R on T Phenomenon
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It was 1988 and I had just joined my house job after completing my internship at SMHS hospital, Srinagar. I was in the outpatient department, when a farmer from Shopian district came to me with a history of palpitations. I ordered an ECG, and picked up VPC’s, 5 to 7 per minute. I got up, walked to the room of my consultant and presented my patient with confidence and pleaded for admission in the ward. My consultant took the ECG in his hand and was repeatedly going through it and then uttered, “Look doctor, this patient does not need admission for VPC’s but I am seeing something very dangerous. His VPC is coming just at the end of his T wave and this can be dangerous. Let us admit him for observation in our cardiac unit and attach a monitor immediately and tell the staff nurse to record any abnormality”.

I accompanied the patient, and followed all the orders of the consultant. I was still there watching the rhythm, when the patient became pale, closed his eyes and started convulsing. He was incontinent. I immediately asked for a diazepam injection and gave it intravenous. The patient was quiet and flaccid. His pulse and blood pressure was not recordable. I thought that it could be R on T phenomenon. The rhythm on the monitor was strange and I could not identify it. However I thought it appropriate to give a D.C. shock. It was the first time, I was doing this. So I could not do it well. I immediately gave a second one. It went good. I firmly applied the paddles and also put a little weight on it. Immediately, I noticed a change in the cardiac rhythm on the monitor and I could recognize that it was a normal sinus rhythm. I felt the pulse. His blood pressure was recordable but the patient did not regain his consciousness because he was under the sedative effect of Diazepam. Meanwhile, the rhythm was being continuously recorded.

When our registrar came, I narrated the whole story to him and he started examining the evidence. He declared that patient had indeed developed an R on T phenomenon and the patient had gone into V.T. and V.F. Because of this, the patient developed hypoxia and then a convulsion. He ordered for suction of airway which we had not done so far. He also thought of the possibility of intubation and ventilation. However his respiration was good. It added to my anxiety, when he mentioned that the patient might have developed hypoxic brain damage. I could not sleep well that night and had some very bad dreams. Next day early morning, I reached the hospital early to know about the condition of the patient. I was once again shocked when I saw that the patient was sitting on the bed, without any monitor leads, oxygen, or venous line and was taking salted tea with corn cakes as if he was hungry for many days. I repeatedly asked him, as to what had happened to the patient who was here yesterday, till the nurse of the ward came and told me that he, in fact, was the patient.

Conflict of Interest: None

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