Letters to the Editor

Among the 3 siblings, only 1 presented pathological baseline ECG findings (type 2); he has a son with a type 1 ECG pattern. An EEF study was performed, but arrhythmia was not induced. At the time of writing, after more than 12 months of follow-up, no arrhythmic event has been observed and the baseline ECG is always similar to the previous one.

The patient presented no chest pain during the exercise test, not even during the episode of sustained monomorphic ventricular tachycardia. Therefore, we must presume that the clinical symptoms are not related to the tachycardia. Furthermore, the patient had not previously reported the presence of palpitations and syncopal episodes. An ischemic etiology of the tachycardia was ruled out by catheterization.

The malignant ventricular arrhythmia documented in our case presented during early recovery from the exercise test, immediately after maximum effort, when the sympathetic stimulus produced by exercise starts to diminish. Vagal tone is greater at this time and may have been the cause of the arrhythmia. An interesting aspect of this case is the negative EEF results. These 2 points are important, because the electrophysiological study, a diagnostic test of proven usefulness, was negative, whereas a nonroutine test for this condition triggered arrhythmia.

It is worth noting that our patient SMVT, although sustained polymorphic ventricular tachycardia is much more common in this syndrome. It is also interesting that the tachycardia presented RBBB morphology, which is evidence of left ventricular origin, making this an even more curious case. In our opinion, this isolated finding does not provide a basis for recommending routine use of exercise testing for Brugada syndrome in clinical practice, although there may be a group of patients in whom recovery after strenuous exercise triggers arrhythmia, making it advisable to conduct prospective studies to determine whether the test should be routinely done among such patients.

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Cardiac Shotgun Pellet in the Interventricular Septum

To the Editor:

The treatment for cardiac wounds due to pellets from firearms is still controversial because of the limited number of cases analyzed at each hospital, and the enormous variation in the location of intracardiac pellets and the symptoms they produce. The therapeutic options for this entity include conservative treatment, pericardial drainage, and surgical removal of the shotgun pellet, although each patient’s treatment should be individualized. We describe an adult with a firearm-related cardiac wound in which a shotgun pellet became lodged in the interventricular septum and was successfully treated using a conservative approach.

A 37-year-old man consulted at our hospital for a hunting accident in which he was wounded with a firearm from an approximate distance of 20 m. At arrival, the patient was conscious, hemodynamically stable, and with good oxygen saturation. The physical examination revealed multiple wounds 0.5 cm in diameter caused by shotgun pellets in the legs, arms, abdomen, and anterolateral region of the left thorax. There were no signs of heart or respiratory failure.

The electrocardiogram showed sinus rhythm with no other alterations; the chest x-ray detected multiple substernal and bilateral intrathoracic shotgun pellets associated with a left pneumothorax that required percutaneous drainage. The echocardiogram detected moderate pericardial effusion (1 cm
The treatment of heart wounds due to shotgun pellet should be individualized. The success of conservative treatment in this case supports the concept that projectiles located in the interventricular septum may be well-tolerated and only require monitoring, provided that the patient remains asymptomatic and hemodynamically stable. Surgical examination and excision should be considered with the onset of arrhythmias, heart failure, ventricular septal defect, or cardiac tamponade.

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