

Brugada sindrom - gdje smo danas - prikazi slučajeva

Brugada syndrome - where do we stand today - case reports

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Uvod: Brugada sindrom (BrS) ima nisku prevalenciju (14-30:10000). BrS karakteriziraju tipične promjene elektrokardiograma (EKG) i visoka incidencija nagle srčane smrti (NSS), a češći je u muškaraca te Azijata. Jedina prevencija NSS kod BrS bolesnika je implantacija ugradbenog kardioverter defibrilatora (ICD). Konzensus izjava HRS/EHRA/APHRS¹ jasno nalaže razloge za implantaciju ICD-a, a asimptomatski bolesnici te oni s nejasnom sinkopom nalaze se u tzv. sivjoj zoni.^{2,3} Prikazujemo pristup bolesnicima "Brugada-like" EKG promjenama u našem centru.

Prikaz slučajeva: 1) 40-godišnji muškarac je upućen zbog perzistentne fibrilacije atrija. U EKG-u je prisutan tip II promjena. Obiteljska anamneza je negativna na NSS, bolesnik nikada nije imao sinkopu. Učinjena je izolacija plućnih vena (PVI), kasnije provokacijski test ajmalinom (pozitivan), a nakon toga i elektrofiziološka studija (EPS) koja je bila negativna. 2) 36-godišnji muškarac je upućen radi sinkope koju je razvio za vrijeme piknika za vrućeg dana u mirovanju. U EKG-u je prisutan tip II. Holterska kao i neurološka obrada su uredne. Obiteljska anamneza je negativna na NSS. Ajmalinski test je bio pozitivan, a EPS negativna. Oba bolesnika su dobila preporuke o izbjegavanju specifičnih lijekova, promjeni stila života kao i agresivne antipireze. Smjernice za BrS jasno preporučuju da se ICD implantira osobama koje su preživjele kardijalni arrest, i/ili postojanu ventrikulsku tahikardiju (VT). ICD može biti koristan u bolesnika sa spontanom tipom I BrS i sinkopom, a o ICD-u se može razmisliti kad imaju inducibilnu aritmiju (EPS). Prvi bolesnik ne zadovoljava kriterije stoga je za sada dalje kontroliran. Također, bolesnik je godinama prije dolaska u centar bio liječen propafenonom bez ikakvih tegoba što vjerojatno govori u prilog male mogućnosti razvoja VT/VF. Konačno, bolesnik je imao fibrilaciju atrija koja je povezana sa češćim ventrikulskim aritmijama u BrS pacijenata koja je za sada izliječena putem PVI. Drugi bolesnik je imao sinkopu prilikom izlaganja vrućini u mirovanju, ali mehanizam sinkope se ne mora pripisati aritmiji, također u EKG u je prisutan tip II i nema inducibilnu aritmiju, stoga je i on dalje kontroliran.

Zaključak: Potencijalno letalne aritmije u asimptomatskih bolesnika pojavljuju se u 1-8% kroz prosječno tri godine (Brugada; Eckardt; Probst). Preporuke o potrebi EPS nisu u potpunosti definirane, stoga i dalje provodimo EPS kao dodatni stratifikacijski postupak u pristupu bolesnicima s BrS.

Introduction: Brugada syndrome (BrS) has low prevalence (14-30:10000), it is more common in men and people from Asia, and it is characterized by typical ECG changes as well as high incidence of sudden cardiac death (SCD). ICD implantation is the only SCD prevention option. HRS/EHRA/APHRS Consensus article¹ states the indications for ICD implantation, but asymptomatic patients, or those with syncope of unclear origin can be hard for risk stratification.^{2,3}

Case reports: We are presenting two cases from our hospital. A 40-year-old male was seen for atrial fibrillation and type II ECG changes. There were no SCD in family, and he never had syncope. Pulmonary vein isolation (PVI) was done, then ajmaline test (positive) and finally electrophysiology study (EPS) (negative). A 36-year-old male with type II ECG was admitted after syncope which occurred during rest on a hot day at a picnic. Holter as well as neurologic workup were normal. Ajmaline test was positive and EPS negative. Both patients were instructed to avoid specific drugs, to change lifestyle and prevent high fever with antipyretics. Guidelines clearly state ICD should be implanted to SCD survivors or sustained ventricular tachycardia (VT), it can be useful in patients with type I ECG changes and a syncope, and it may be considered in EPS inducible patients. First patient is in follow up because he doesn't fulfill any criteria. Also he was previously treated with propafenone without any problems, which is also a possible sign of lower risk for SCD, finally he was successfully treated for atrial fibrillation, which is linked ventricular arrhythmias in BrS patients, so this was also a tool to lower his risk. Second patients had a syncope, but other syncope etiologies are possible, he has type II ECG changes and arrhythmia is not inducible therefore he is also in follow up.

Conclusion: Potentially lethal arrhythmias in asymptomatic patients develop in 1-8% in 3 years (Brugada; Eckardt; Probst). Finally, EPS recommendations are not clearly defined, therefore we are still conducting EPS as an adjuvant tool for risk stratification.

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