

Courtesy of Dr. Stephen Fenton

Chest pain after kickboxing



Dr Stephen Fenton

Dr Stephen Fenton is a cardiologist in private practice with the Sydney Cardiology Group.

PRESENTATION

A 34-year-old man presents with mild dyspnoea with activity such as walking up hills and working out at the gym.

He has been working for a year as a stockbroker, which he finds stressful. He has smoked heavily since the age of 18, and there is a history of hyperlipidaemia, for which he is on medication. There is no significant family history of heart disease or hypertension.

He describes an episode of quite

significant chest pain after kickboxing about 18 months ago. He did not seek medical attention at the time.

Physical examination reveals a BP of 135/80 mmHg and is otherwise normal.

Based on the ECG above, choose the correct response to the following:

Q1) How would you report this ECG?

1. Old inferolateral myocardial infarct
2. Right bundle branch block
3. Normal ECG
4. Possible previous anteroseptal infarct
5. Acute inferior infarct.

Q2) The next most appropriate test would be which one of the following:

1. Echocardiogram
2. MRI
3. CT angiogram
4. Coronary angiogram
5. Electrophysiology study.

DISCUSSION

This young man has concerning risk factors and his ECG is abnormal. There are pathological Q-waves in the inferior leads and also in leads V5-V6 and possibly V4.

These changes are consistent with previous infarction involving the inferolateral area. (The correct answer to Question 1 is therefore no. 1.)

The diagnosis of an old inferolateral

He has smoked heavily since the age of 18, and there is a history of hyperlipidaemia

myocardial infarct can be established by assessing left ventricular function, and this will be best done with a transthoracic


echo. (The correct answer to Question 2 is therefore no. 1.)

OUTCOME

The echo demonstrated significant inferolateral akinesis with a consequent reduction in global left ventricular systolic function and ejection fraction in the order of 40 per cent.

Further investigation will be required, including functional testing, and this could be performed most efficiently by a stress echo.

A nuclear perfusion study could be considered, and in a young patient like this, there may be a case for proceeding with a formal coronary angiogram.

This is a very young patient with documented coronary artery disease and previous infarction. He will need close ongoing surveillance and very aggressive management of his risk factors. 

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