Double whammy - ACS with undifferentiated anemia

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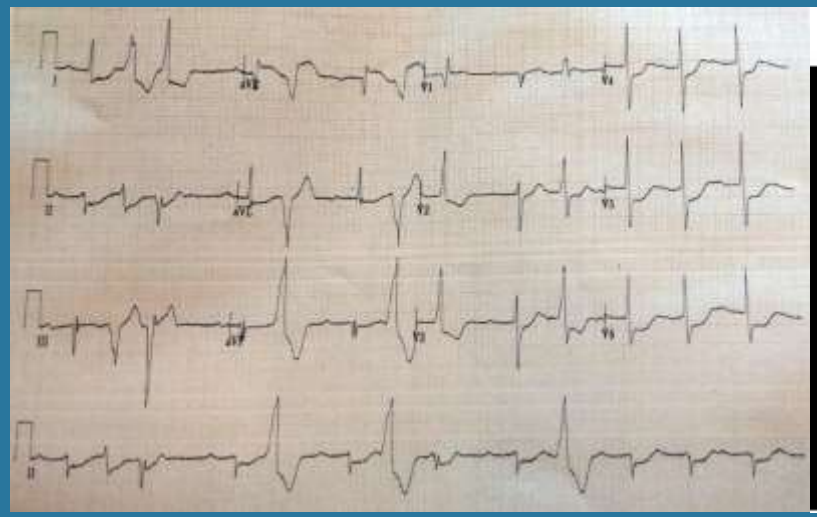
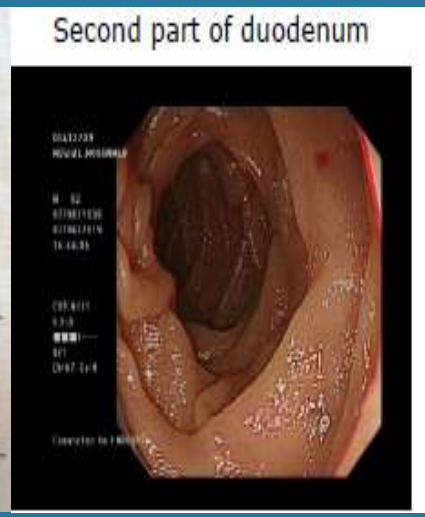
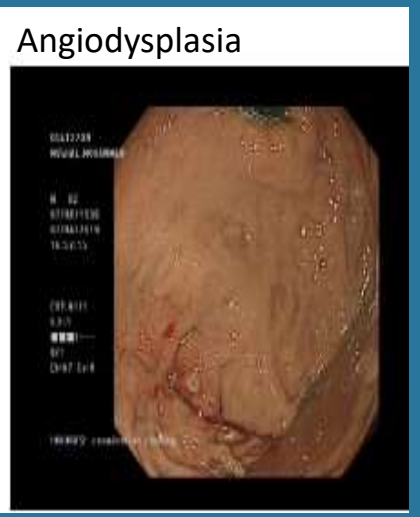
CASE PRESENTATION: 82 year old male, with history of ischemic heart disease and TIA, presented with cardiac sounding chest pain and was pain free on arrival at ED. ECG showed positive AVR and global ST depression from V1-6. His blood gas showed Hb of 76g/L while it was 111g/L four weeks ago. He denied any overt bleeding. He was on aspirin 75 mg OD and omeprazole. On examination there was no dependent edema but chest had bibasal crackles with dual heart sounds. Abdomen was soft with no malena on rectal exam.







MANAGEMENT AND OUTCOME: CT aortogram was negative for dissection. Patient was managed as NSTEMI with dual antiplatelets and fondoparinux after discussion with cardiology. Blood tests showed raised urea (9.1 mmol/L) and Hb of 71g/L with low MCV. Initial trop was 2179 ng/L.

Endoscopy later in the day showed angiodysplasia in stomach and dudeonum and hemostasis was established with argon photocoagulation.

KEY LEARNING POINTS:

- ECG with positive AVR and global ST depression is suggestive of a proximal left coronary main artery lesion and is **sometimes considered STEMI equivalent**.
- With respect to antiplatelets and anticoagulation, we took a risk based approach with shared decision making with the patient and input from hematology and cardiology. Given the high probability of proximal lesion, its use was considered justified.
- Post endoscopy, it was felt that patient might have suffered a type 2 ischemic event from anemia. Thus antiplatelets and anticoagulants were withheld and outpatient cardiology appointment was made.
- Type 2 myocardial infarction is caused due to either increased oxygen demand or decreased supply.