

P256

Takotsubo syndrome early after treatment due to non cardiotoxic chemotherapy agents

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Physicians have encountered cardiotoxicity in different situations. The most known scenario is heart failure after especially anthracycline treatment. In this case, immediately after chemotherapy typical Takotsubo syndrome developed and was diagnosed with normal coronary angiography with apical ballooning movement in ventriculography. Acute cardiotoxicity may depend on different pathogenesis than ordinary toxicity mechanism.

Case report: A 65 years old female attended emergency department with epigastric pain after chemotherapy. She had vinorelbine and gemcitabine treatment for malignant urotelial renal carcinoma. The patient was consulted with cardiology department, because of progressive high troponin T levels. She had no prior history except urotelial carcinoma for one year and hypertension for seven years. Her prior chemotherapy protocols included carboplatine and docetaxel. She did not describe typical angina pectoris or shortness of breath.

Electrocardiography (ECG) at admission had symmetrical T wave inversion on precordial derivations (figure 1). Echocardiography (echo) showed typical apical ballooning of the left ventricle (figure 2 and 3). We do not know the patient's prior cardiac performance and acute coronary syndrome and Takotsubo syndrome were our preliminary diagnosis. Normal coronary arteries were seen on coronary angiography, ventriculography revealed apical ballooning movement of the left ventricle (Figure 4) and this supported our diagnosis as Takotsubo syndrome. She was already on valsartane 160 mg daily for hypertension and we included metoprolol 50 mg daily and enoxaparine 6000 IU s.c twice a day. For several days deep symmetrical T wave inversion persisted on ECG. After third day her ECG changings resolved (Figure 5) and echo images had recovered. The patient was discharged uneventfully and is followed.

Abstract P256 figures

