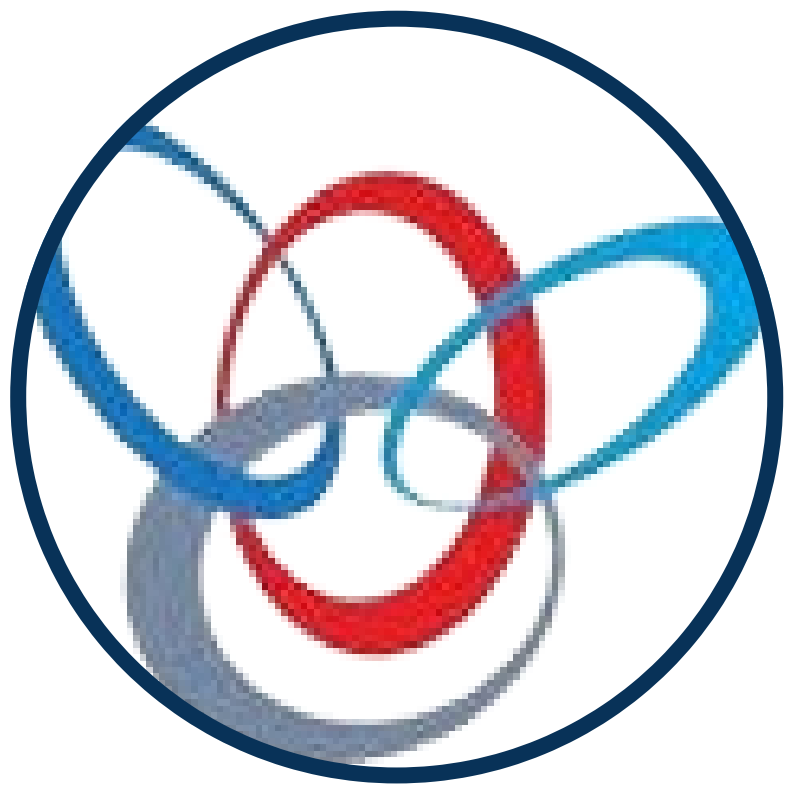


3rd International Conference on Cardiology and Cardiovascular Innovations July 21-22, 2026 | Vienna, Austria



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The Alive “Cardiac Voodoo” - Concomitant status epilepticus, atypical posterior reversible encephalopathy syndrome and Takotsubo cardiomyopathy

Aim

To report a life-threatening brain-heart comorbid clinical case with also intricate management.

Methods/Design

Case Report. 48-year-old female, with reported generalized tonic-clonic (GTC) seizure activity > 30 minutes at home, was brought unconscious to our hospital. One more recurring GTC seizure was witnessed in ED with no consciousness regain. SE treatment and intubation were performed in ED prior to admission to ICU.

Results

Brain MRI hospital day (HD) 1 revealed T2/FLAIR hyperintensities (HI) in the left parietal and bilateral parieto-occipital cortex. A diagnosis of posterior reversible encephalopathy syndrome (PRES) was made. Brain MRI on HD 2 showed improvement of all HI but 4.6/2.8 cm HI in the left parietal cortex, eventually diagnosed as brain mass. EKG on admission showed ST elevation in V1 segment. TTE on HD 2 revealed 1.3 cm left ventricle (LV) apical thrombus (LVAT), hypokinesia, LVEF of 10-15%. IV Heparin was initiated. Coronary angiogram was negative for significant coronary artery disease. Takotsubo cardiomyopathy (TC) was diagnosed. Repeat TTE (HD 8) showed improvement of LVEF to 35-40% and to 50-55% at 19 days post discharge. On HD 8, patient was extubated, had normal neurological examination but mood changes from known bipolar disorder. On HD10, patient was discharged against medical advice on Eliquis, Keppra and with follow-up care.

Discussion/Conclusions

Our clinical vignette highlights the importance of recalling the “cardiac voodoo” heart-brain syndrome and stresses the early EKG and TTE roles in a patient with life-threatening simultaneous occurrence of SE, PRES, left parietal brain mass, for to diagnose comorbid TC with LVAT, with no evidence of which occurred first. The major consequent therapeutic decisions pinpoint the low threshold for cardiac evaluation to mitigate the high-risk morbidity and mortality of such complex potentially fatal cases, when post-seizure TC could present atypically with only hypotension and tachycardia without dyspnea or chest pain.