

ERRATUM

In the answer to the photo quiz 'A patient with dyspnoea, subfebrile temperature and electrocardiographic abnormalities' by H.J. Jansen, H. Haerkens-Arends and G. Vervoort, in the Netherlands Journal of Medicine 2005;63(3):118, the wrong figure was published as figure 2.

We therefore provide you with the correct version of the photo quiz in this issue. Our apologies for any inconvenience caused.

A patient with dyspnoea, subfebrile temperature and electrocardiographic abnormalities

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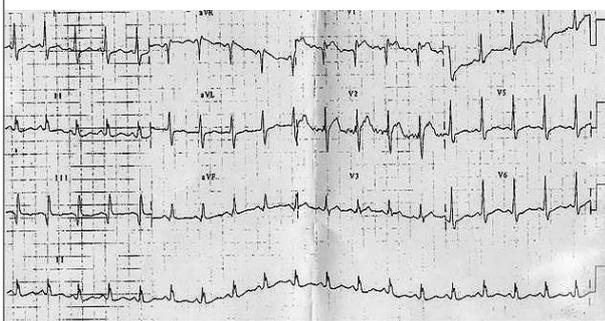
CASE REPORT

A 66-year-old man was admitted to our hospital because of dyspnoea and slightly elevated body temperature (38.1°C). A month before admission the patient suffered an ischaemic cerebrovascular accident. His medical history also revealed a myocardial infarction seven years ago and a transient ischaemic attack.

On physical examination his blood pressure was 130/80 mmHg, pulse 102 beats/min and regular; the central venous pressure was clearly elevated. The respiratory rate was 36 breaths/min. Examination of the lungs and heart revealed no abnormalities. The right lower extremity was red, warm and swollen and painful on palpation.

Laboratory tests were performed. An arterial blood sample showed no abnormalities. Lactate dehydrogenase was 566 U/l and troponin I 0.51 µg/l. A chest X-ray showed no abnormalities. His electrocardiogram (ECG) is shown in figure 1.

Figure 1 12-lead electrocardiogram of the patient



WHAT IS YOUR DIAGNOSIS?

See page 238 for the answer to this photo quiz.

ANSWER TO PHOTO QUIZ (ON PAGE 231)

A PATIENT WITH DYSPNOEA, SUBFEBRILE TEMPERATURE AND
ELECTROCARDIOGRAPHIC ABNORMALITIES

DIAGNOSIS

The ECG showed a sinus tachycardia of 111 beats/min, an incomplete right bundle branch block and a so-called McGinn-White S₁Q₃T₃ pattern.¹ There were no signs of acute ischaemia.

Because a pulmonary embolism was considered, a high-resolution spiral computed tomography angiography was performed.² This showed a massive pulmonary embolism presenting as a classic saddle embolus at the bifurcation of the main pulmonary artery extending into the left and right pulmonary arteries (*figure 2*).

Figure 2 High-resolution spiral CT-scan angiography presenting the saddle embolus



A transthoracic echocardiography was performed which showed dilatation of the right ventricle with tricuspid regurgitation and systolic pulmonary artery hypertension of 58 mmHg, compatible with massive pulmonary embolism.³

The patient was treated with intravenous heparin/low-molecular-weight heparin and acenocoumarol. Because of a recent cerebrovascular accident we considered thrombolytic therapy to be contraindicated.^{4,5} After eight days the patient was discharged. During follow-up the patient remained asymptomatic.

Classic features of massive pulmonary embolism at electrocardiography¹ and echocardiography³:

- Sinus tachycardia
- (Incomplete) right bundle branch block
- McGinn-White S₁Q₃T₃ pattern, which means S wave in lead I, Q wave in lead III and a flattened or negative T wave in lead III
- Right ventricular dilatation and systolic pulmonary hypertension

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