A 69-year-old woman presented with acute onset of chest pain and diffuse ST-segment elevation suggesting ischemia (Figure 1). The creatine phosphokinase–MB was elevated, and in view of ongoing chest discomfort, she was referred for urgent cardiac catheterization.

Coronary angiography revealed normal coronary arteries. Ventriculography demonstrated a markedly abnormal left ventricle, with apical ballooning in systole (Figure 2A and 2B). Overall left ventricular function was depressed, with an ejection fraction of 33% and severe mitral regurgitation (Figure 2A and 2B). A midcavity left ventricle gradient of 25 mm Hg was also noted. With supportive therapy, spontaneous clinical recovery occurred within 1 week and left ventricular function returned to normal on follow-up echocardiography at 40 days.

Figure 1. Twelve-lead ECG showing normal sinus rhythm and extensive anterior wall ST-segmental abnormalities.

Figure 2. End-diastolic (A) and end-systolic (B) frame of left ventriculography showing anterolateral, anteroapical, and apical inferior wall dyskinesis with hypercontractile base (left ventricular apical ballooning).
Transient Left Ventricular Apical Ballooning
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