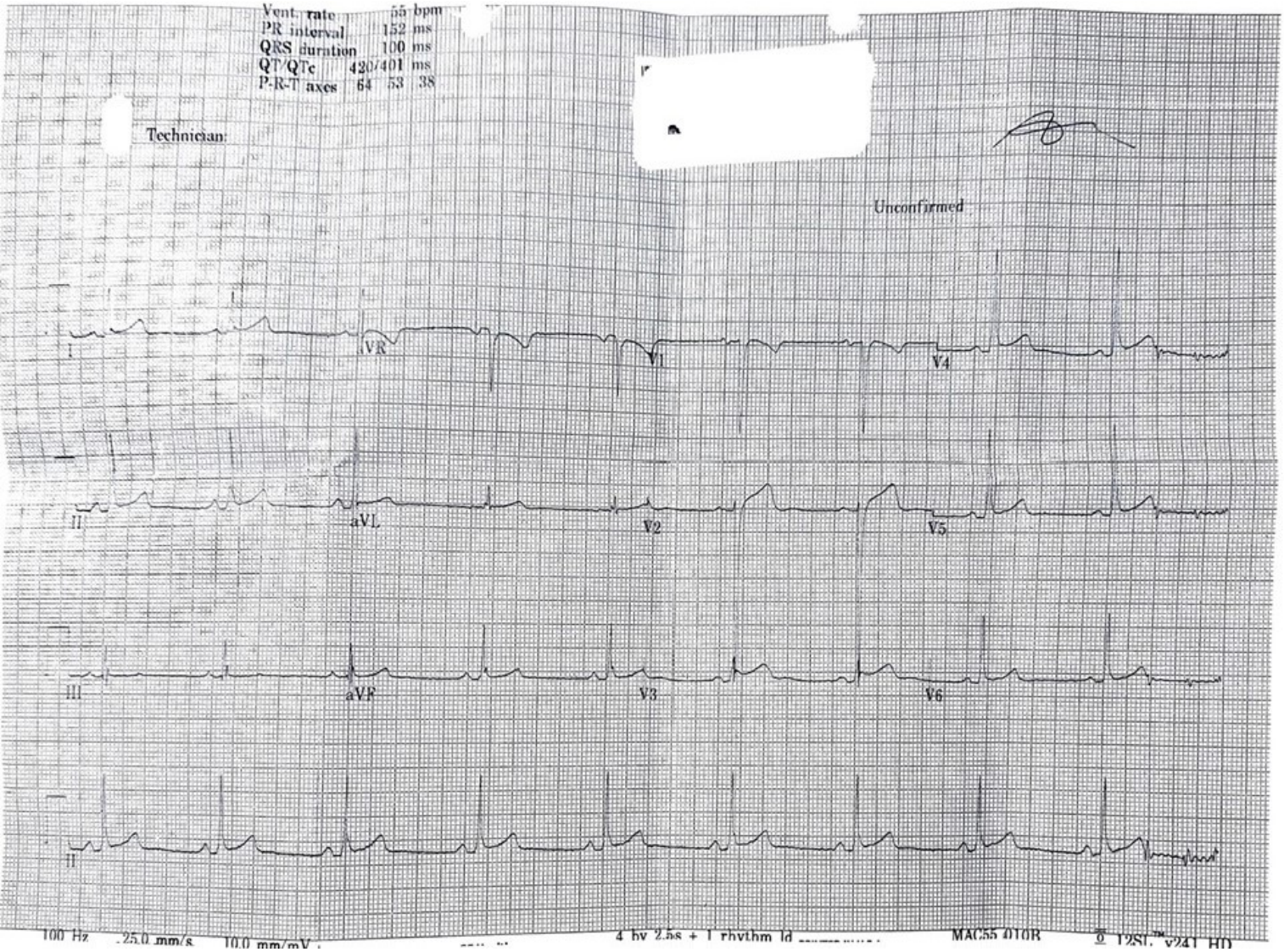
Trigger 1:
29 yo M presents with a 3-day history of worsening, acute onset central chest pain. Today he describes the pain as an 8/10, tight in character, without radiation to the jaw or shoulder, with no associated symptoms.

Task 1: Interpret the ECG and based on the presentation and the ECG provide a diagnosis.

Task 2: Provide initial management.

Move onto the next part.


Vent. rate 55 bpm
PR interval 152 ms
QRS duration 100 ms
QT/QTc 420/401 ms
P-R-T axes 64 53 38
Technician:
Unconfirmed
I
II
III
aVR
aVL
aVF
V1
V2
V3
V4
V5
V6
II
100 Hz 25.0 mm/s 10.0 mm/mV
4 by 2.5s + 1 rhythm ld
MAC55 010R
12SL™ v241 HD

Rate	54 BPM	
Rhythm	Regular sinus rhythm	
Axis	No axis deviation	
Intervals (ref. ranges)	PR (120-200ms)	WNL at 120ms
	QRS (<120ms)	WNL <120ms
	QT (<480ms)	WNL at 200ms
Segments	PR Segment depression in Lead II, aVF especially. Often subtle 0.5-1mm drop is often all you will see. TP downsloping of equal to or greater than 1mm seen in multiple leads best seen in Leads II and V4. This is **spodicks sign** ST segment - concave ST elevation in leads I, II, aVF, V2, V3, V4, V5, V6. Reciprocal ST segment depression in aVR	
Interpretation	This is an ECG of a 25yo M, the rate is 54 mildly bradycardic, the rhythm is regular, and sinus and the axis is normal. There is evident TP down sloping indicative of spodicks signs and PR segment depression seen best in leads II and aVF. PR Segment depression can be caused by atrial ischaemia or pericarditis. With almost global concave ST segment elevation and PR segment depression and spodicks sign the most likely diagnosis is acute stage 1 **pericarditis**.	

Management:

- **High dose NSAIDS for 4 weeks** (Ibuprofen 600mg PO every 8 hours, decrease dose 200-400mg every 1-2 weeks).
- **PPI's (Omeprazole or pantoprazole)** - to stop GI ulcer formation from high dose NSAIDS.
- **Colchicine** - improves response, decreases recurrence and increases remission.