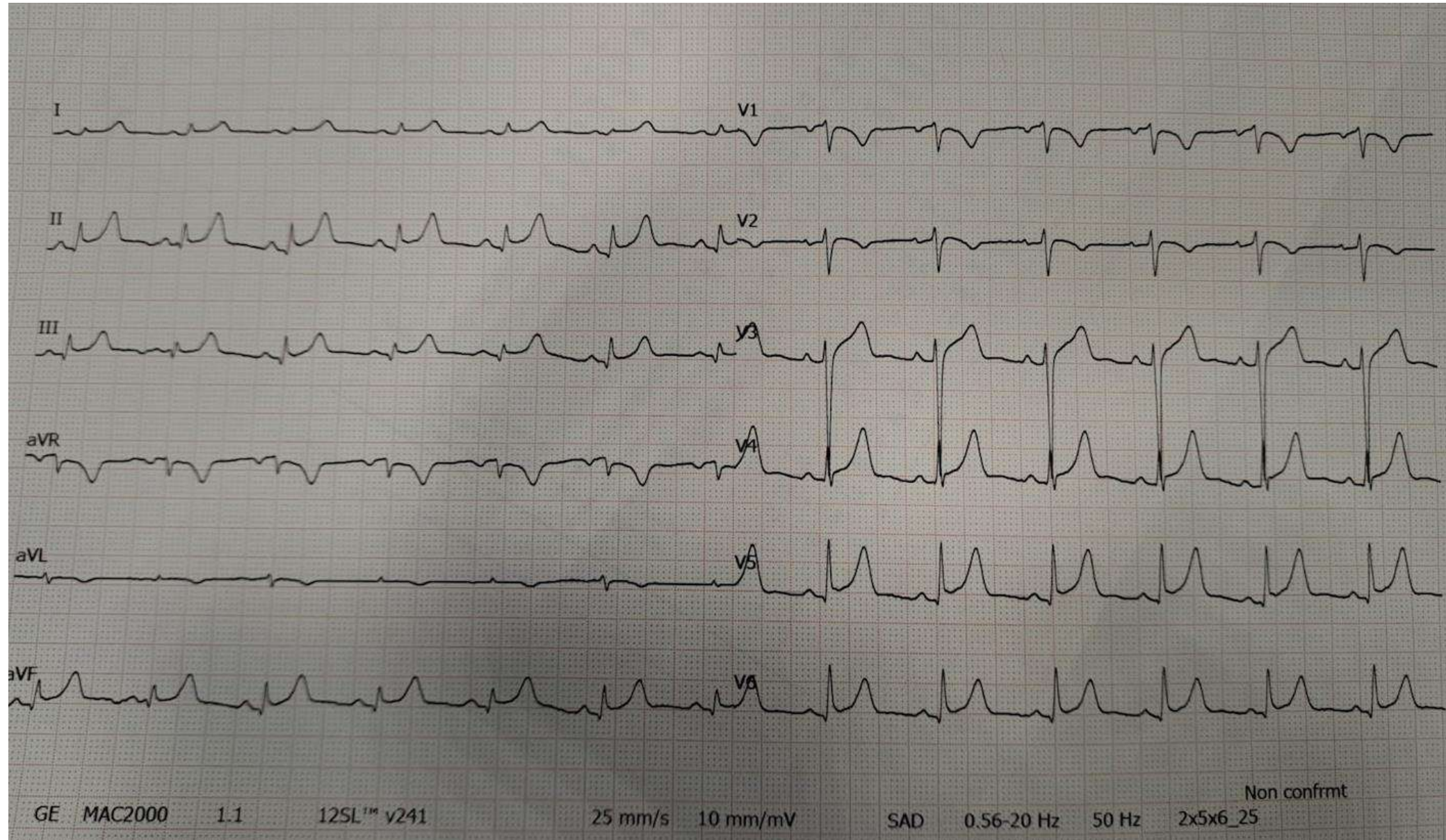
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LPH

5



CASO CLINICO 5 - donna, 84 anni



ESAME EMOCROMOCITOMETRICO

Leucociti (WBC)	13,0	*	x10 ³ /uL	[4,0 - 10,0]
Eritrociti (RBC)	4,79		x10 ⁶ /uL	[4,00 - 5,50]
Emoglobina (HGB)	12,8		g/dL	[12,0 - 16,5]
Ematocrito (HCT)	40		%	[37 - 47]
Volume corpuscolare medio (MCV)	83,7		fL	[82,0 - 98,0]
Contenuto emoglobinico medio (MCH)	26,7	*	pg	[27,0 - 32,0]
Concentrazione emoglobinica media (MCHC)	31,9		g/dL	[31,0 - 37,0]
RDW-CV	14,2		%	[11,5 - 16,5]
Piastri (PLT)	294		x10 ³ /uL	[130 - 500]

Formula Leucocitaria

Neutrofilii	75,0	*	%	[40,0 - 74,0]	9,730	*	x10 ³ /uL	[1,600 - 7,400]
Linfociti	14,4	*	%	[19,0 - 48,0]	1,860		x10 ³ /uL	[0,760 - 4,800]
Monociti	9,8		%	[2,0 - 11,0]	1,280	*	x10 ³ /uL	[0,080 - 1,100]
Eosinofili	0,2		%	[<7,0]	0,030		x10 ³ /uL	[<0,700]
Basofili	0,4		%	[<2,0]	0,060		x10 ³ /uL	[<0,200]

GLUCOSIO NEL SANGUE

<i>Esochinasi</i>	92		mg/dL	70-100 nella norma <92 se in gravidanza 100-125 alterata glicemia a digiuno (IFG)
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CREATININA NEL SANGUE

<i>Enzimatico</i>	0,68		mg/dL	[0,55 - 1,02]
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FILTRATO GLOMERULARE (eGFR CKD-EPI)

	80		mL/min/1,73m ²	>= 90 nella norma 60-89 lieve riduzione 30-59 moderata riduzione 15-29 marcata riduzione <15 severa riduzione
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SODIO NEL SANGUE

<i>ISE indiretto</i>	140		mmol/L	[136 - 146]
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POTASSIO NEL SANGUE

<i>ISE indiretto</i>	3,9		mmol/L	[3,4 - 5,1]
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PROTEINA C REATTIVA (PCR)

<i>Immuno-turbidimetrico</i>	14,50	*	mg/dL	[<0,50]
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PROCALCITONINA

<i>Chemiluminescenza</i>	0,47		ng/mL	<0,5 rischio basso di sepsi grave e/o shock settico da >=0,5 a <=2,0 rischio moderato di avanzamento a sepsi grave e/o shock settico >2,0 rischio elevato di sepsi grave e/o shock settico
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ASPARTATO AMINOTRANSFERASI (AST)

<i>IFCC (senza P5P)</i>	28		U/L	[<35]
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ALANINA AMINO TRANSFERASI (ALT)

<i>IFCC (senza P5P)</i>	20		U/L	[<35]
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SODIO NEL SANGUE

<i>ISE indiretto</i>	141		mmol/L	[136 - 146]
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POTASSIO NEL SANGUE

<i>ISE indiretto</i>	4,3		mmol/L	[3,4 - 5,1]
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TROPONINA - I HS

<i>Chemiluminescenza</i>	6,9		ng/L	[<11,6]
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PROCALCITONINA

<i>Chemiluminescenza</i>	0,25		ng/mL	<0,5 rischio basso di sepsi grave e/o shock settico da >=0,5 a <=2,0 rischio moderato di avanzamento a sepsi grave e/o shock settico >2,0 rischio elevato di sepsi grave e/o shock settico
--------------------------	-------------	--	-------	--

84 anni, ipertesa, dislipidemia. Non note allergie.

SAD. Spondilodiscoartrosi. Osteopenia.

Nota cardiopatia valvolare con FE conservata in follow up periodico. Insufficienza mitro-aortica lieve moderata (Ecocardio 02/2018: FE di norma, Asx lievemente dilatato).

Nel 2023 due ricoveri per polmonite in Medicina Susa.

Terapia Domiciliare: CardioASA 100 mg • Bisoprololo 1.25 mg 1 cp ore 8 • Sertralina 50 mg 1 cp ore 8 •

Furosemide/spironolattone 25/37 mg 1 cp ore 8 • Rosuvastatina/ezetimibe 10/10 mg 1 cp ore 18 • Integrazione vitamina D (colecalfiferolo). • Lasix 25 mg 1/2 cp

Attuale accesso DEA per dolore toracico con caratteristiche tipiche per dolore pericarditico (evocato da inspirazione profonda e posizione clinostatica).

ECG: RS, sopraST concavo diffuso con associato sottoslivellamento tratto PR. Richiesta valutazione urgente per sospetto STEMI.

Alla mia valutazione pz sintomatica per dolore pericarditico, lieve desaturazione in aria ambiente.

Ematici in corso. Da eseguire Rx torace.

Ecoscopia: VSx non dilatato con normale funzione contrattile globale e segmentaria (FE 65%). Diastole di I grado. Camere dx regolari, ASx dilatato. IM lieve, IAo lieve e IT lieve, grad VA dx 20 mmHg. Lievissimo versamento pericardico circonferenziale (max 4 mm) senza il minimo impatto emodinamico. VCI piccola e collabente. Visualizzato lieve versamento pleurico basale sx.

Se si conferma aumento indici di flogosi agli ematici e possibile concomitante focolaio broncopneumonico si conclude per PERICARDITE ACUTA parapneumonica.

SEMI-SEDUTO

L

Data - ora **19/02/2026 11:11**

NOTE REFERTO

RADIOGRAFIA (RX) DEL TORACE DI ROUTINE, NAS, 1 PROIEZIONE semiseduto

Cardiomegalia.

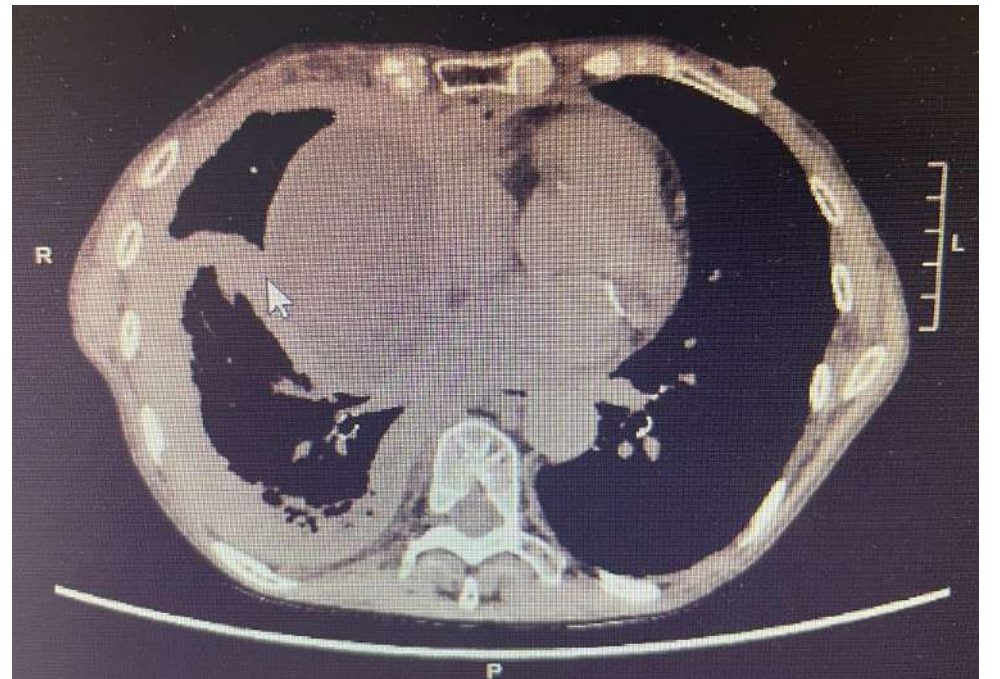
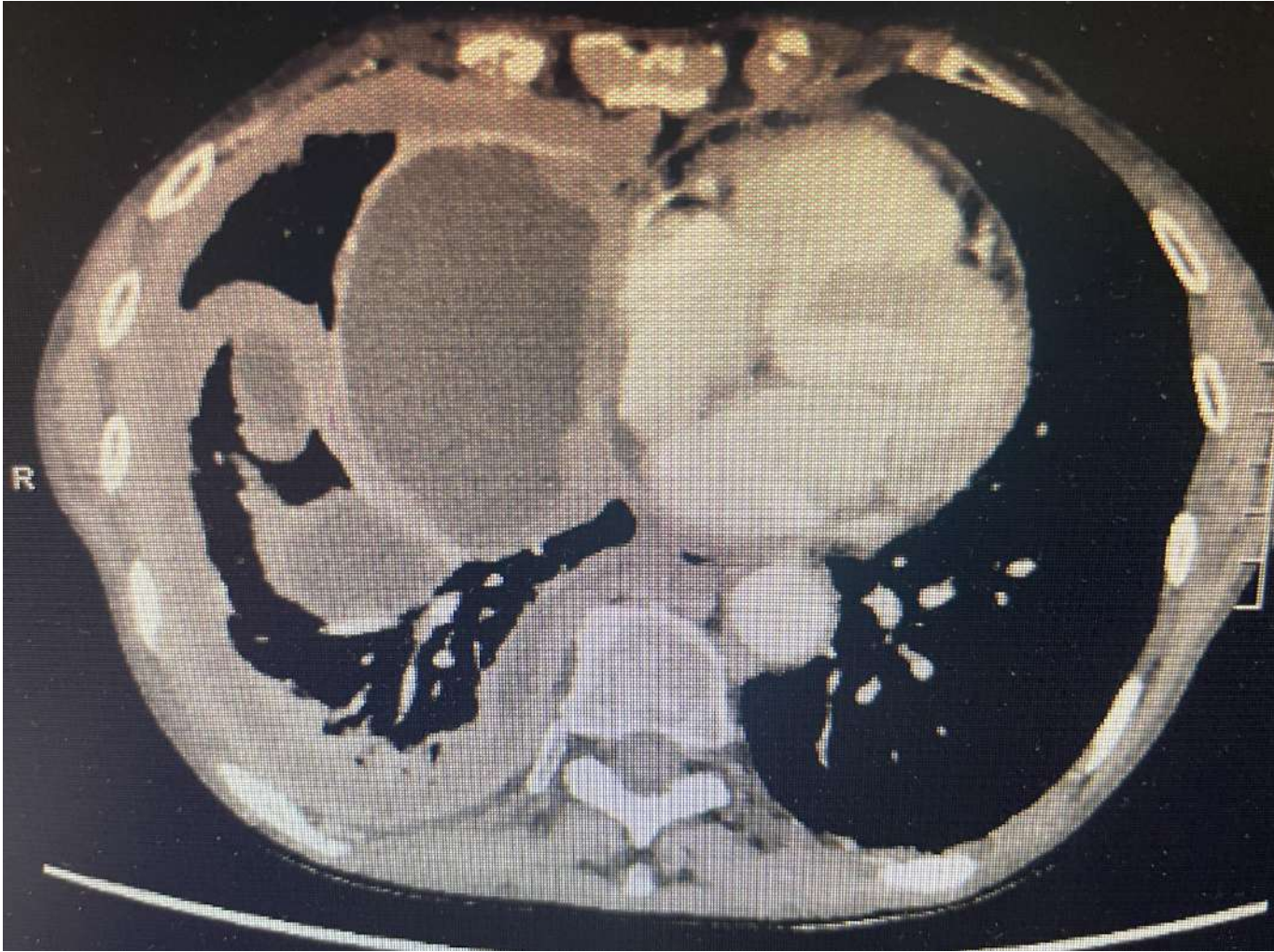
Ridotto di volume il polmone di destra con massa paracardiaca di grosse dimensioni e ispessimenti pleurici.

Risalita del emidiaframma di destra con versamento pleurico.

Libro il seno costo-frenico di sinistra.

Cuore mal valutabile.

Necessaria TC eventualmente con MDC.



CASO CLINICO 6

- **Iperteso, 65 anni, ex fumatore**
- **Nessun precedente di rilievo**
- **Da 20 giorni dispnea da sforzo**

Giunge Osp. Spoke dopo circa due ore di dolore toracico persistente in shock cardiogeno

Cute fredda sudata; Pressione 70 mmHg massima; Polso piccolo celere

Vigile cosciente respiro spontaneo

ECG immediato

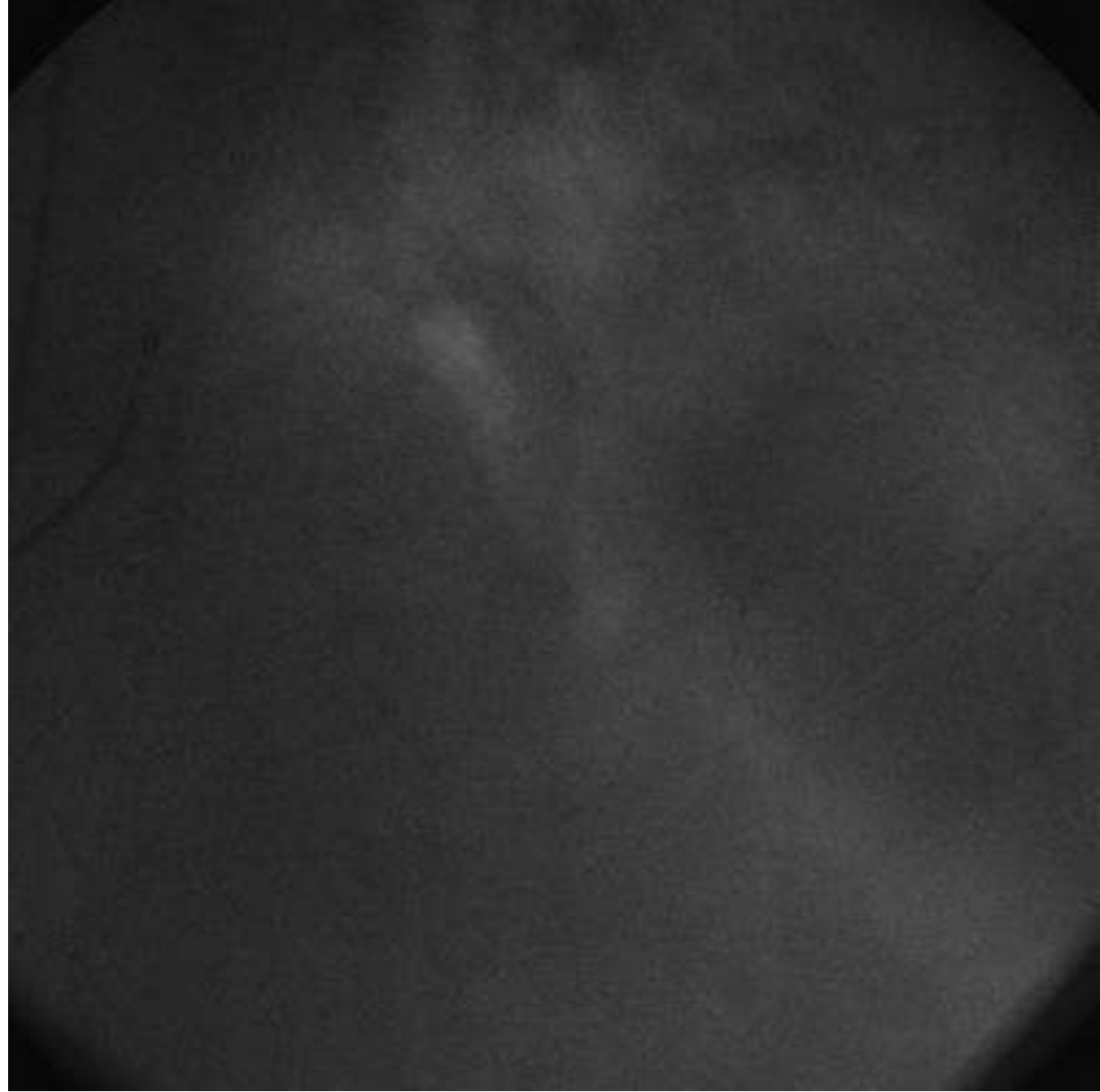
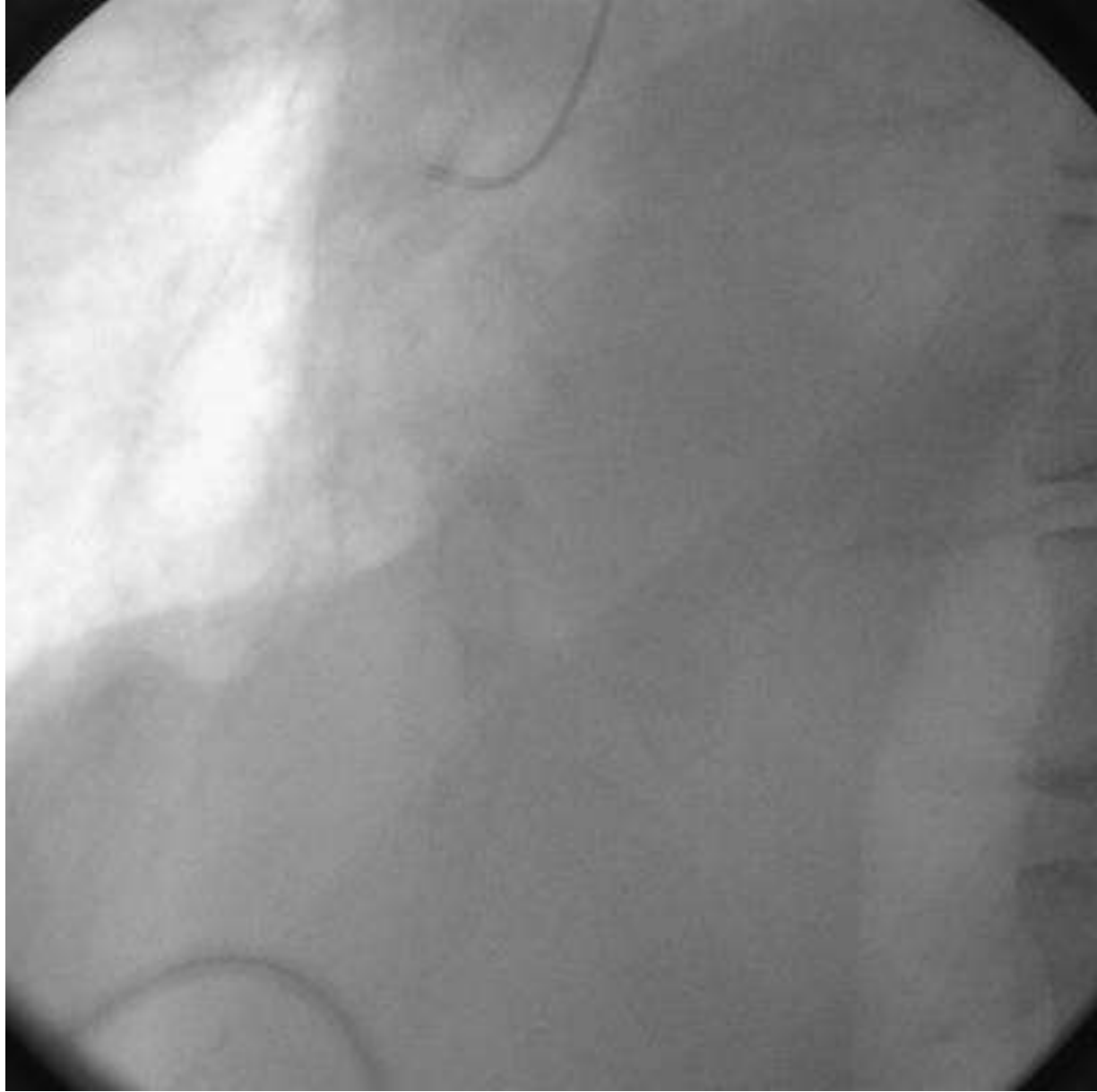
Prelievi ematici

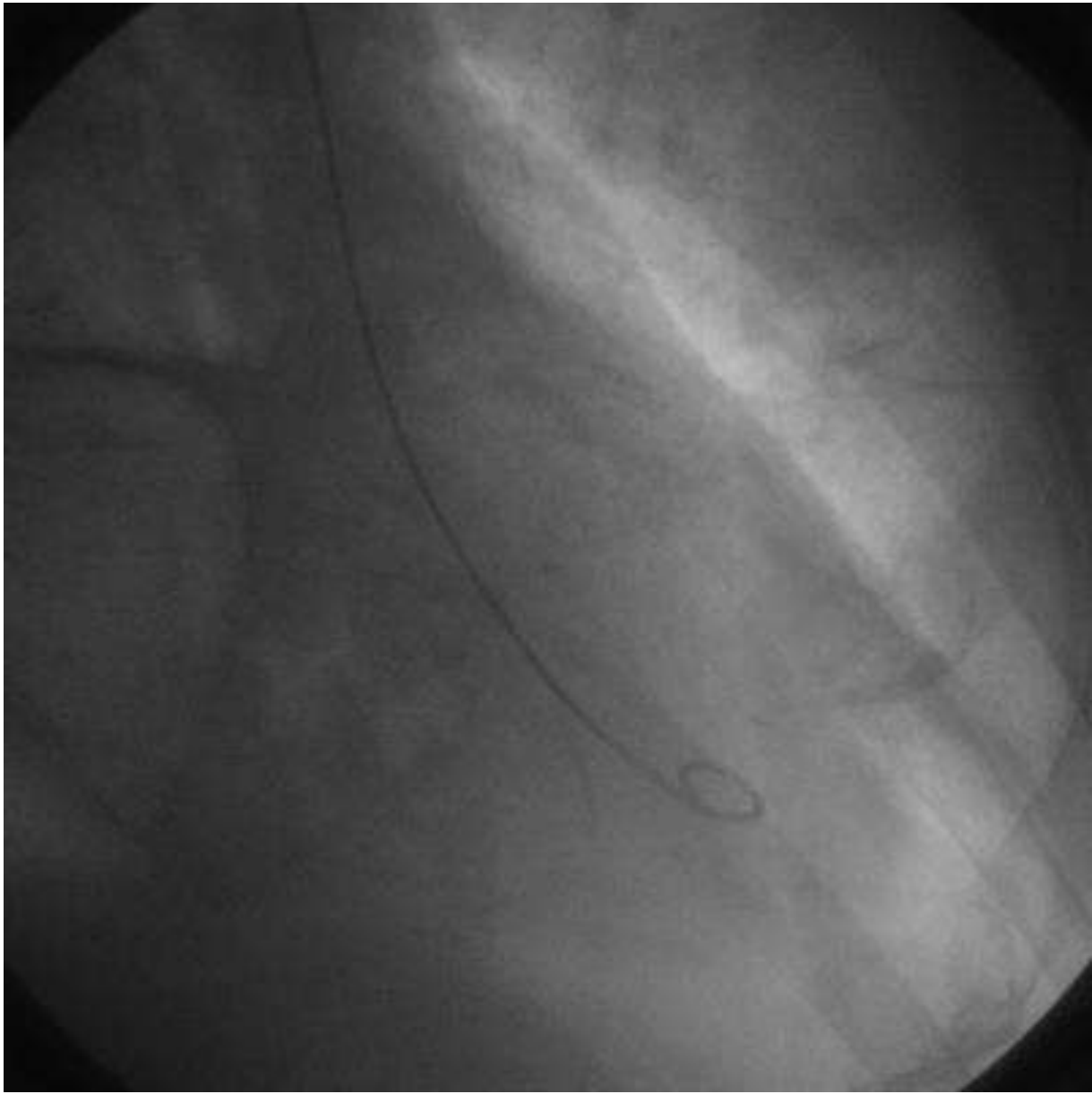
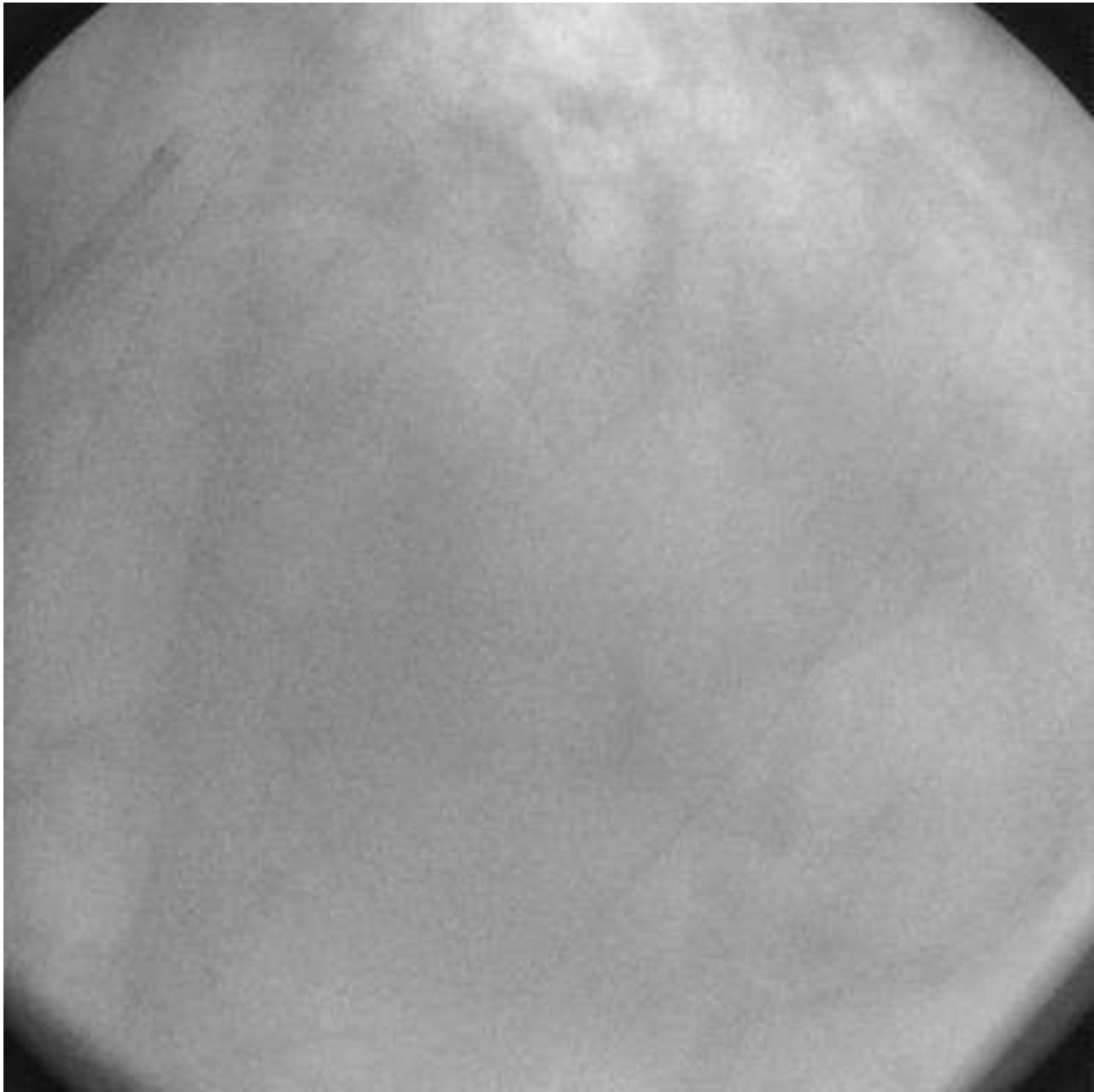
.05 10:50:12

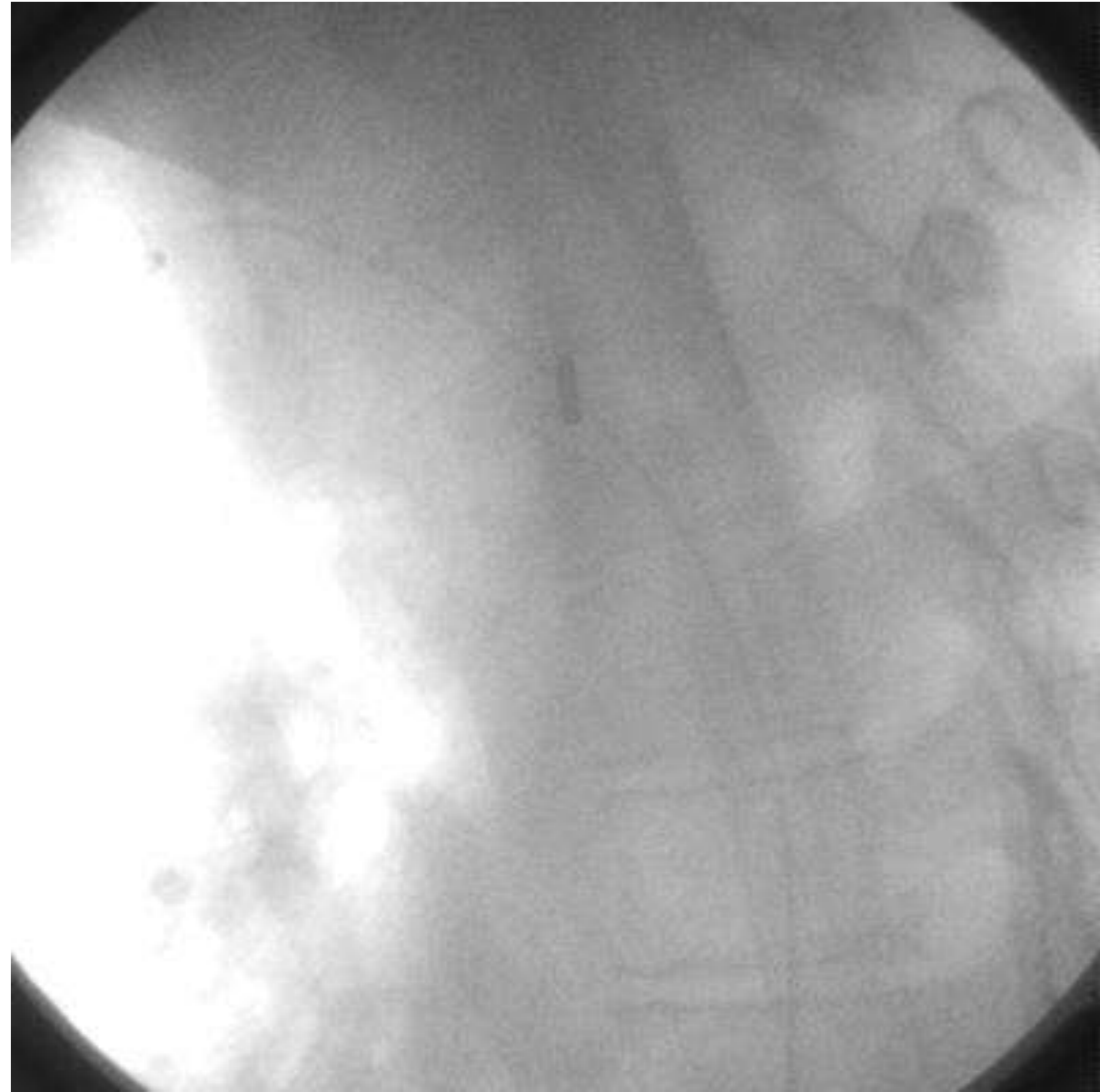
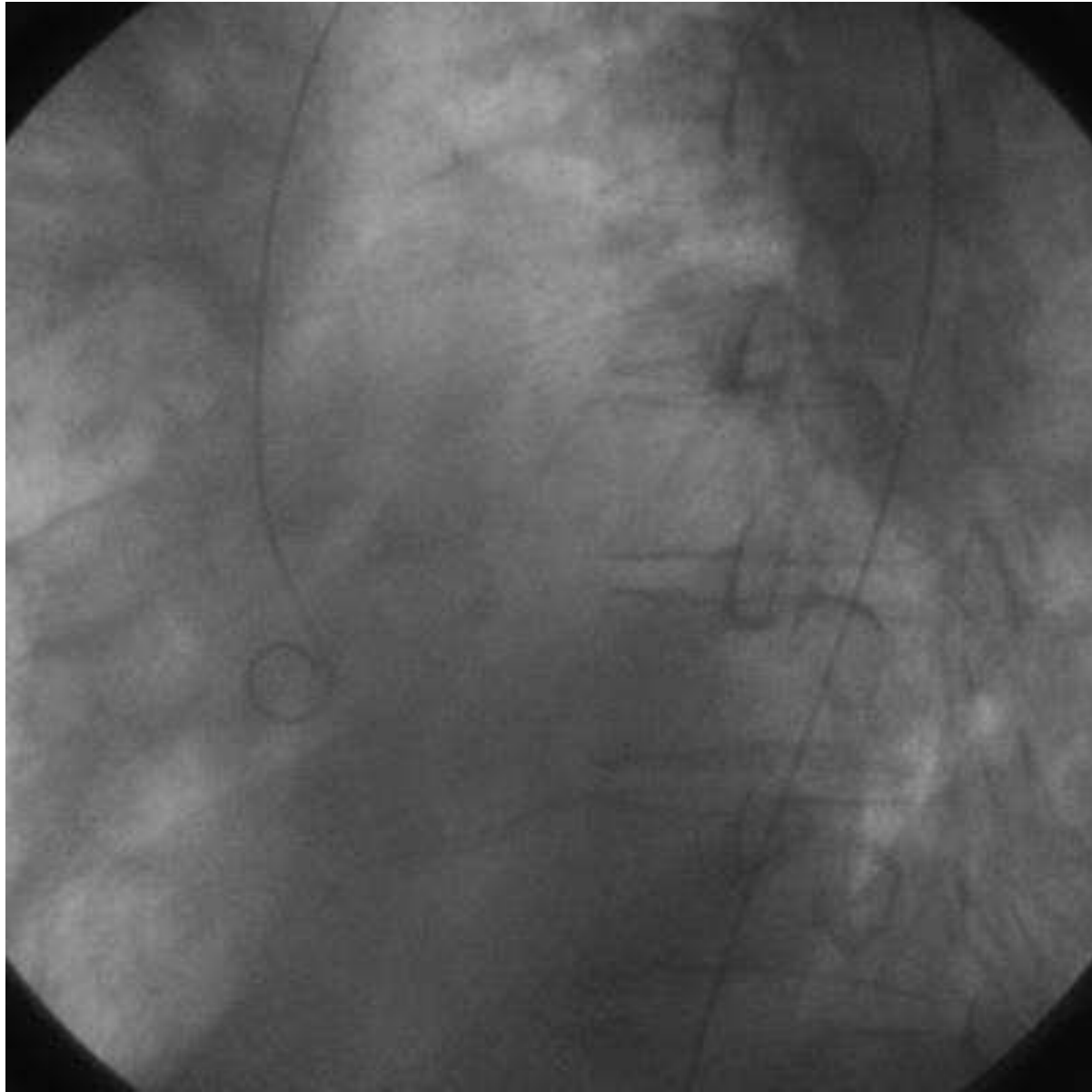
1313138/min 10 mm/mV

LU 28.NOV.25 10:50:21









[A]

TC ADDOM
28/11/2005
13.31.46



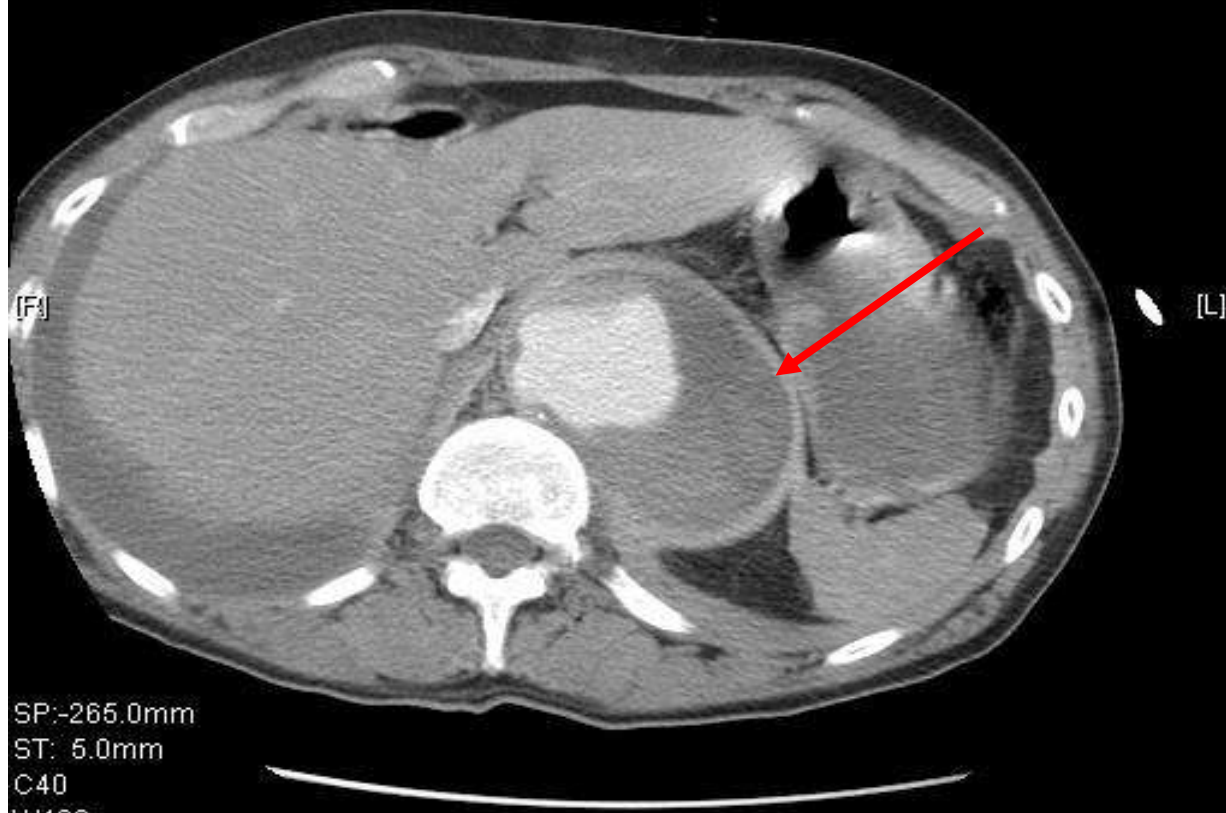
SP: -230.0mm
ST: 5.0mm
C40
W400
Not for diagnostic use

[P]

GE MEDICAL SYSTEMS

[A]

TC ADDOM
28/11/2005
13.31.46



SP: -265.0mm
ST: 5.0mm
C40
W400
Not for diagnostic use

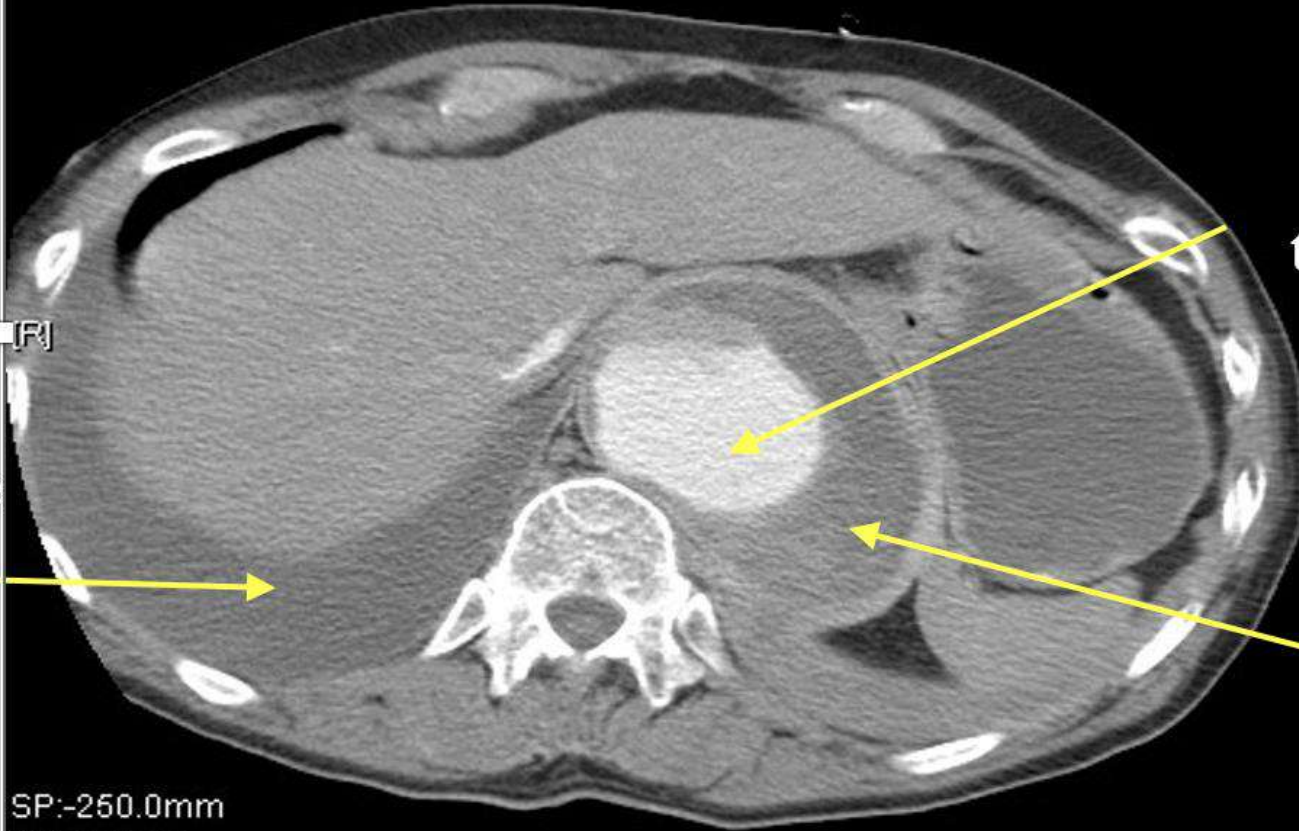
[P]

GE MEDICAL SYSTEMS

51

[A]

TC ADDOM
28/11/2005
13.31.46



**Aorta
toraco/add**

[L]

emotorace

**Ematoma/
rottura**

SP: -250.0mm
ST: 5.0mm
C40
W400

Not for diagnostic use

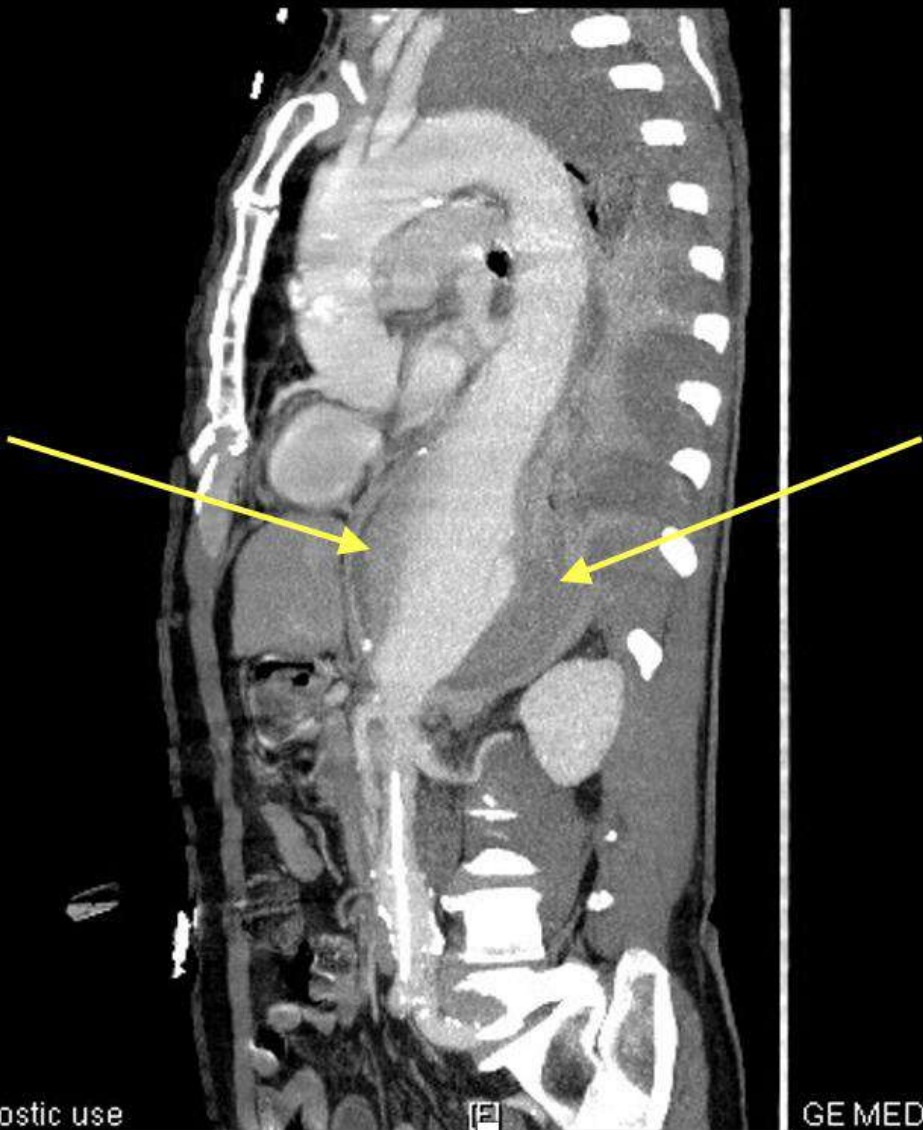
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GE MEDICAL SYSTEMS

[H]

TC ADDOM
28/11/2005
13.31.46

1



[AR]

[PL]

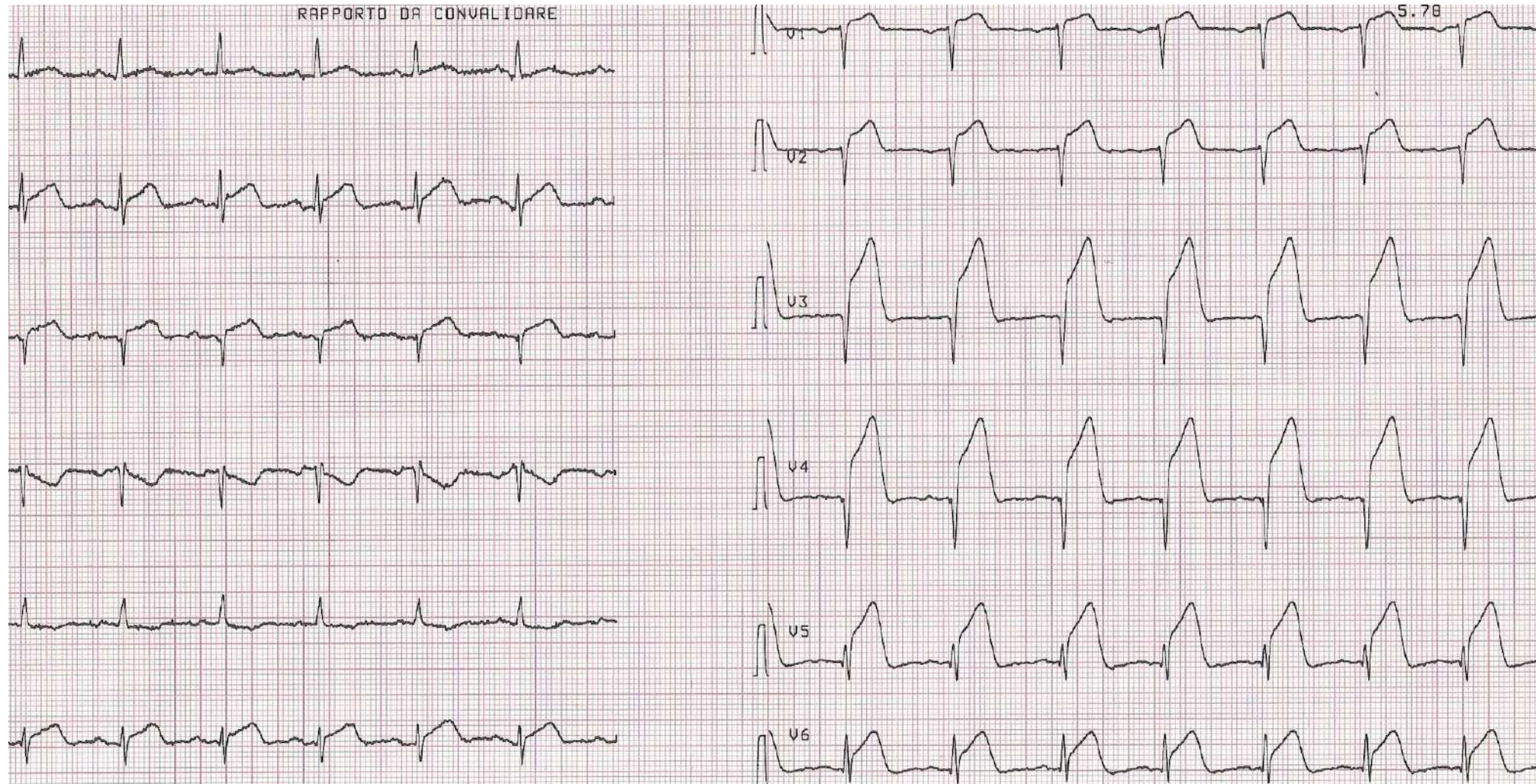
SP:mm
ST: 9.0mm
C101
W382
Not for diagnostic use

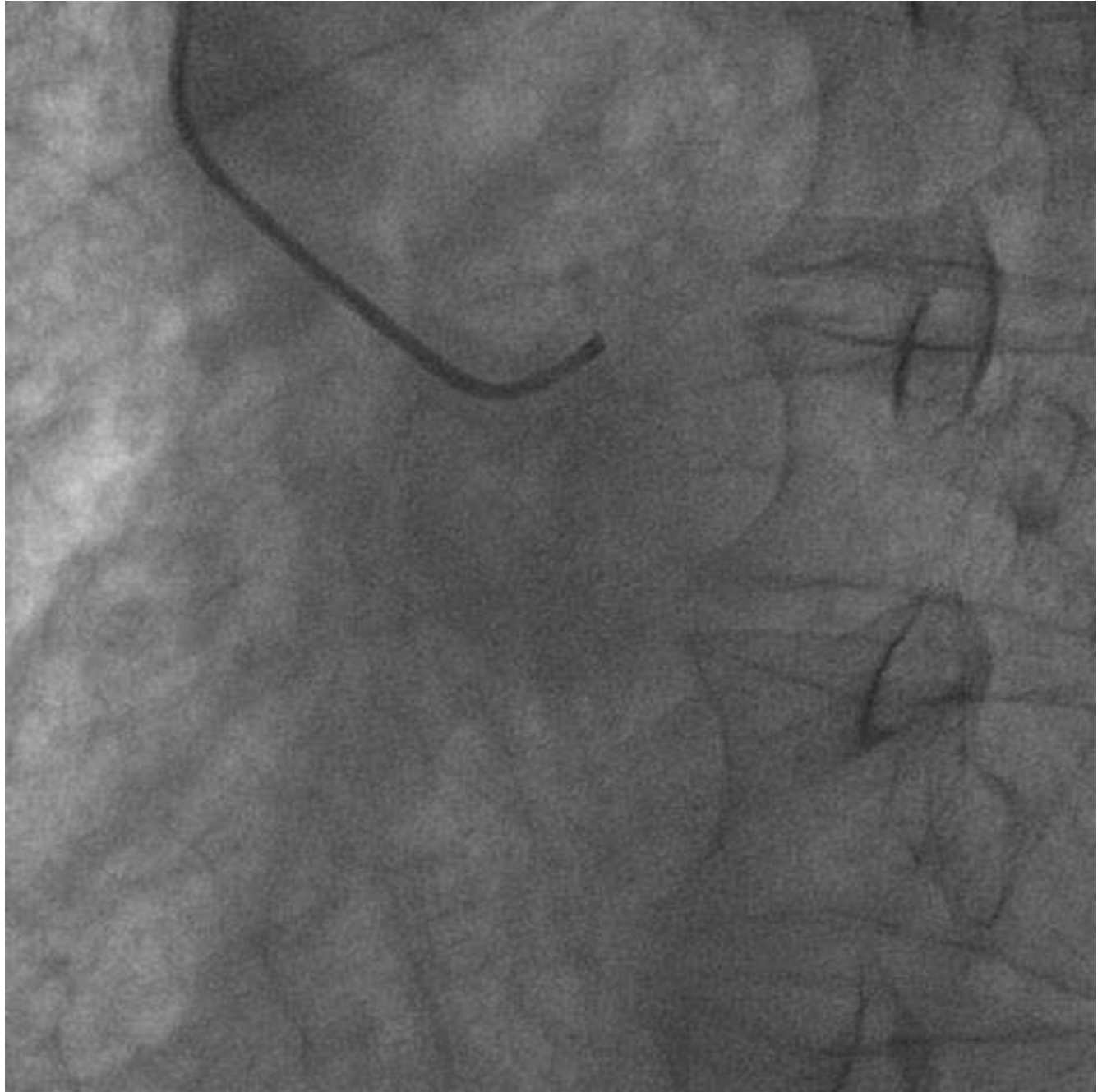
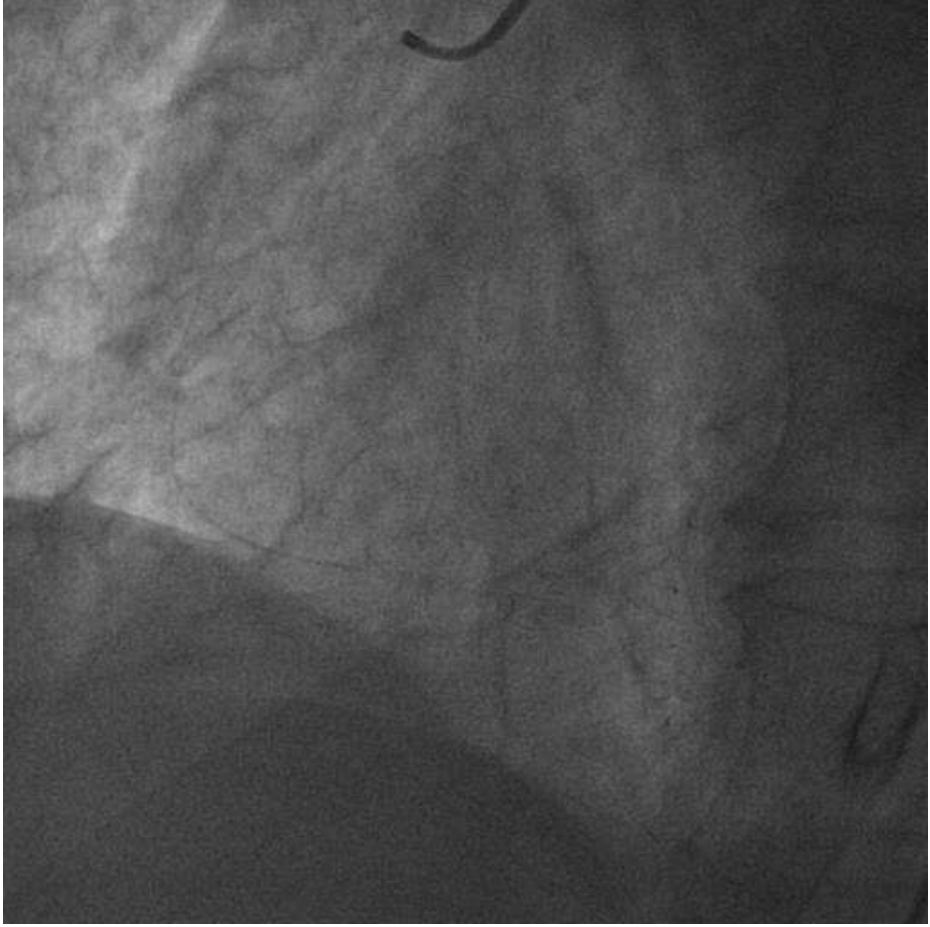
[F] GE MEDICAL SYSTEMS

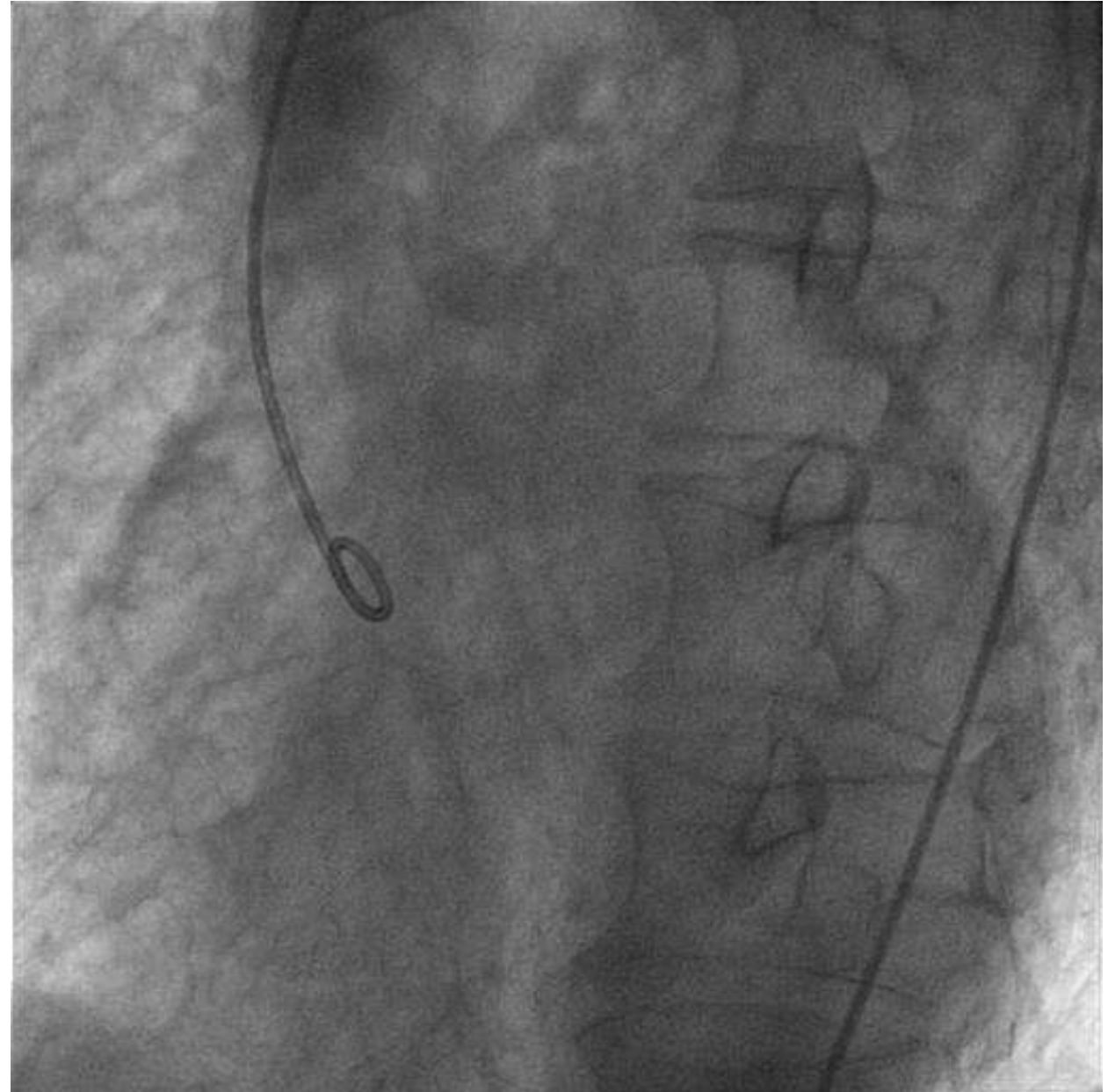
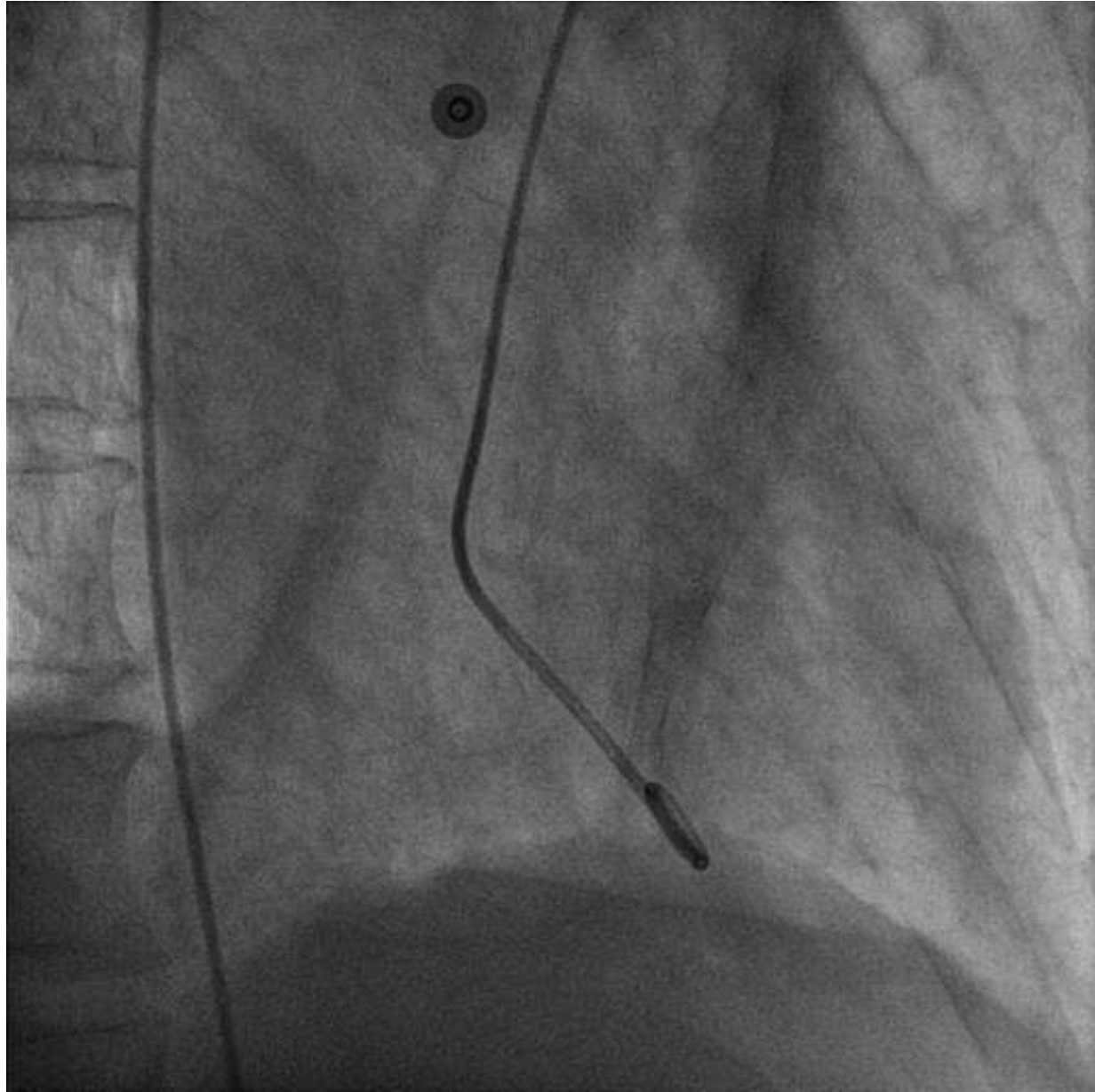
- **Esami ematici confermano grave anemia e leucocitosi**
- **Interruzione immediata eparina e rimozione IABP**
- **Protamina per antagonizzare Eparina**
- **Riportato ACT < 200**
- **Infusione plasma+ emazie gruppo O in vena centrale**
- **Ulteriore deterioramento emodinamico**
- **Necessita' di intubazione ed assistenza rianimatoria**
- **Trasferimento presso H. Molinette per valutare possibilita' di posizionare endoprotesi**
- **Decesso per shock emorragico irreversibile**

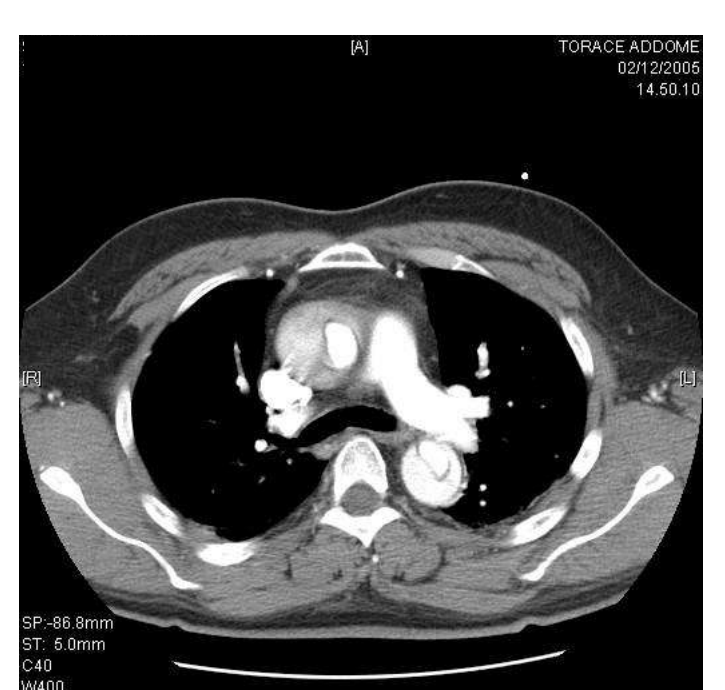
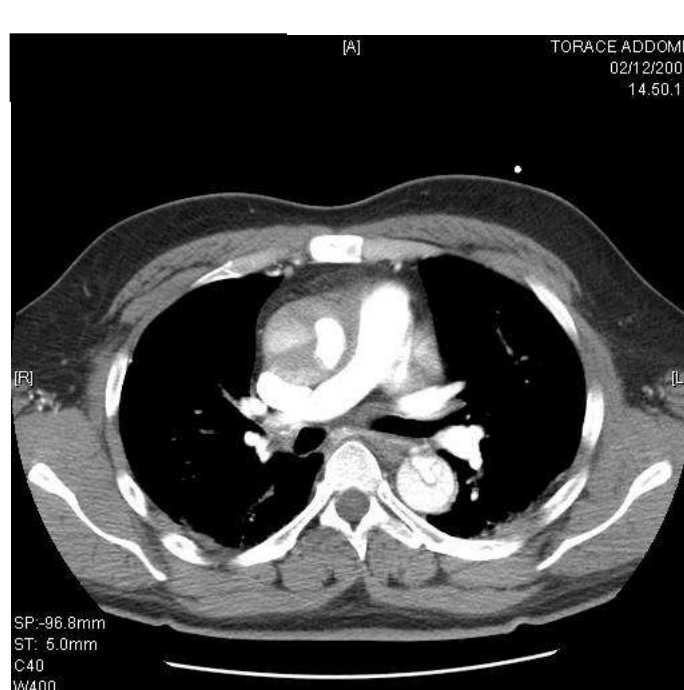
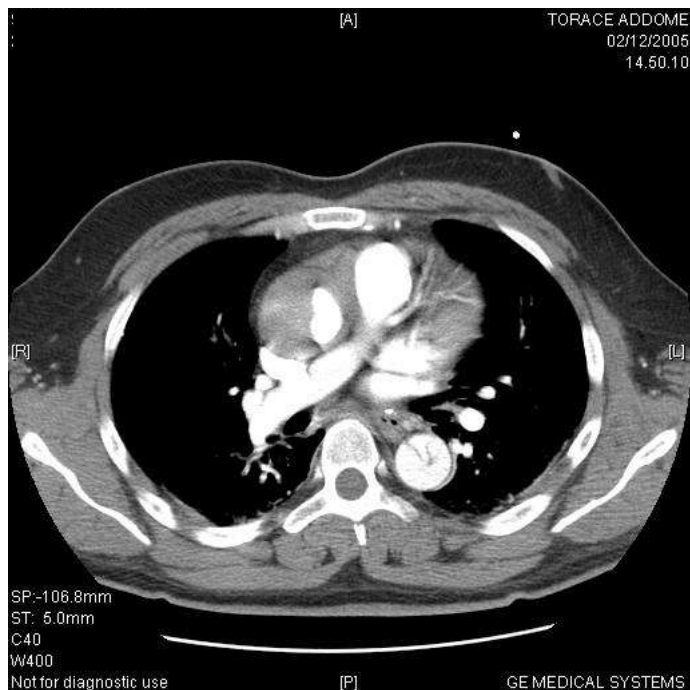
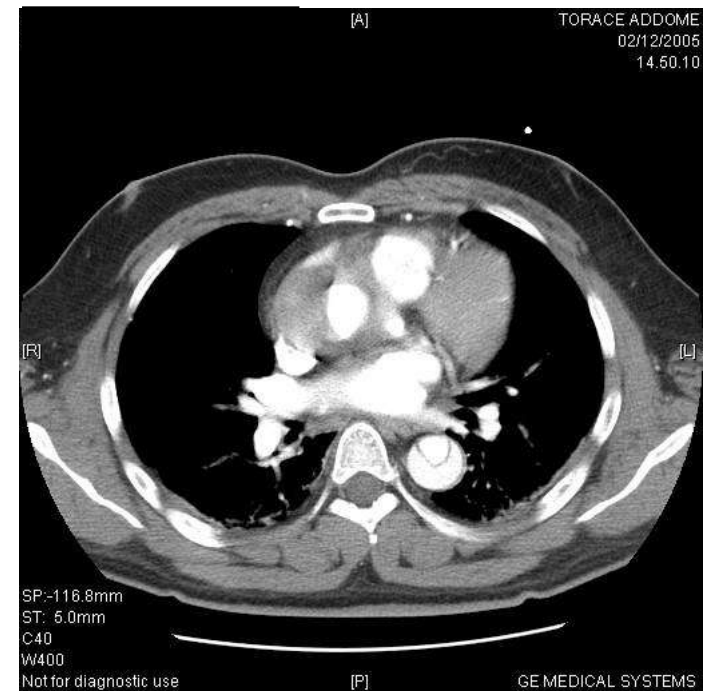
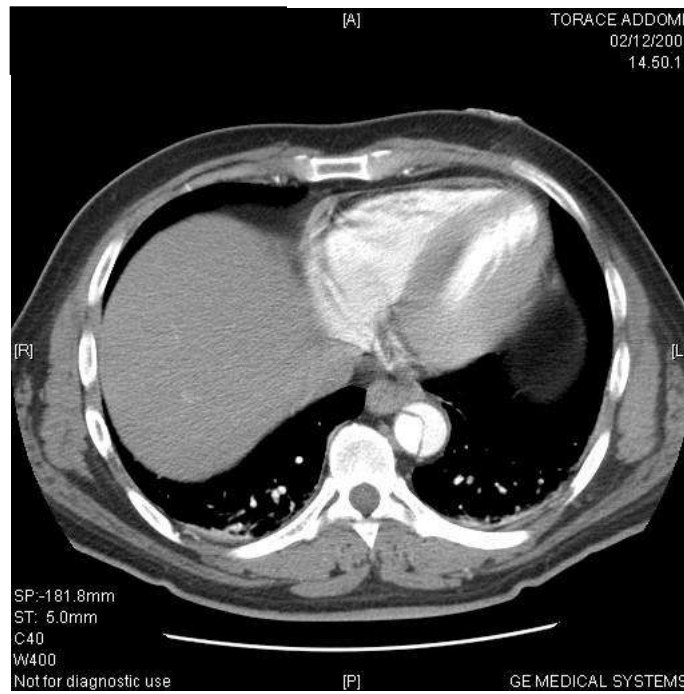
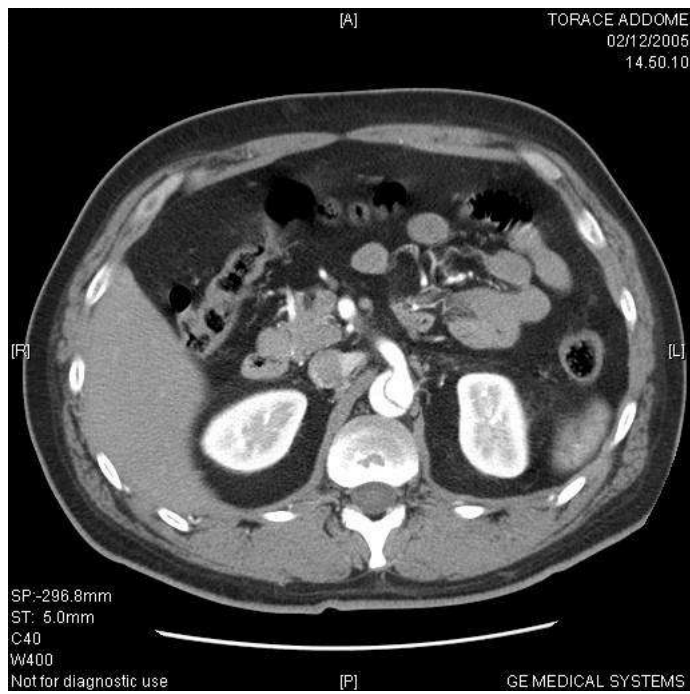
CASO CLINICO 7

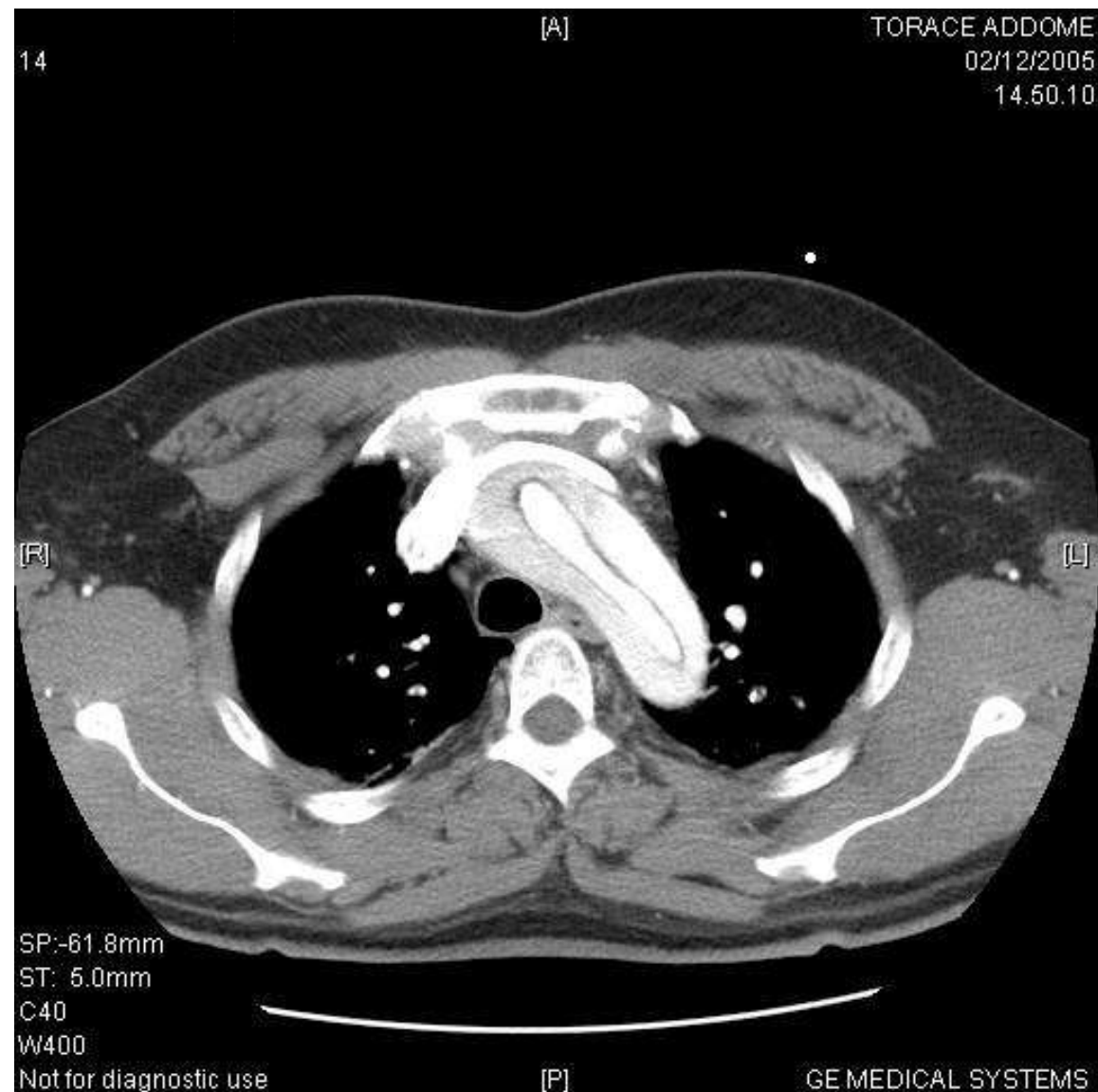
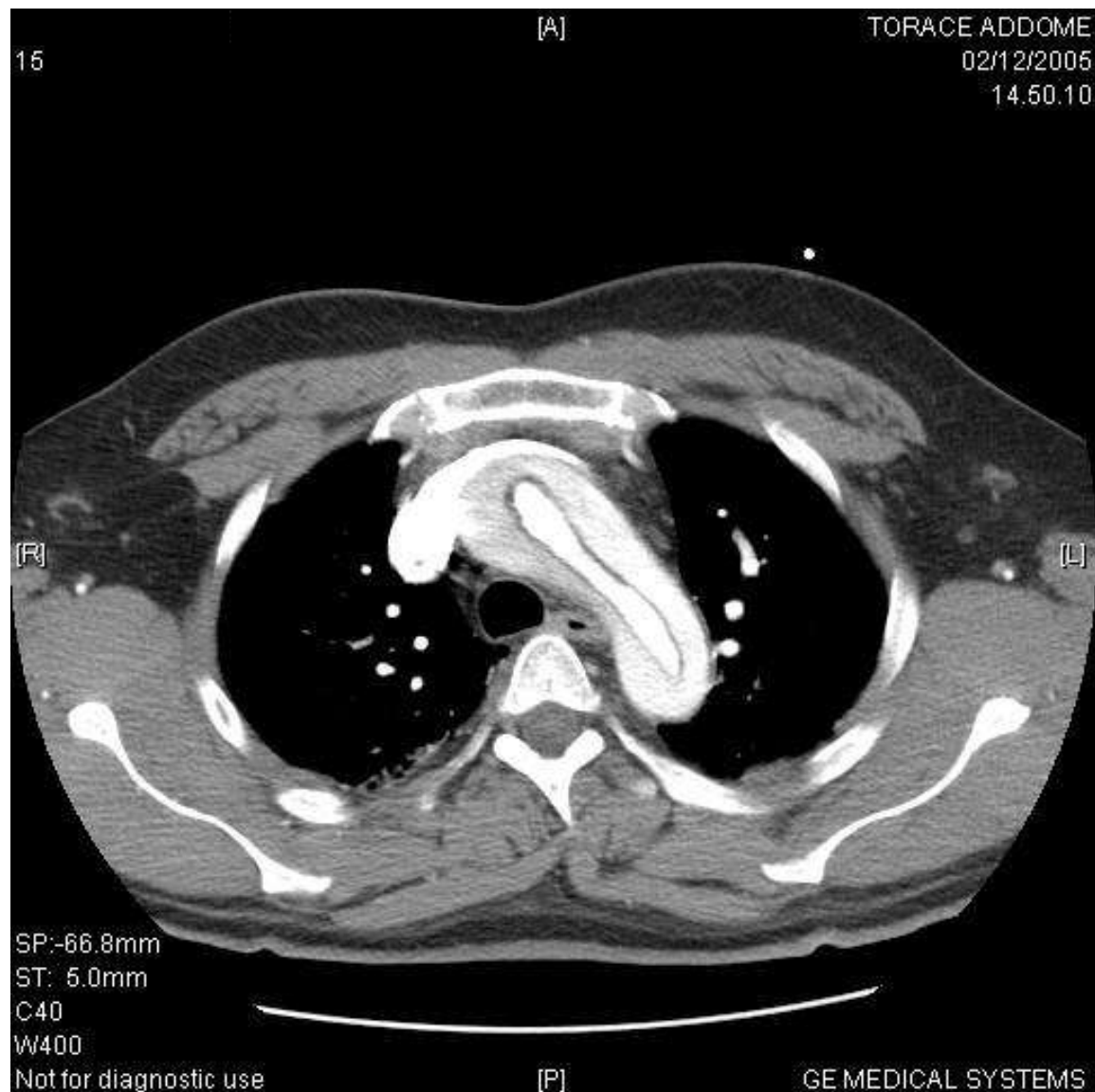
DONNA DI 55 ANNI CON STEMI ANT SHOCK









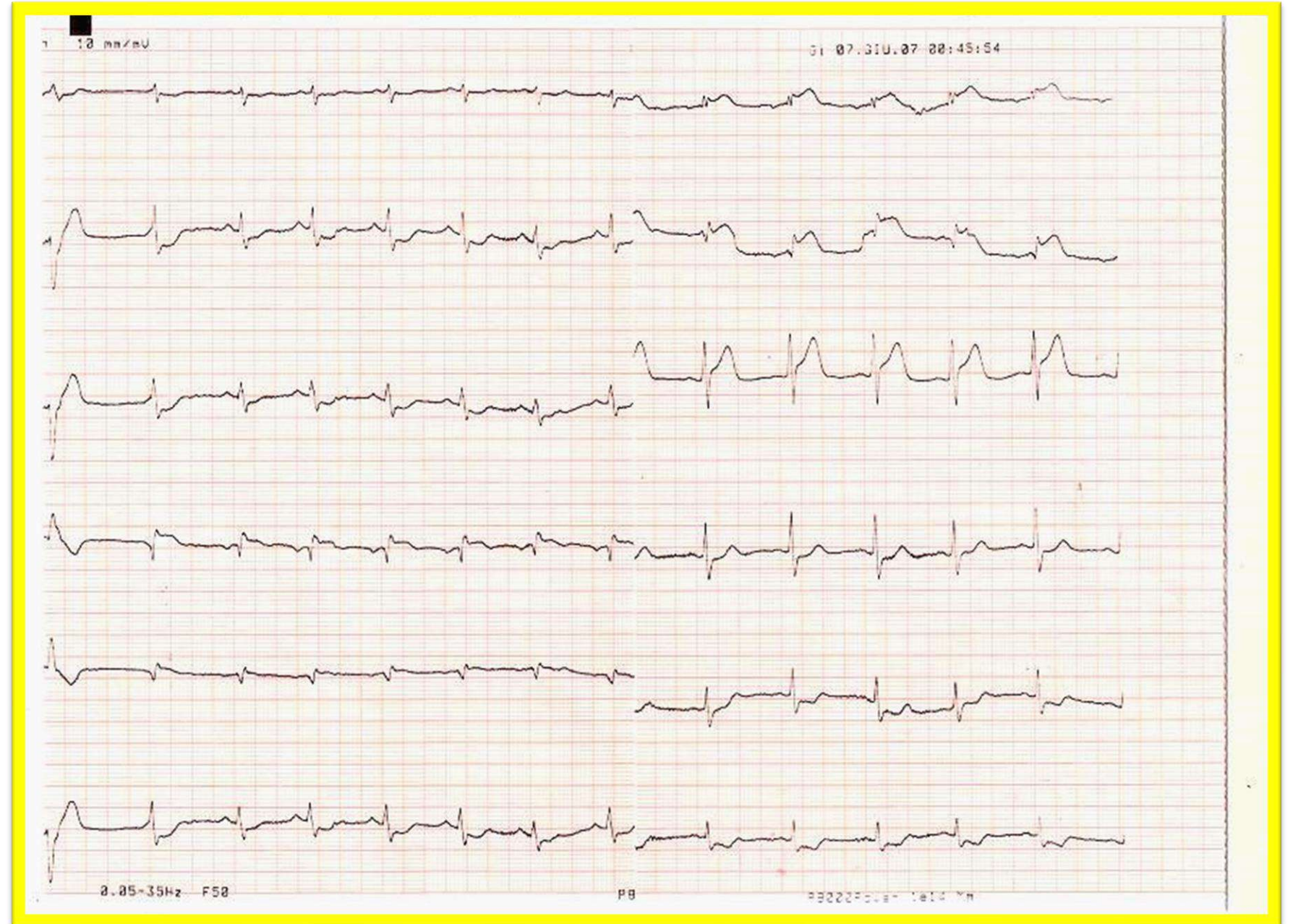


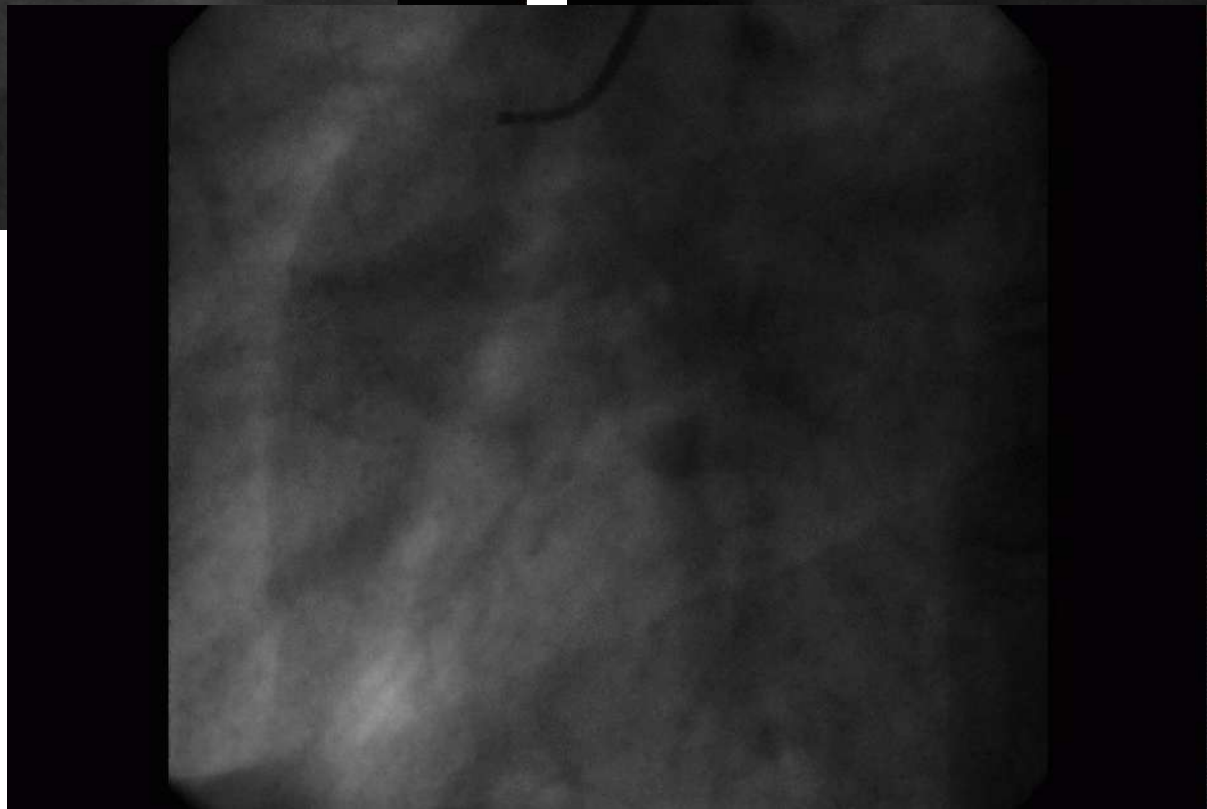
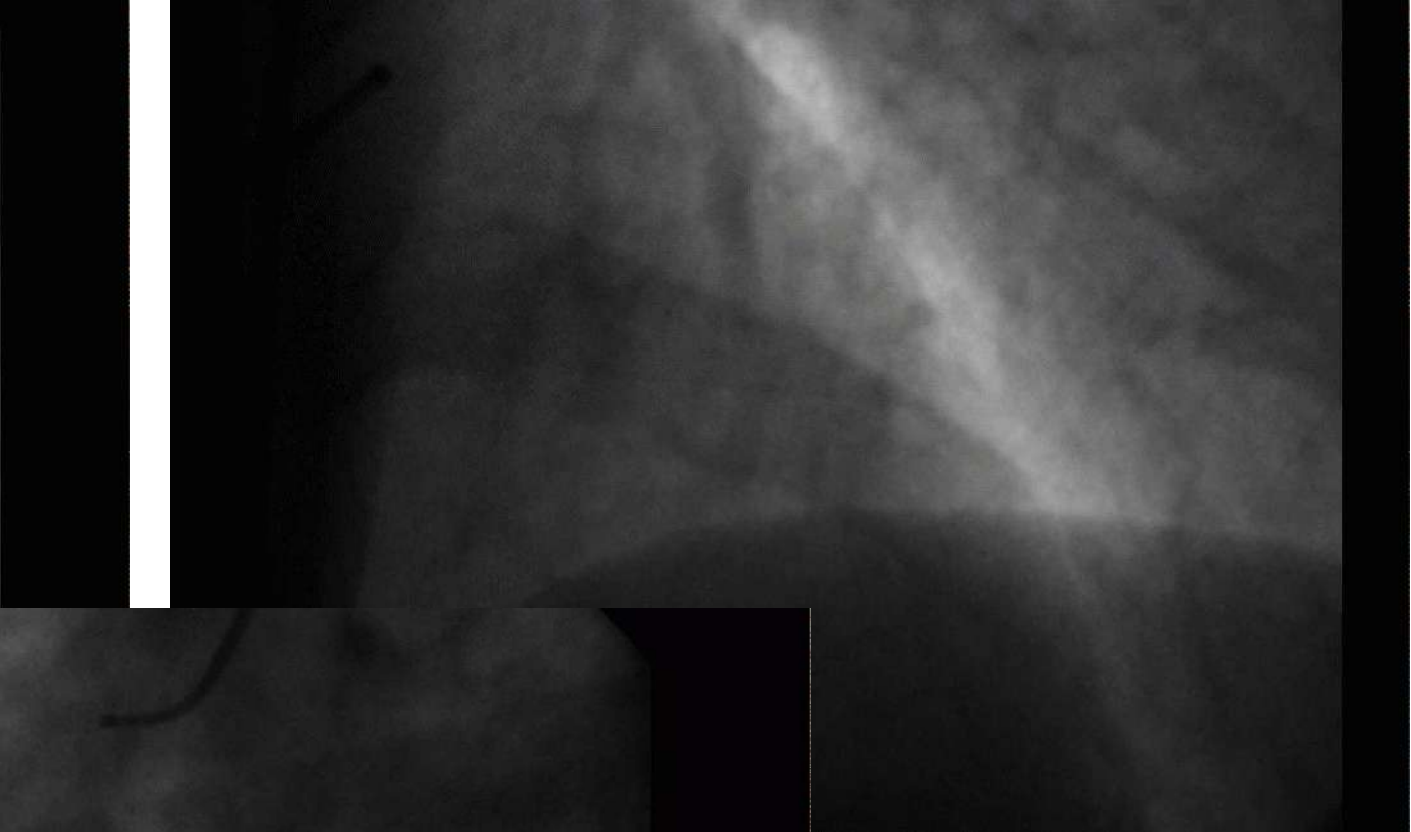
CASO CLINICO 8

60yo male, hypertensive, smoker
COPD. Peripheral vasculopathy -
previous femoral grafting.

CASO CLINICO 9

M.R. aa 41 , dolore toracico, dispnea acuta ingravescente, ipotensione.



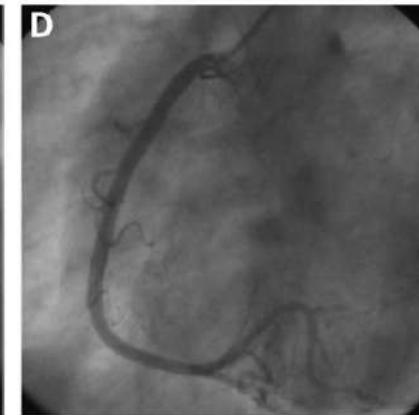
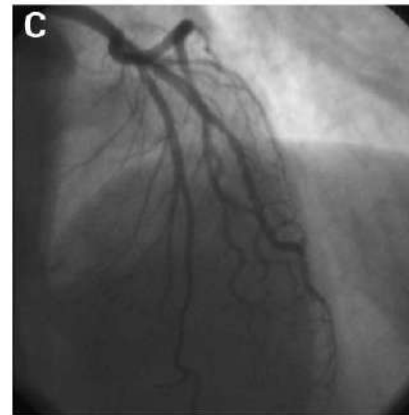
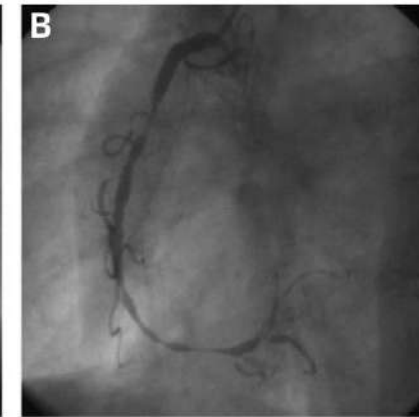
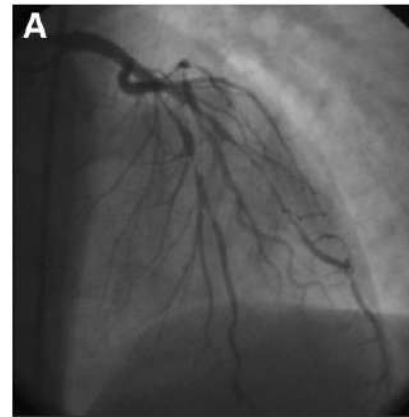


Acute myocardial infarction due to coronary vasospasm and salbutamol abuse

A 41-year-old woman was referred to our institution owing to acute myocardial infarction. She had a history of cigarette smoking, hyperlipidaemia and asthma. On the day of admission she had taken high doses of a β_2 agonist (inhaled salbutamol 2 g as cumulative dose) because of worsening asthma attacks. She presented to the emergency room with acute onset of chest pain and severe dyspnoea.

An electrocardiogram showed ST-segment elevation in anterior leads, and initial laboratory studies included marked hypokalaemia (2.7 mEq/l). An emergency coronary angiography was performed. It showed three-vessel coronary vasospasm with multiple, multifocal stenosis (panels A and B); after intracoronary injection of nitrates the coronary spasm completely resolved (panels C and D). Cardiac ultrasound was normal with no evidence of contractile dysfunction and normal ejection fraction. The patient was treated with aspirin, nitrates, diltiazem and potassium supplements and her symptoms improved. At 12 hours troponin I peaked at 5 ng/ml (normal value ≤ 0.12 ng/ml). Thrombophilic conditions were excluded (homocysteine, antithrombin III, proteins C and S, anti-phospholipid antibodies, activated protein C resistance, factor V Leiden mutation were within normal limits).

Cases of non-Q myocardial infarction are rarely reported in previously healthy people who have used adrenergic agonists (such as clenbuterol); it has been suggested that coronary vasospasm is the cause of the infarction based on the absence of significantly obstructive coronary artery disease or coronary



cerina ic

**ONCHIALE
UTAMOLO**

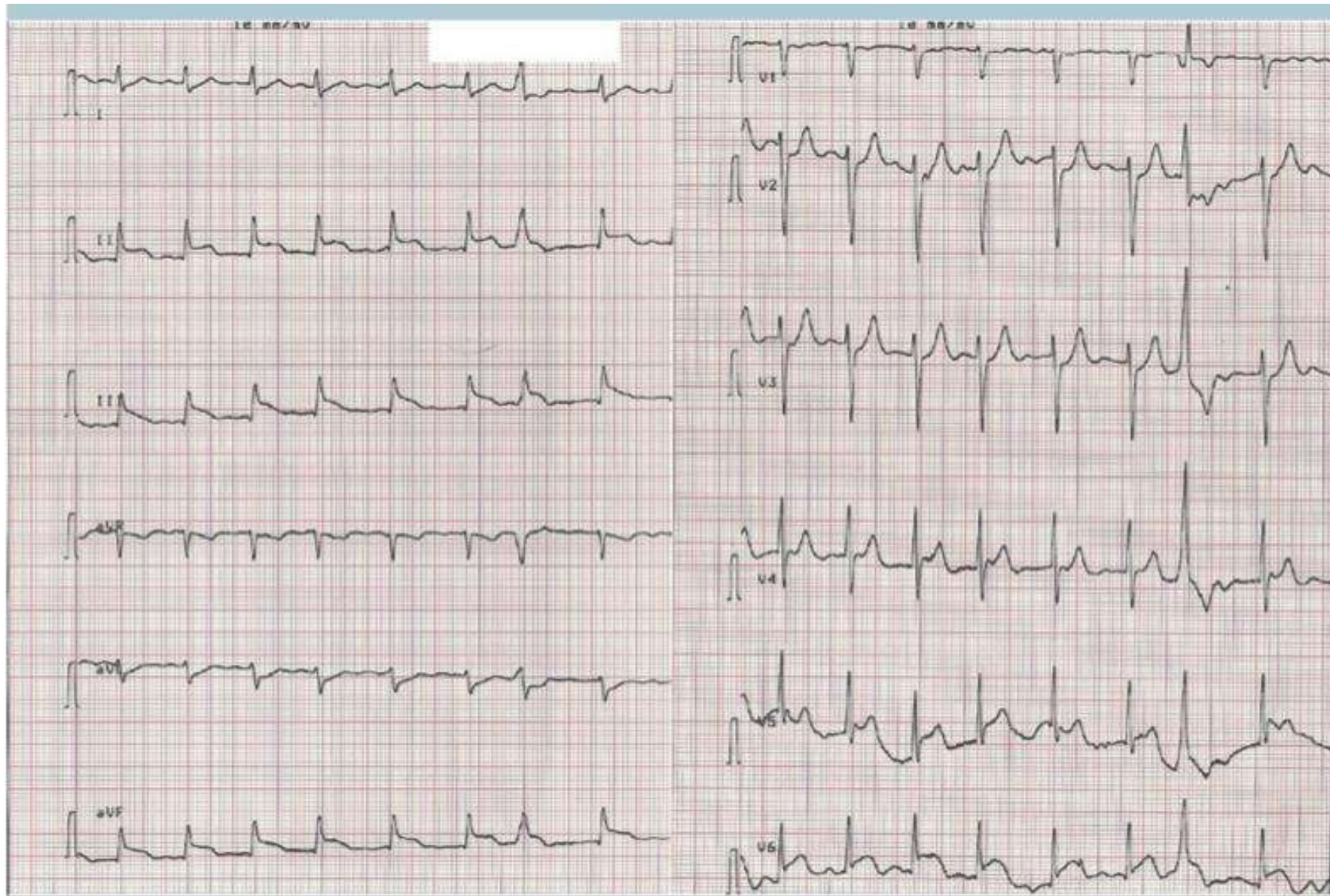
thrombi at angiography. In our case report coronary artery spasm was well documented, suggesting that salbutamol abuse can be an unexpected cause of acute myocardial infarction.

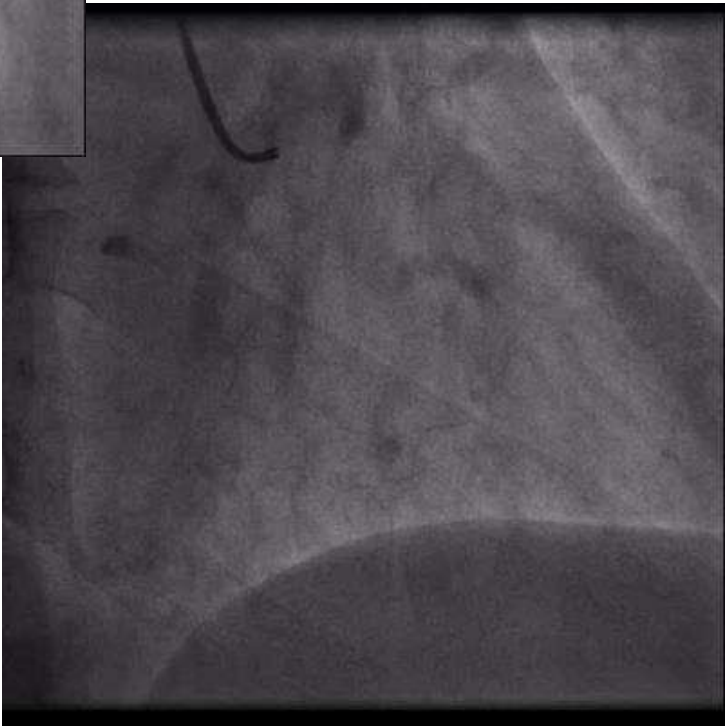
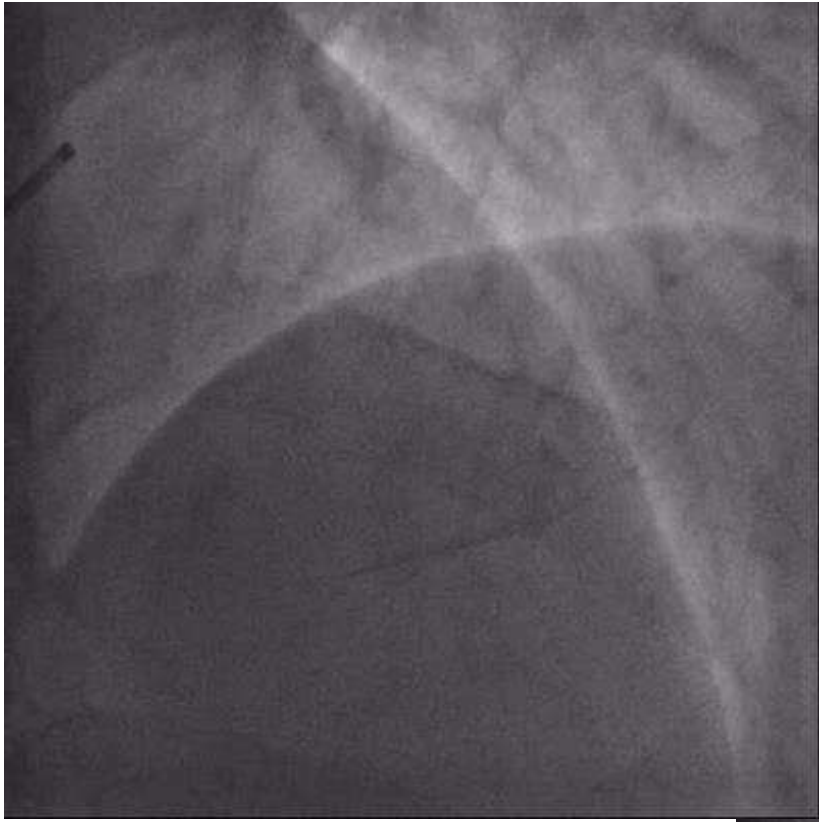
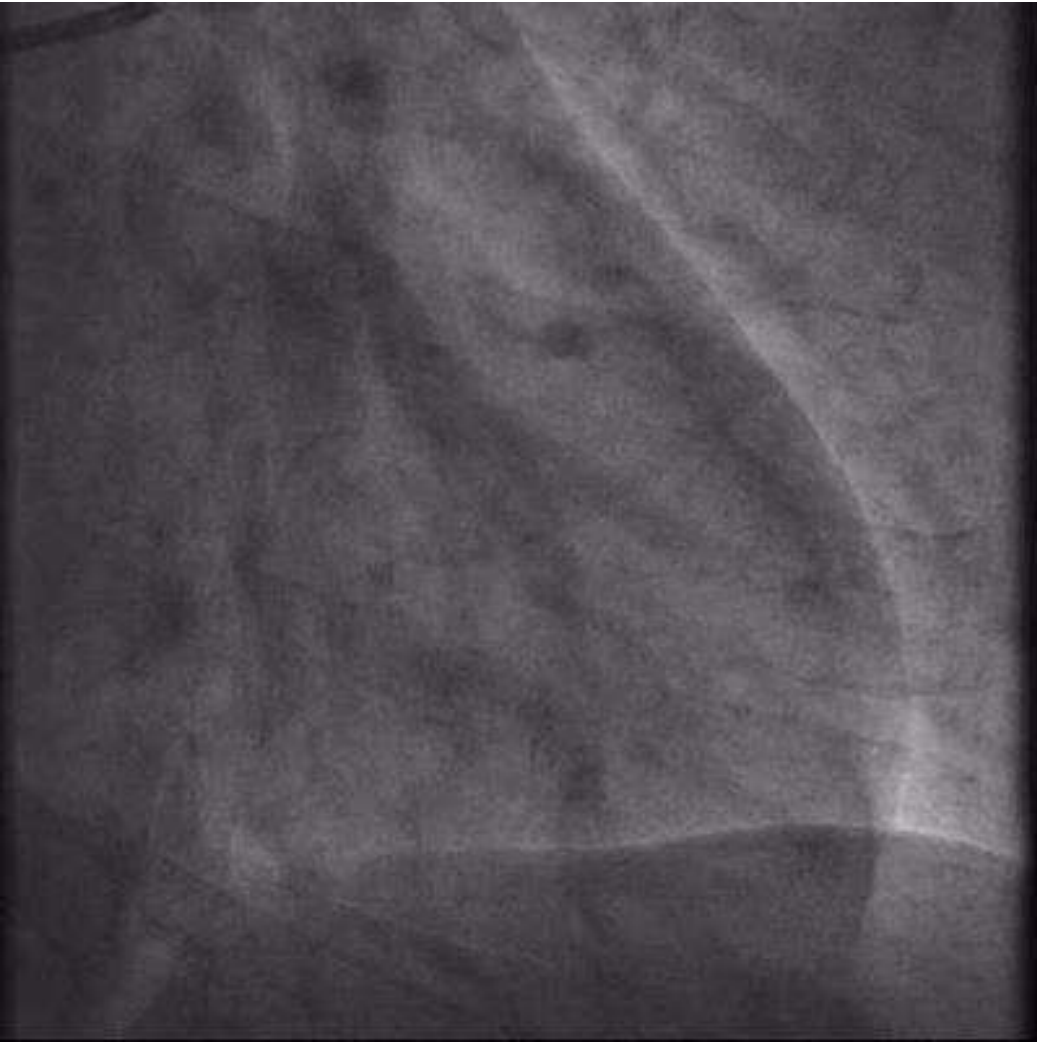
S Ferrua, F Varbella, M R Conte

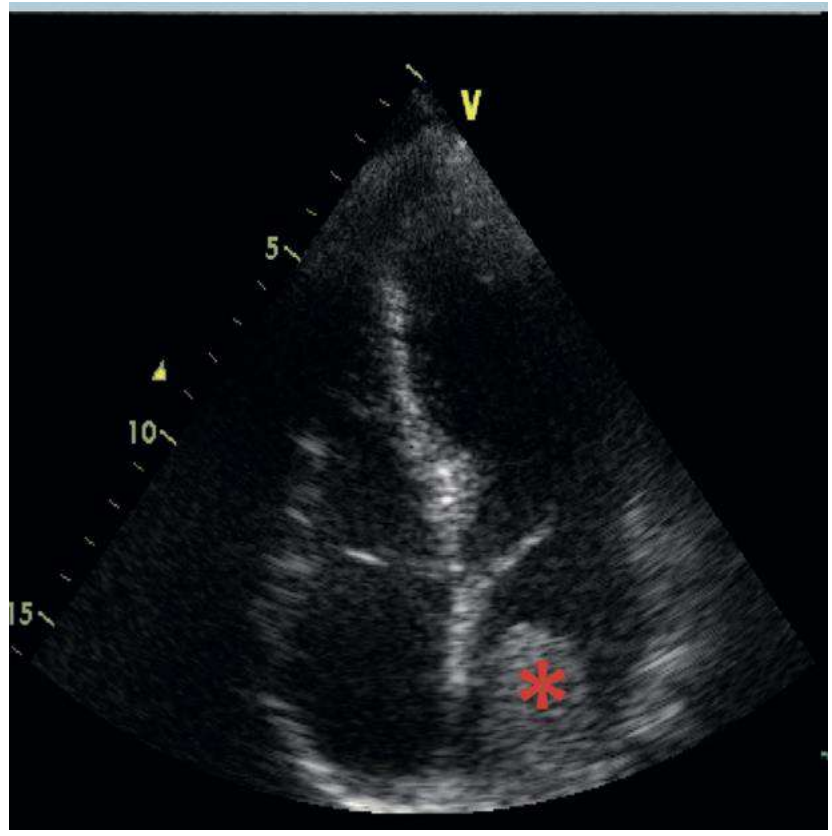
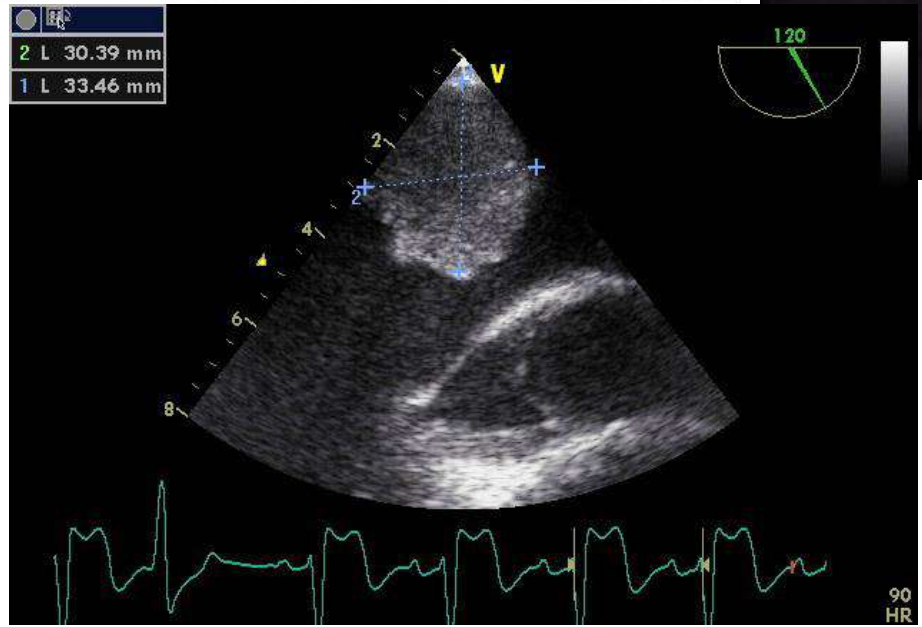
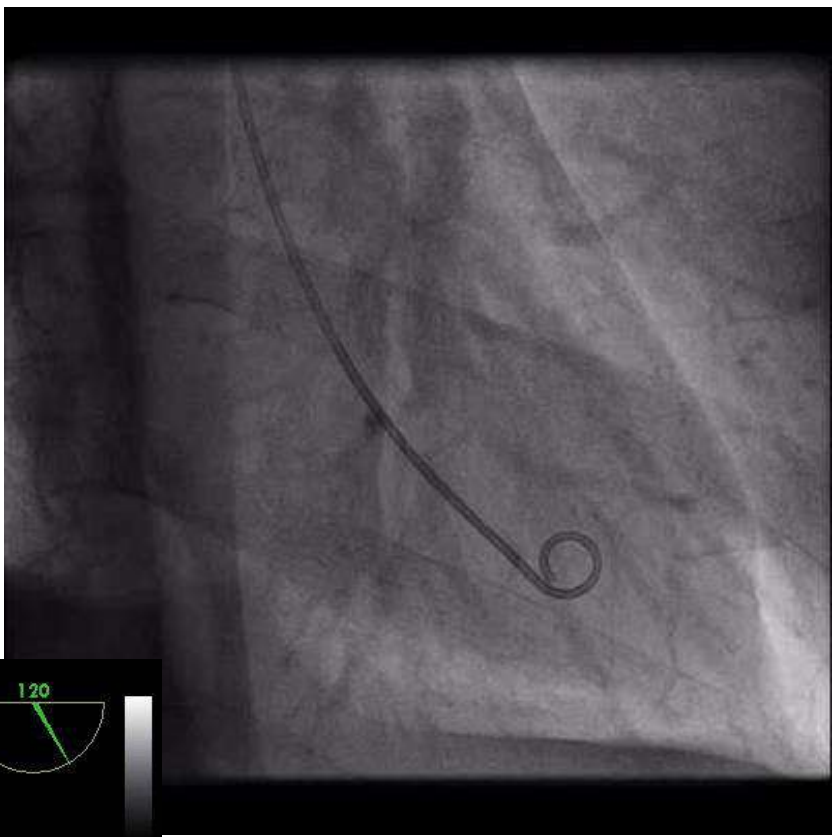
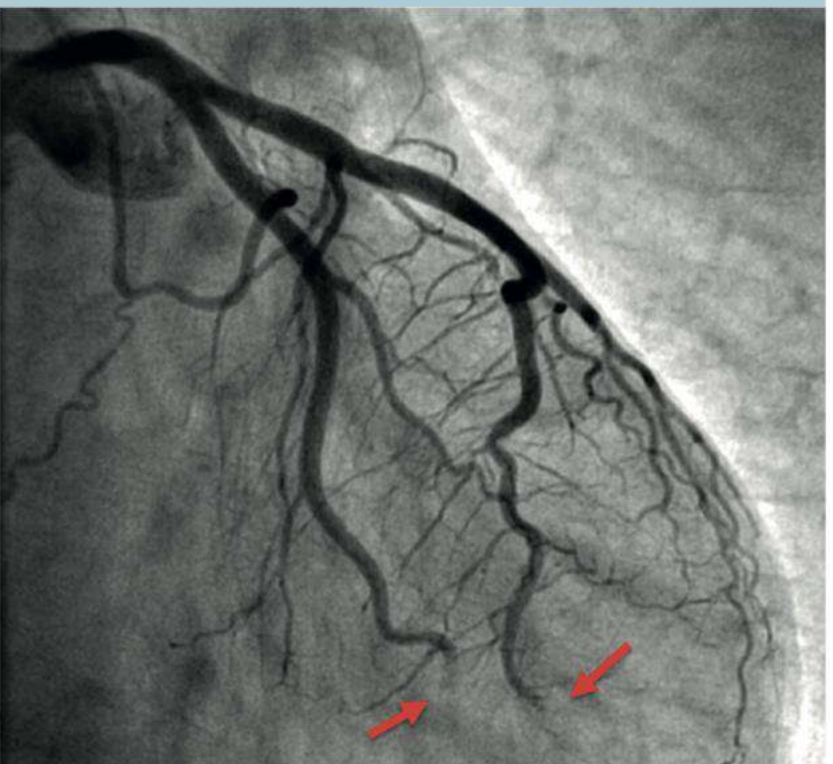
stefania.ferrua@virgilio.it

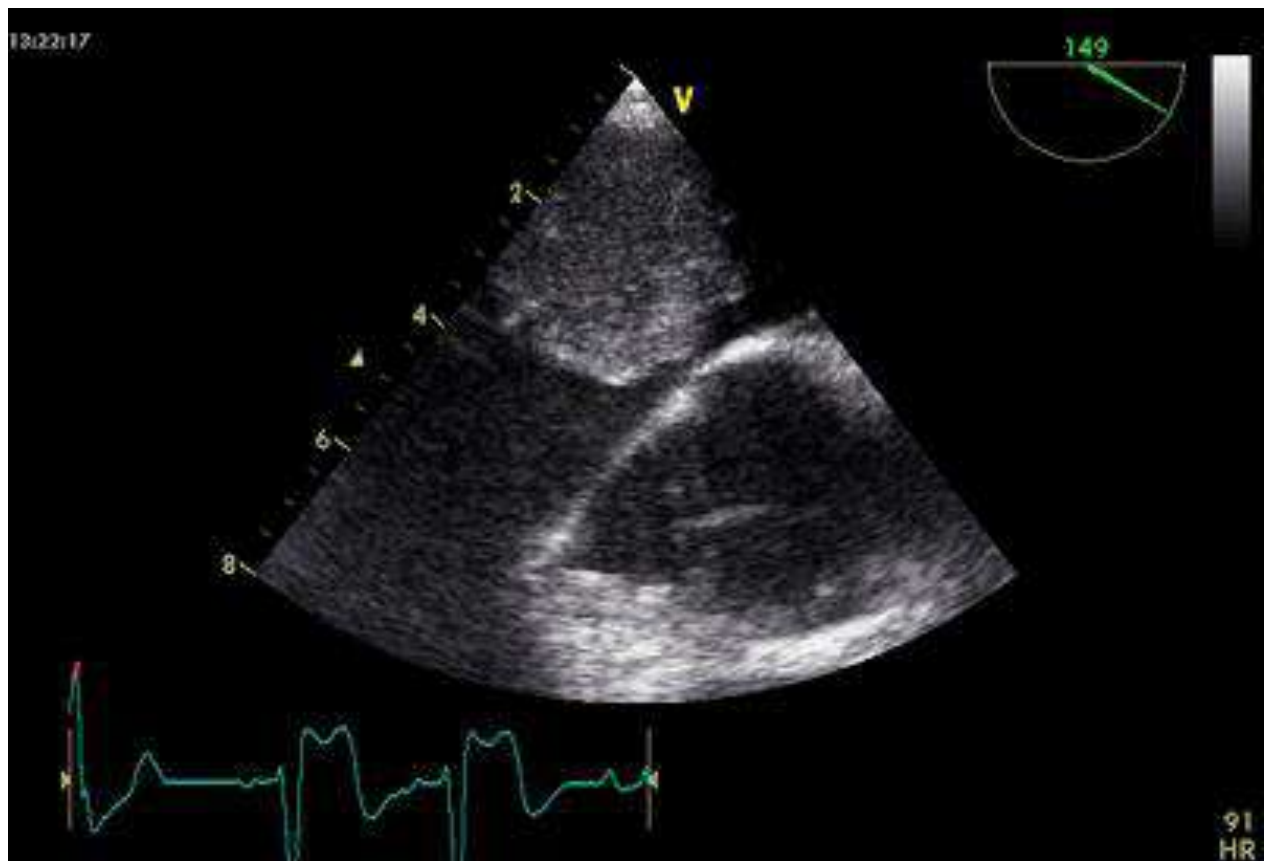
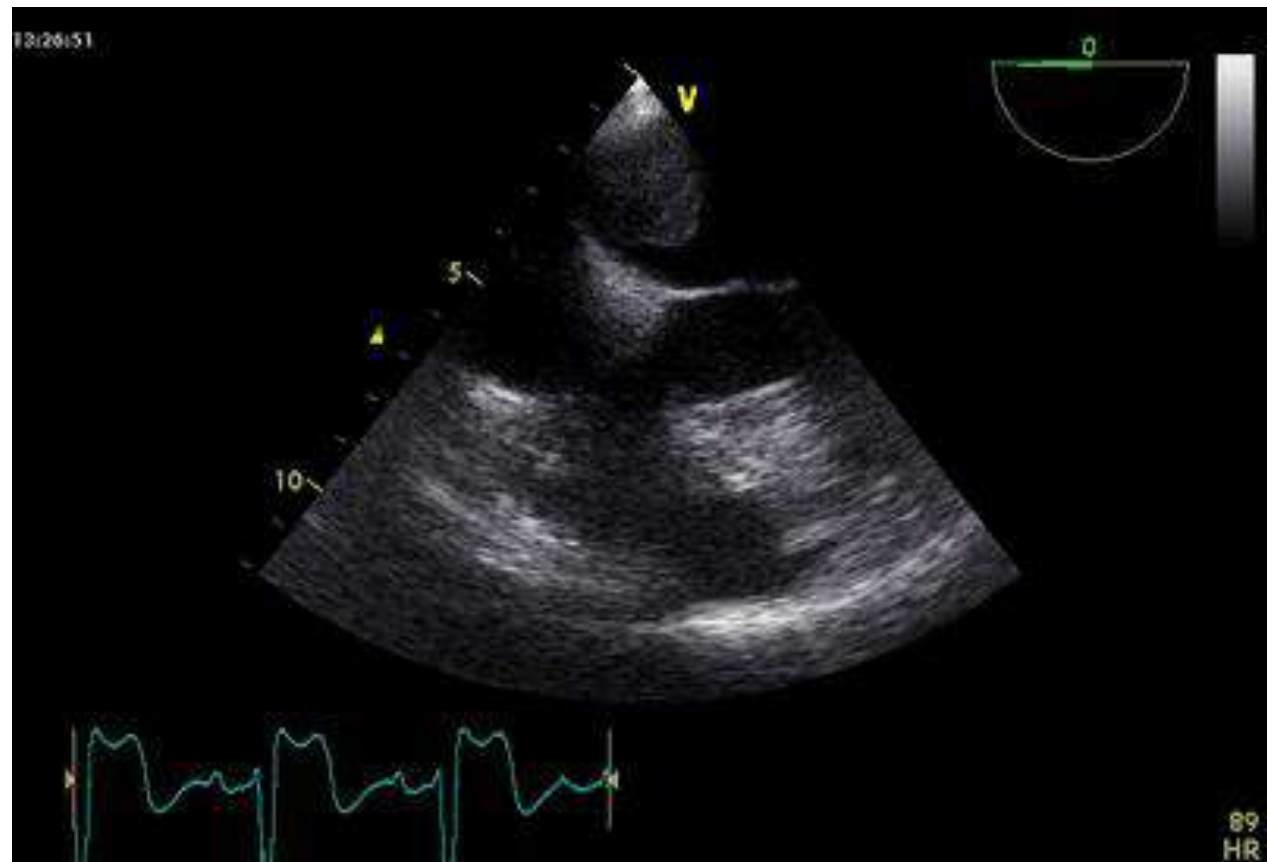
Heart 2009;95:673. doi:10.1136/hrt.2008.161638

CASO CLINICO 10, uomo 52 anni









Embolia coronarica da mixoma atriale: una rara causa di infarto del miocardio? Caso clinico e revisione della letteratura

Gianmaria Scherillo^{1,2}, Enrico Cerrato³, Stefania Ferrua⁴, Ilaria Meynet⁴, Marco Lococo⁴,
Paolo Calabrò^{1,2}, Mauro Rinaldi⁵, Ferdinando Varbella^{3,4}

¹Dipartimento di Scienze Mediche Traslazionali, Università degli Studi della Campania "Luigi Vanvitelli", Caserta

²Divisione di Cardiologia, AORN Sant'Anna e San Sebastiano, Caserta

³Unità Interaziendale di Emodinamica, Ospedale Universitario San Luigi Gonzaga, Orbassano (TO)

⁴Cardiologia, Ospedale degli Infermi ASLTO3 Rivoli, Torino

⁵Cardiochirurgia Universitaria, Città della Salute e della Scienza, Torino

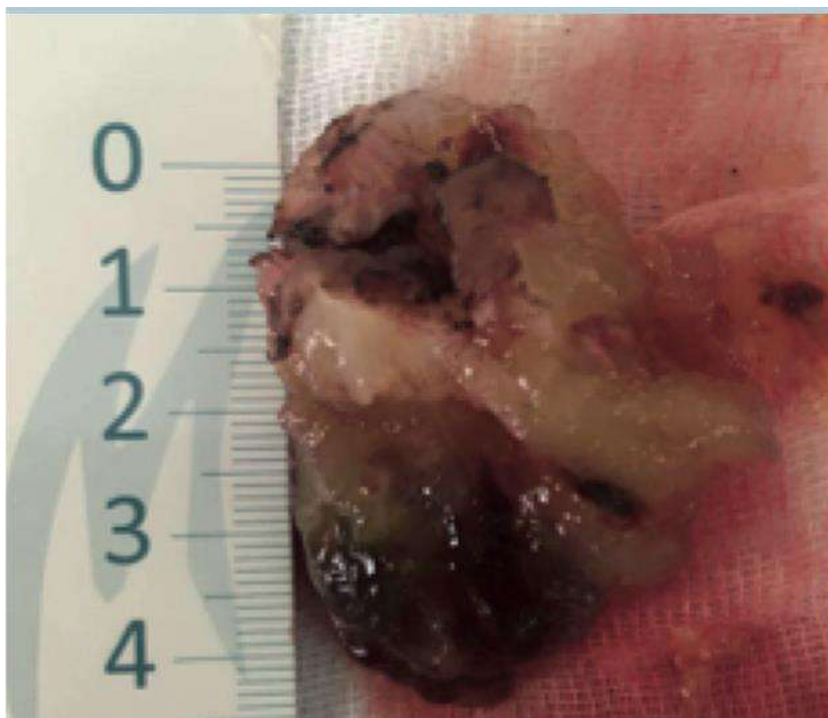


Tabella 1. Revisione della letteratura dei casi pubblicati di embolia coronarica secondaria a mixoma atriale (n=91).

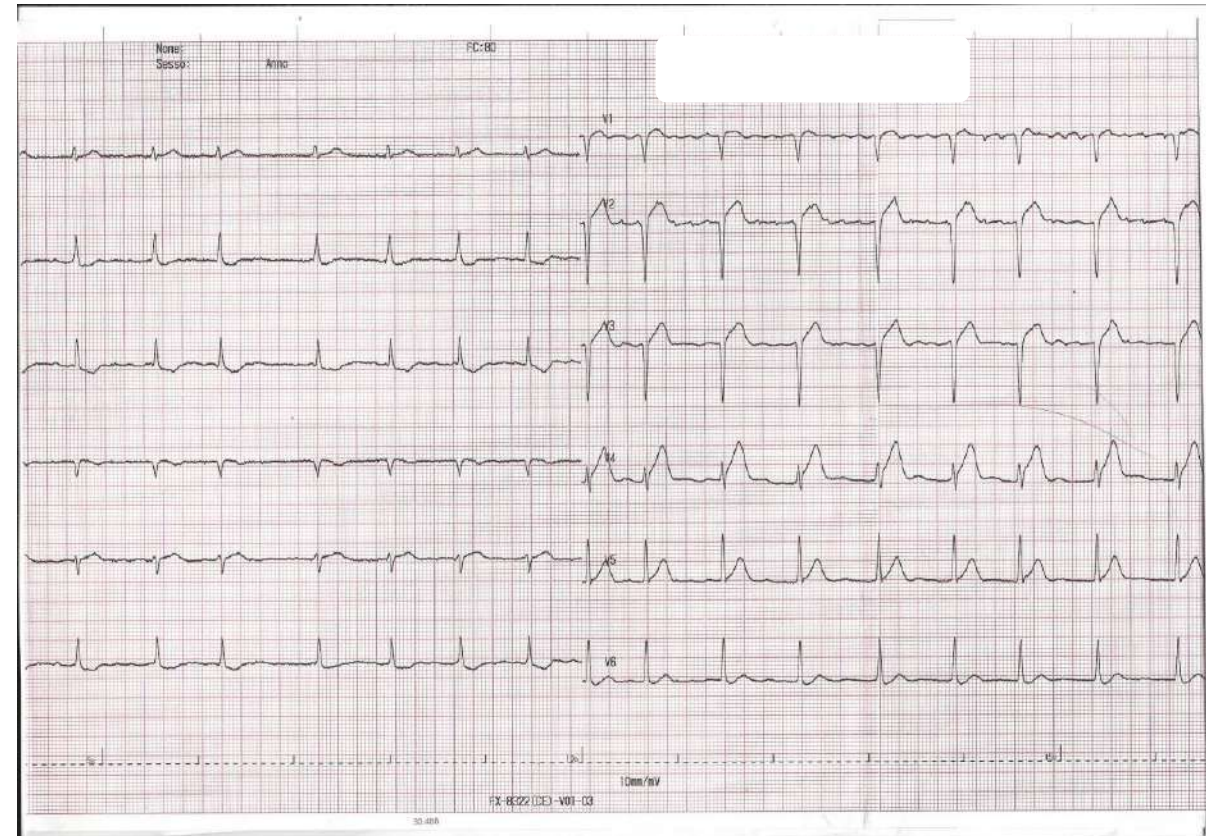
Età (anni)	47.6 ± 16.3
Sesso maschile	46 (52%)
MINOCA	42.2%
Multivasale	7.7%
IVA	20%
Coronaria destra	17.7%
Circonflessa	12.2%
Non nota	2.2%
PCI	16 (17.6%)
Successo	11 (68.7%)
Wire crossing	1 (9%)
POBA	2 (18.2%)
Stenting diretto	2 (18.2%)
Tromboaspirazione	6 (54.5%)

IVA, arteria interventricolare anteriore; MINOCA, infarto miocardico in assenza di coronaropatia ostruttiva; PCI, procedura coronarica percutanea; POBA, angioplastica coronarica con solo pallone.

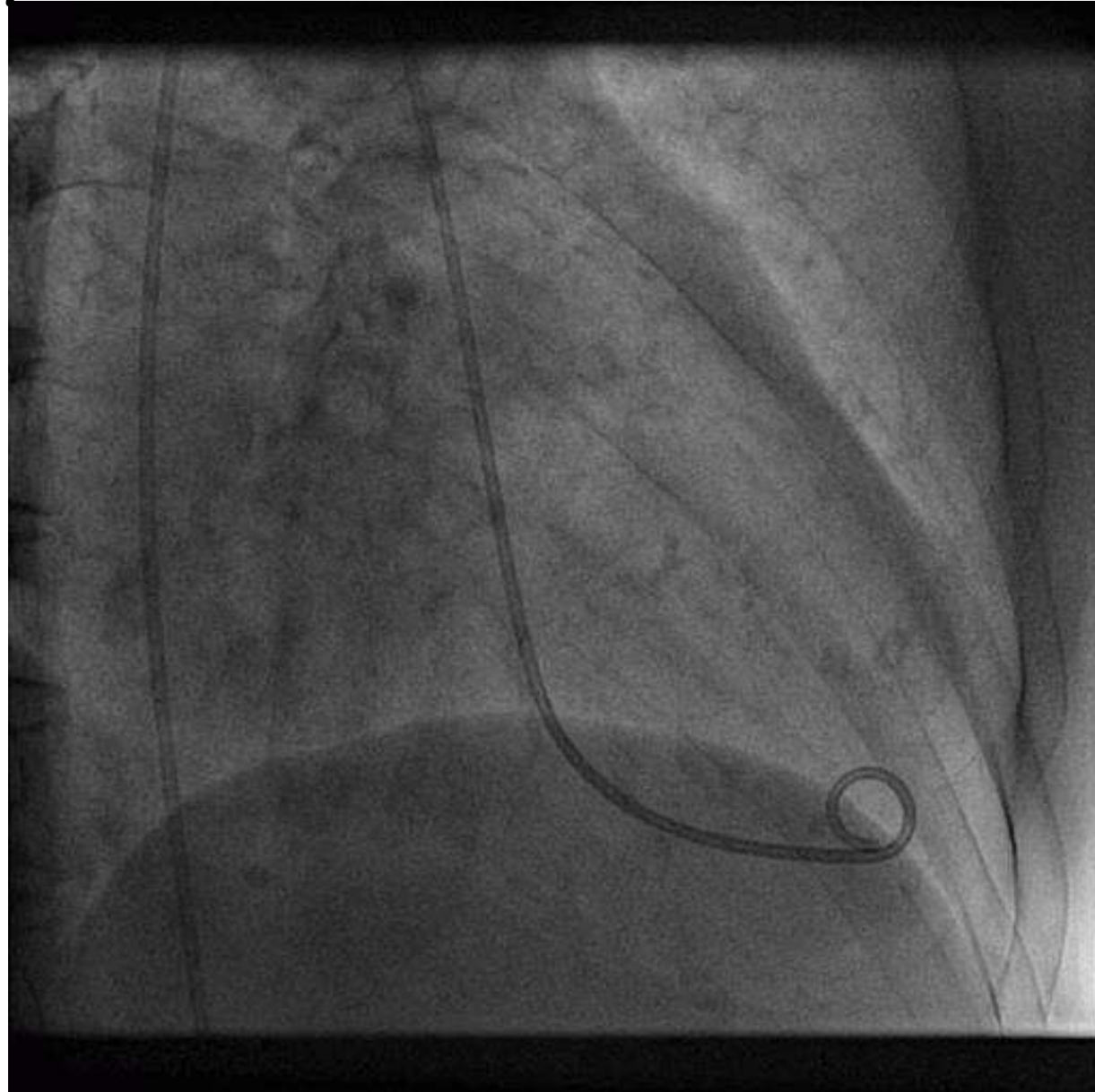
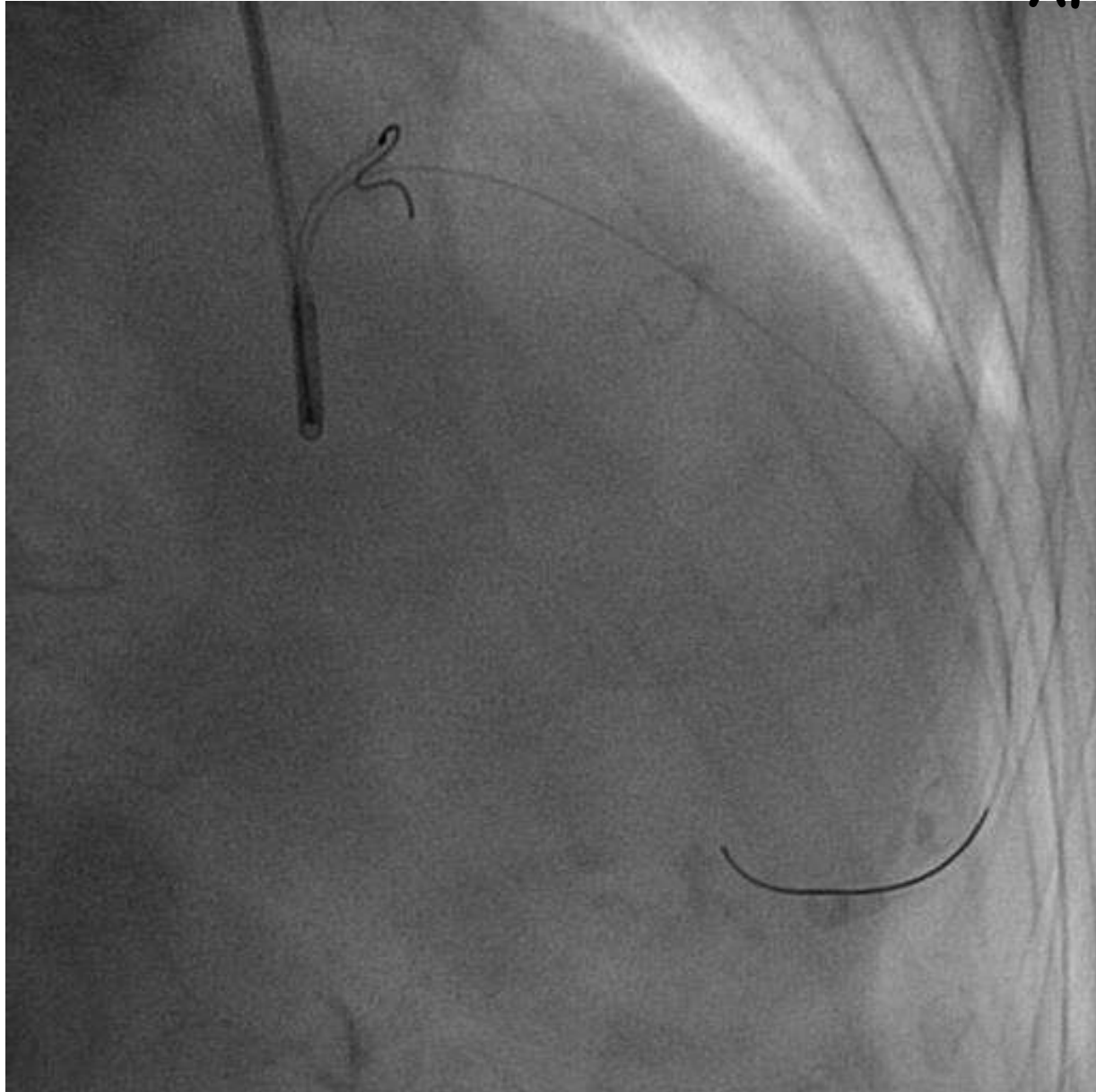
CASO CLINICO 11



**DONNA DI 85 ANNI CON STEMI
ANT**



**DONNA DI 85 ANNI CON STEMI
ANT**

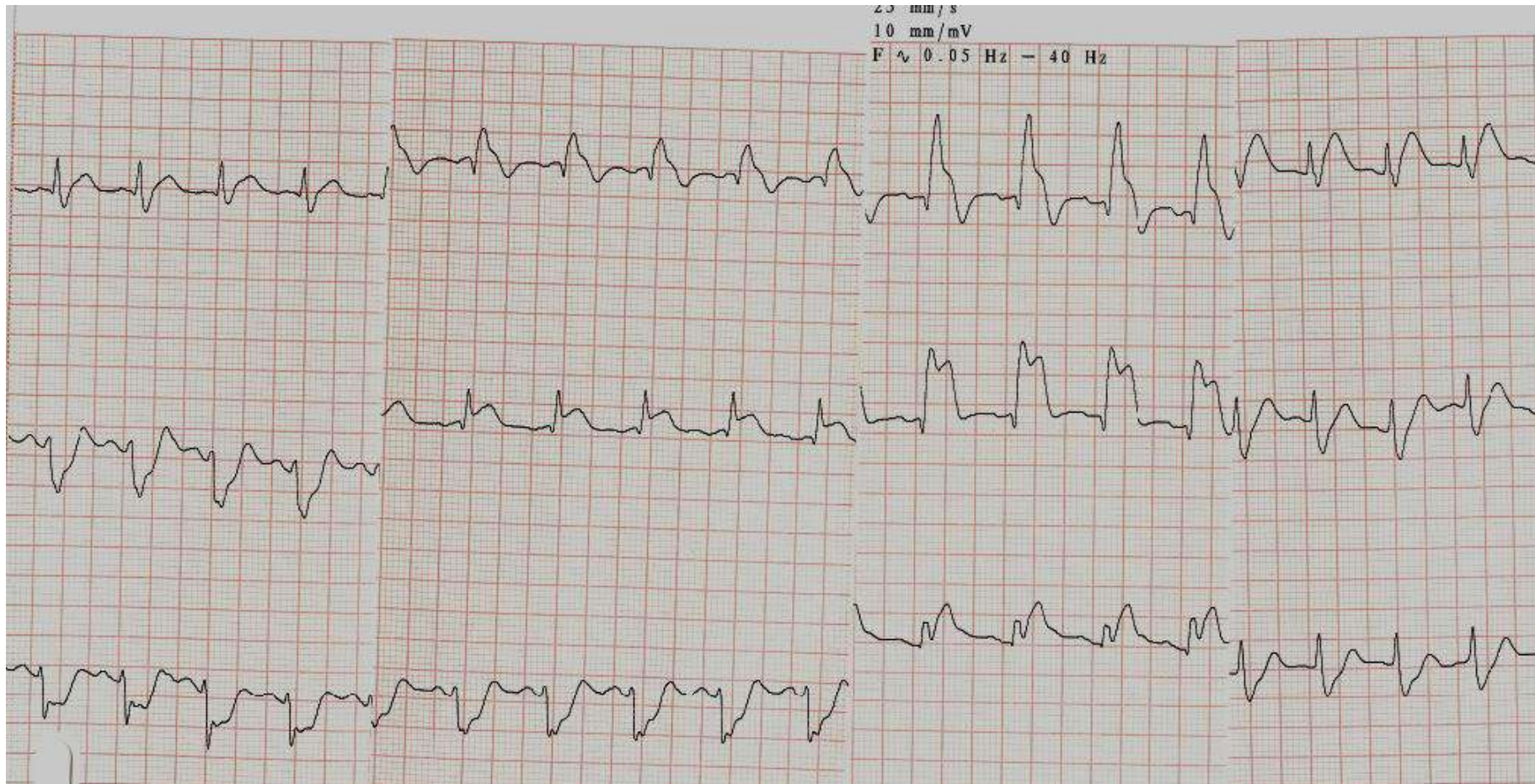


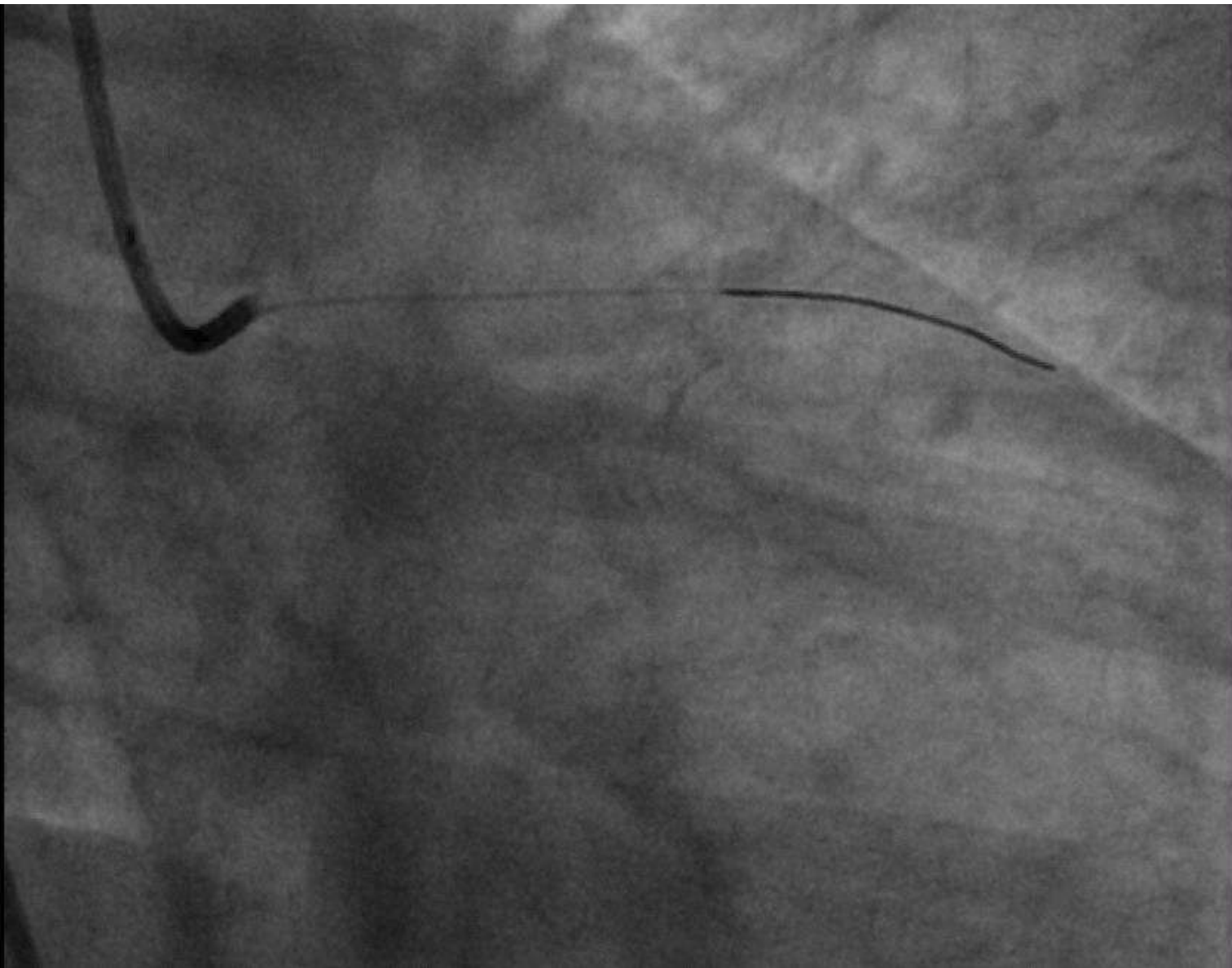
DONNA DI 85 ANNI CON STEMI ANT

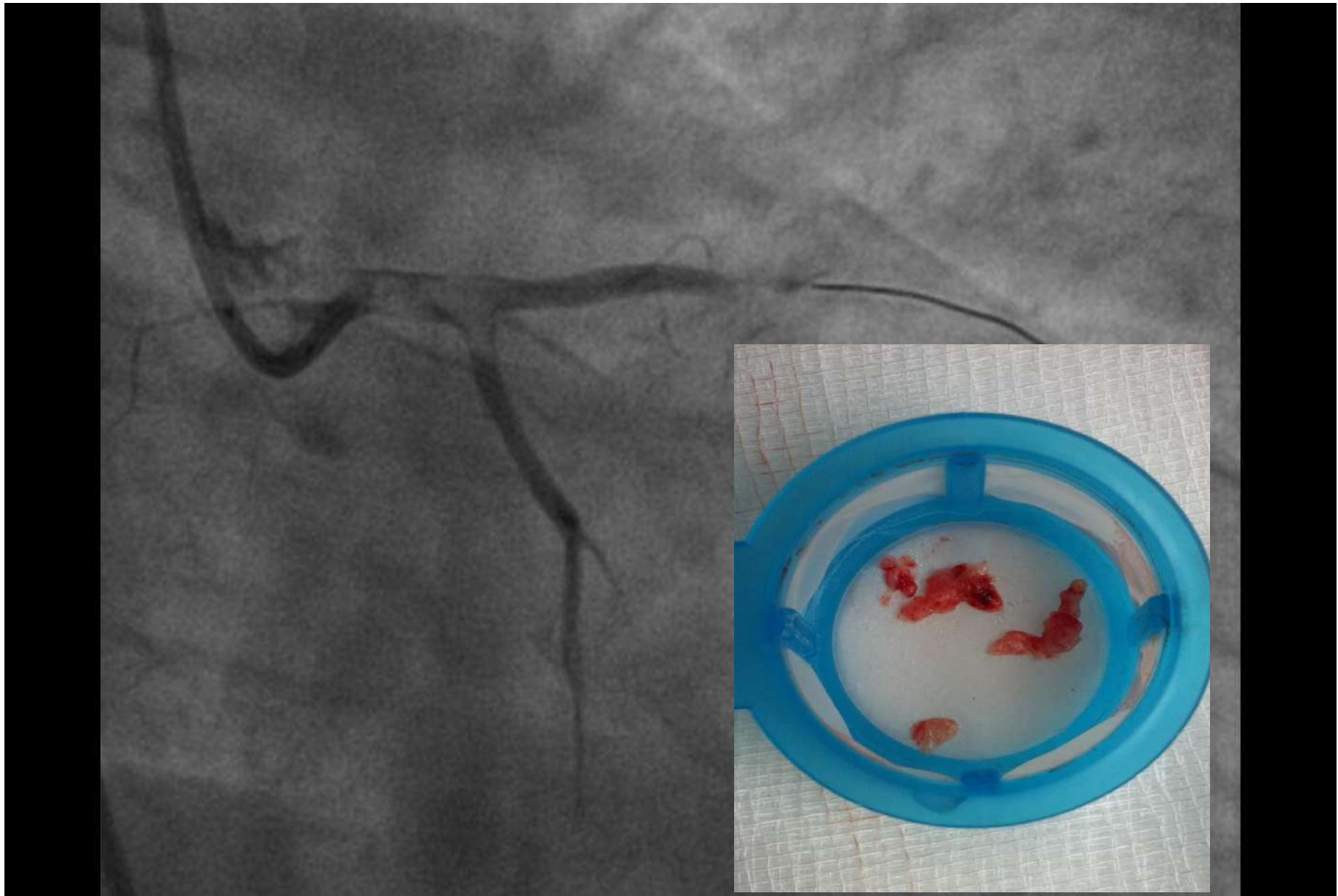


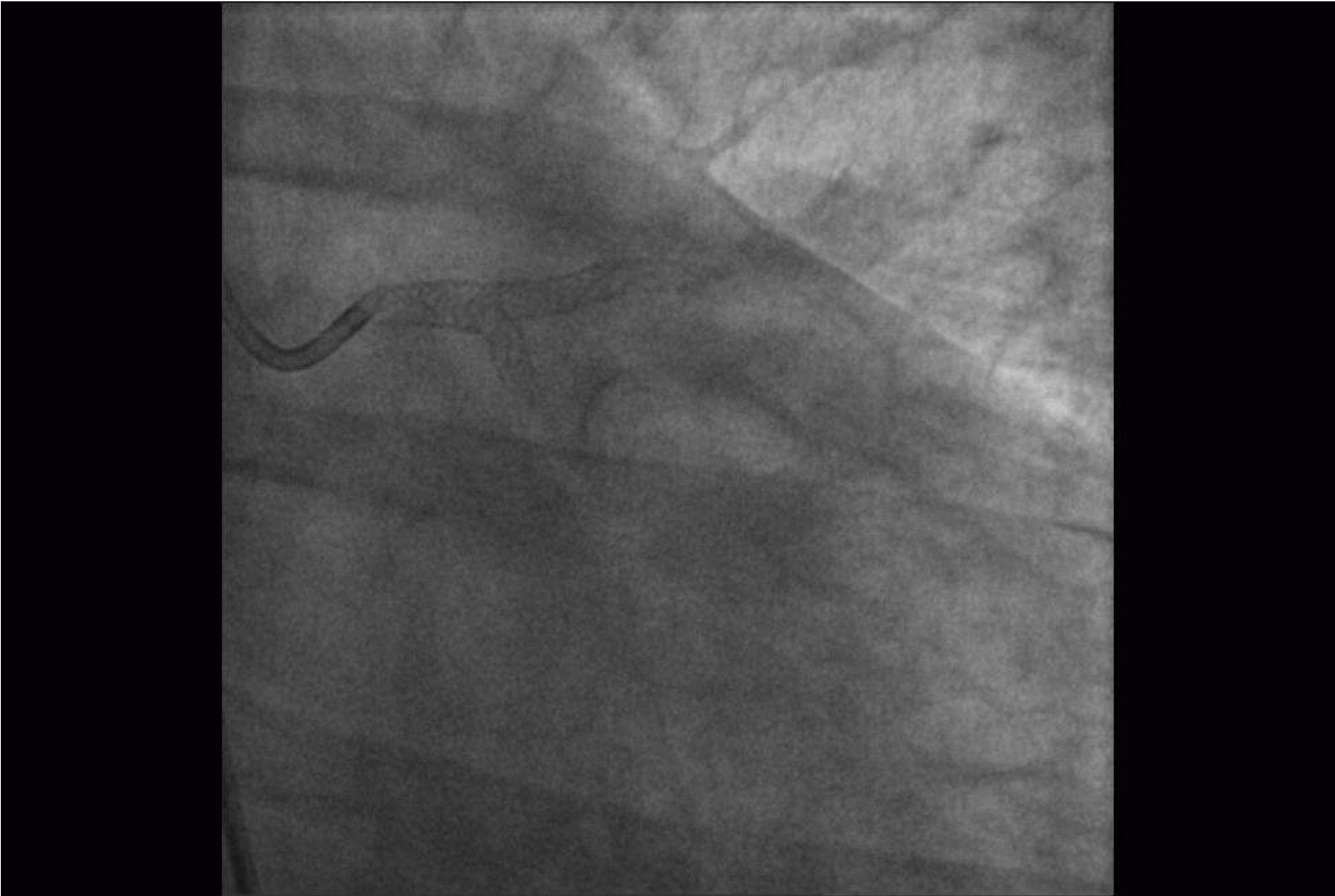
CASO CLINICO 12

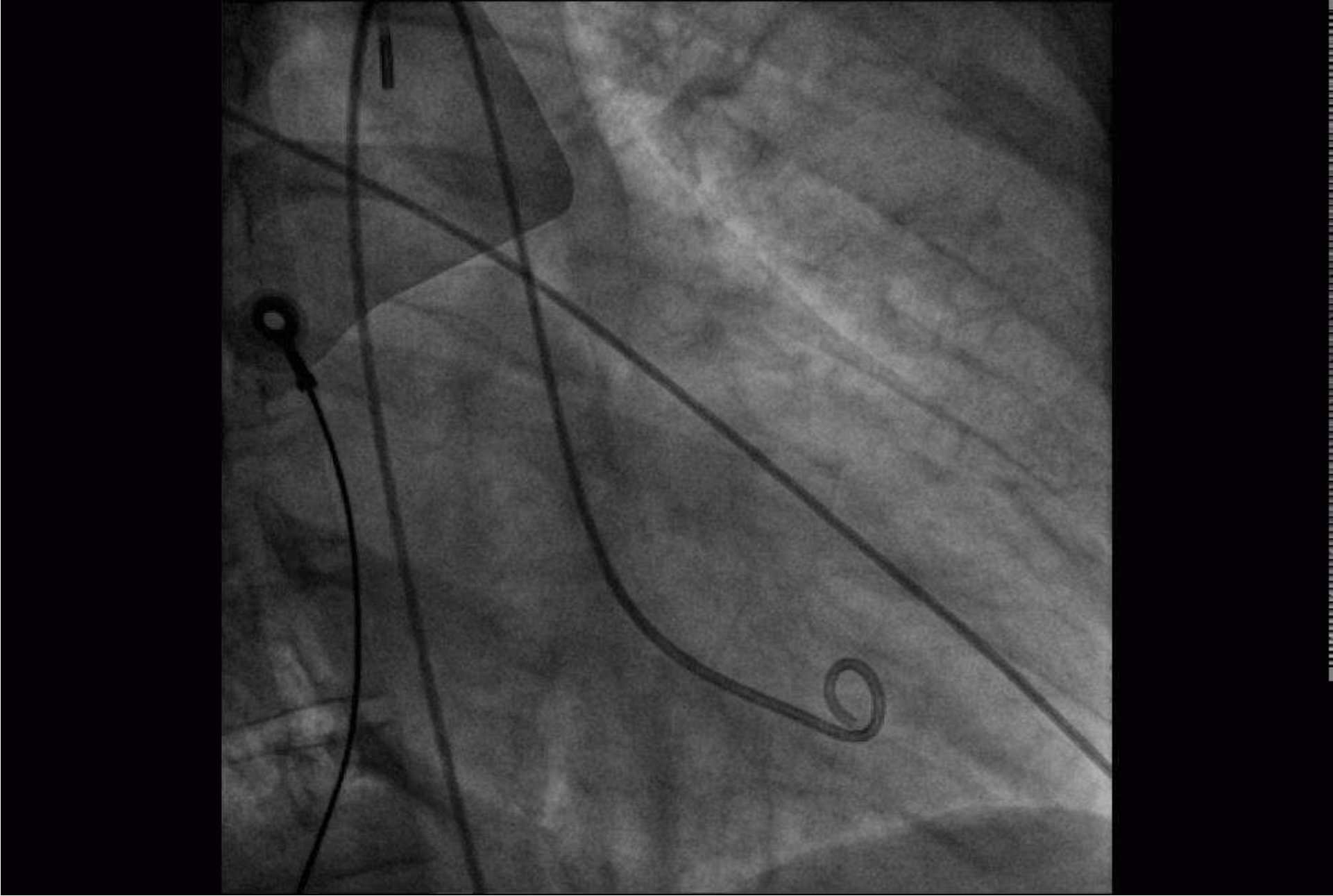
**Valeria G. aa 40 fumatrice + estroprogestinici
diagnosi tardiva > 15 ore SHOCK CARDIOGENO**

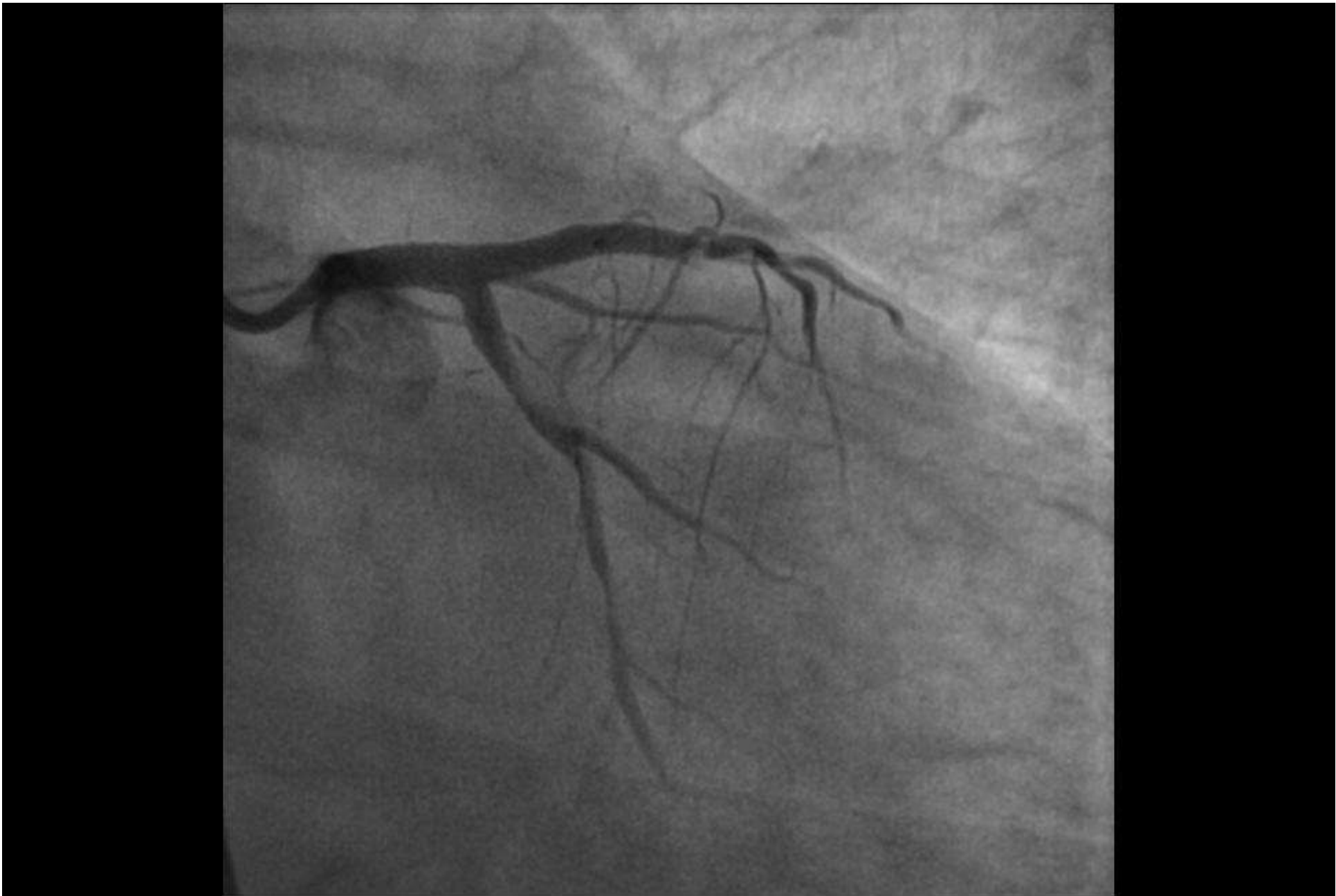












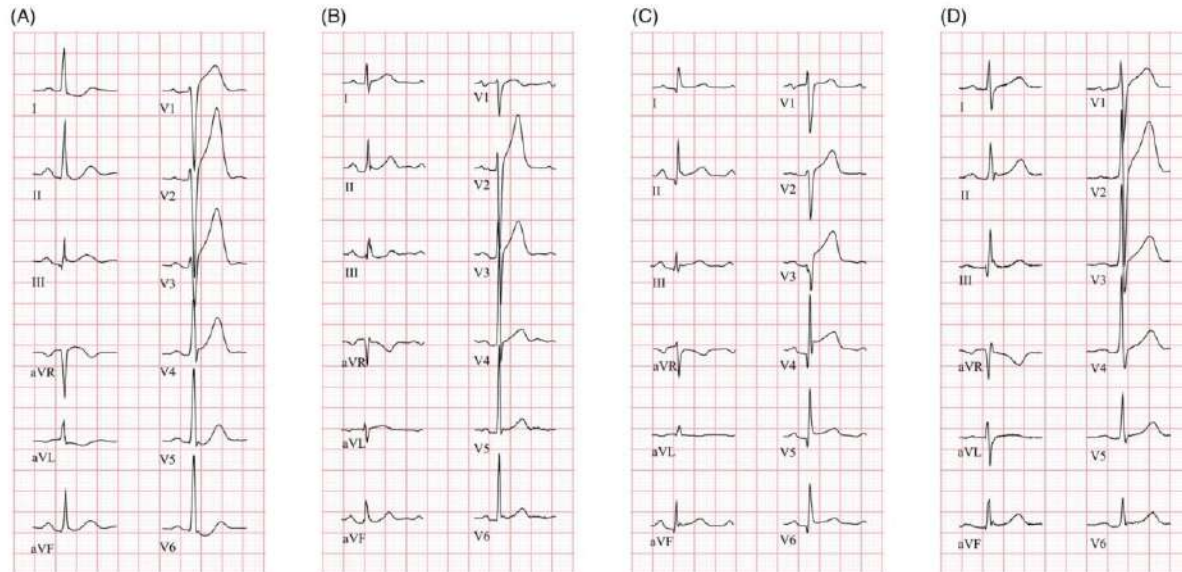
Traferita con IABP > DECESSO DOPO 10 giorni di ECMO

TAKE HOME MESSAGGE

- ***Non tutto ciò che “brilla” è STEMI***
- ***La morfologia conta più dei millimetri***
 - ***concavo***
 - ***convesso***
- ***Controlla lo “specchio” (reciprocità)***
- ***aVR non è una derivazione “dimenticata”***
- ***Diagnosi differenziale “Must Know”***
- ***Contesto clinico è sovrano***

Electrocardiographic changes in the differentiation of ischemic and non-ischemic ST elevation

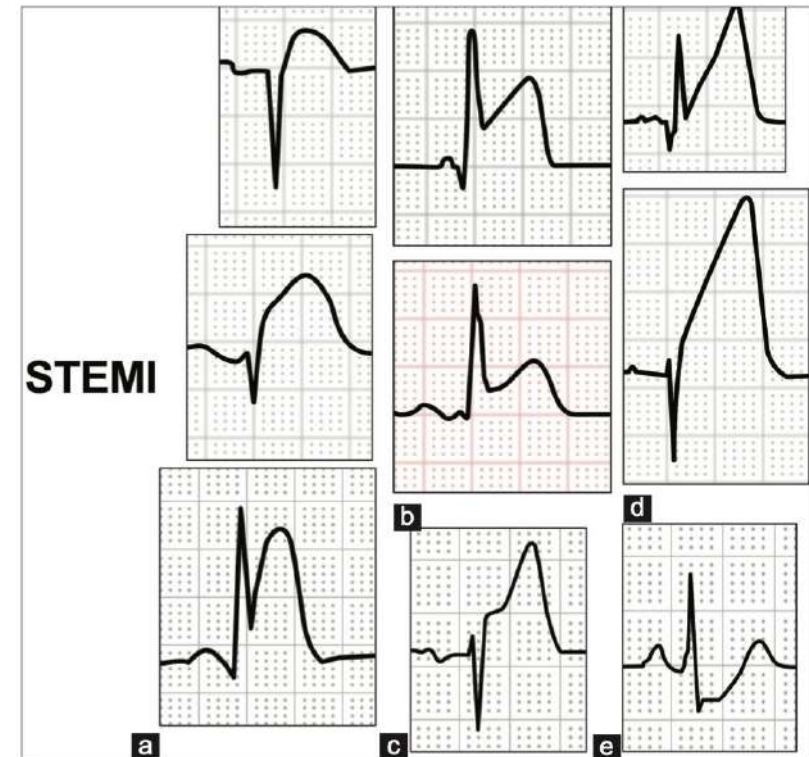
Thomas Lindow, Olle Pahlm, Ardavan Khoshnood, Ingvar Nyman, Daniel Manna, Henrik Engblom, Annmarie Touborg Lassen & Ulf Ekelund



ST-segment elevation myocardial infarction mimics: The differential diagnosis of nonacute coronary syndrome causes of ST-segment/T-wave abnormalities in the chest pain patient

James H. Moak*, Andrew E. Muck, William J. Brady

Department of Emergency Medicine, University of Virginia School of Medicine, Charlottesville, VA, USA
*Corresponding author





GRAZIE PER L'ATTENZIONE



GRAZIE PER L'ATTENZIONE

