**BRUGADA PHENOCOPY, NOT A COPY OF BRUGADA SYNDROME**

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Brugada electrocardiographic patterns consist of a distinct ST elevation pattern in right precordial leads that have been a hallmark of Brugada syndrome (BrS). BrS is an autosomal dominant mutation of cardiac voltage-gated sodium channel that presents with Brugada pattern on EKG in otherwise young, healthy adults, and can predispose them to malignant ventricular arrhythmias and SCD. Unlike BrS, Brugada phenocopy (BrP) are EKG findings that are indistinguishable from brugada pattern seen in BrS and are caused by various clinical circumstances unrelated to sodium channels and resolve upon resolution of inciting injury. Presented below is a case of 1 of the 6 clinical entities that have been identified thus far to cause BrP. A 73-year-old, Hispanic male with HTN, DM, and BPH presented to ED with 1-day history of generalized body aches and chest pain associated with fever and dysuria. He denied history of syncope, palpitations, or prior history of cardiac disease. There is no prior use of Na channel blockers. Denied any family history of cardiac disease. Initial vital signs revealed temperature of 39.1oC. Labs revealed leukocytosis up to 30,000, UA significant for UTI, and elevated serial Troponin with peak of 1.65. Initial EKG revealed ST elevations >2mm with slow concave descent in V1-V2, typical of the coved pattern seen in Brugada type 1. Patient was admitted for NSTEMI and sepsis due to UTI. He was started on continuous heparin infusion and received antibiotics and antipyretics. Left heart catherization demonstrated 50% stenosis of LAD. Serial EKGs and troponins were performed: both of which normalized with defervescence. To differentiate BrP from BrS, systemic diagnostic criteria have been established. This becomes crucial in cases like this where ischemia can either unmask true congenital BrS or induce BrP. The confounding aspect about this case is differentiating whether the Brugada pattern was a true BrS unmasked by a febrile state or an induced BrP from increased cardiac demand in setting of sepsis surfacing the LAD obstruction. We recommend recognizing BrP as a differential diagnosis of BrS and using the diagnostic criteria to assist in diagnosis to avoid unnecessary testing and interventions.