The Clinical Picture
Osborn waves: An inverse correlation with core body temperature

A 22-year-old man was brought to the emergency room after a motor vehicle accident. He was in a deep coma, with a Glasgow coma score of 4 out of 15 (3 being the worst score) and a core body temperature of 36°C (96.8°F). The next day, clinical evidence of brain death was noted, and his core body temperature dropped as low as 29.6°C (85.3°F). At that time, his electrocardiogram revealed sinus bradycardia, with a rate of 48 beats per minute, PR interval 0.24 second,

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QRS interval 0.16 second, corrected QT duration 0.5 second, and classic high-amplitude Osborn waves (J waves) that were evident in all leads. Figures 1, 2, and 3 show the effect of various degrees of hypothermia on the electrocardiogram.

The Osborn wave (J wave) is the result of a transient, outward, potassium-mediated current in the ventricular epicardium but not the endocardium, corresponding to a notch in the action potential. This gives rise to a transmural voltage gradient during early repolarization, which appears as the J wave on electrocardiography. It is more pronounced in hypothermia, disappears after normalization of the body temperature, and is usually evident in the inferolateral leads.

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The three electrocardiograms presented here illustrate several points:

- Classic findings in hypothermia include J waves, sinus bradycardia, prolongation of the PR interval, widening of the QRS complex, and prolongation of the QT interval.
- The lower the core body temperature, the higher the amplitude of the J wave.
- The J wave in brain death (unlike hypothermic causes of the J wave) is not associated with the characteristic signs of shivering in the surface electrocardiogram.
- As hypothermia becomes more profound, the J wave becomes evident in all leads, not only the inferolateral leads.

REFERENCES


ADDRESS: Hesham R. Omar, MD, Internal Medicine Department, Mercy Hospital and Medical Center, 2525 South Michigan Avenue, Chicago, IL 60616; e-mail hesham_omar2003@yahoo.com.