**PERSISTENT ST ELEVATION: HYPERTROPHIC CARDIOMYOPATHY RARELY DISCUSSED**

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ST elevations noted on an electrocardiogram (ECG) can be ominous. When noted in the setting of a total coronary artery occlusion, it infers a high mortality. Mortality rates have dropped due to timelier reperfusion. Though clinicians must respond expeditiously, it is of utmost importance to properly assess the patient and determine whether the ST elevation in fact represents an acute coronary syndrome (ACS). We present a case of persistent ST elevation noted on ECG that does not represent ACS or left ventricular (LV) aneurysm, but rather hypertrophic cardiomyopathy (HCM). This is a 72 year-old-male with history of hypertension and renal cell carcinoma status post nephrectomy who presented with worsening lower extremity pain. Emergency room team obtained an ECG and cardiac biomarkers; due to concern for ST elevation myocardial infarction (STEMI), cardiology was consulted. Cardiology team assessed the patient who had no chest pain (or history of such) and had multiple previous ECGs with ST elevations that were similar in appearance. It was felt that this was not an ACS and thus left heart catheterization (LHC) was deferred. Echocardiography did not reveal regional wall motion abnormalities. Instead, there was moderate LV hypertrophy with dynamic LV outflow tract obstruction. Cardiac enzymes were followed and remained static (range of 0.17-0.3 mg/ml) throughout hospitalization. Serial ECGs were unchanged. Since the patient remained hemodynamically stable, he was discharged home. STEMI is a true cardiac emergency and clinicians often have a low threshold to contact cardiology if concerned. While it is essential to be prudent and not dismiss a STEMI, it is also important to have a broad differential for ST elevation on ECG, as LHC presents its own inherent risks. Two common causes of ST elevations are STEMIs and LV aneurysms. In this case, we present another: HCM. ECG has a specificity of 97% as a tool of diagnosis of HCM and ST elevation has been described as a finding associated with HCM. A thorough history, physical exam, and review of the patient’s records were essential in the management of this patient, who had kidney injury with a solitary kidney, and prevention of unnecessary morbidity from contrast exposure.