

Myopericarditis

A 35 year old man presents to A&E having been awoken with severe central chest pain, sweating and nausea. He was tachycardic, a little hypertensive and pyrexial @ 37.8. He had no risk factors for a cardiac event, therefore was suitable to come to CDU.. He was to have an MI screen and a period of observation.

Day 1

On arrival to CDU he was still tachycardic, however , his blood pressure was lower and his temperature was 37. The routine bloods taken in A&E showed nothing significant except that his CRP was raised @ 43. The four hourly ECG was not due until 11am and the 12 hourly ECG and TroponinI were due @ 15.30. He had still had central chest pain which had not been relieved by S/L Buccal in A&E, therefore, analgesia was given .

The ECG taken on admission to A&E showed possible T wave inversion in lead III. The ECG stated that there was a possible inferior infarct “ACUTE MI”, however it was reported as nil acute. It was repeated 45mins later and stated exactly the same as previous.

The 12 hourly Troponin I and ECG were taken @ 15.30. The ECG showed T wave inversion in lead III and AVF. .It was reviewed by the CDU fellow on duty and nil to thrombylise. The results would not be ready until the next day. The patient was comfortable and did not voice any chest pain to the nursing staff or Doctors.

Day 2

When reviewed by the CDU fellow, the patient complained that he had flu like symptoms for 1/52. The examination was unremarkable. When the CXR was reviewed it showed a bulky mass in the right hilum, prominent vasculature. Collapse ?? neoplastic lesion ? cause.



What is the radiological diagnosis?

What is the diagnosis?

Answer: ? Cardiac Chest Pain ,GORD/PE

How would you manage this patient?

In view of the suspicious mass in the right hilum, the CXR needed to be reported. A further blood test was taken for D-dimer to exclude a possible thrombus. To review when the results were all available

At 12 midday the results were back. The D-dimer was negative, however, the CK was raised @ 763 and the Troponin 1 was also raised @ 9.12. The Dr was informed immediately and came to see the patient within 40 minutes. The patient was made aware of the implications that it was probably myocardial damage secondary to a heart attack or ischaemia. It was discussed with Cardiology and transfer to CCU was arranged immediately. The CXR would be reviewed on CCU with the radiologist.

How would you manage the patient on CCU?

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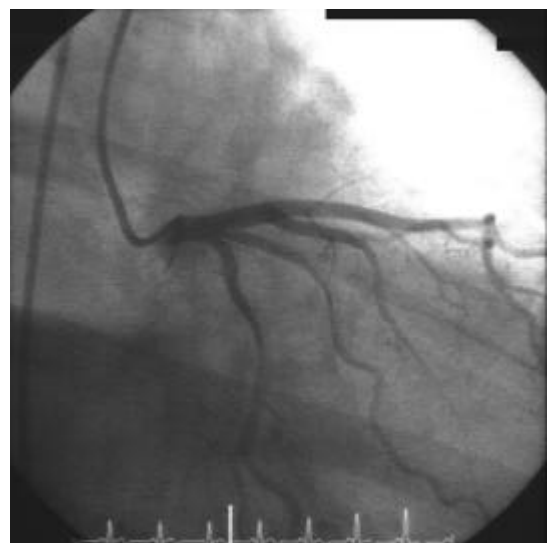
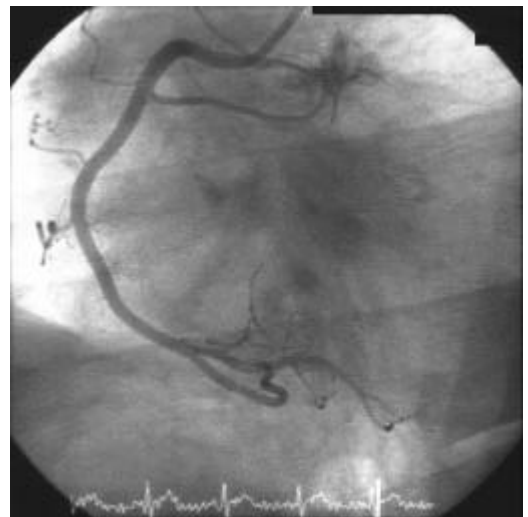
Treat as Acute Myocardial Infarction
Commence Aspirin, Clexane, Beta-blockers and Ace Inhibitors
Will need inpatient Angio to confirm diagnosis
If lesion then PCF
Echo to see if any effusion suggesting pericarditis
Reg review

A portable ECHO was performed on CCU which was completely normal.

Day 3

Reviewed by Dr Mc Lennaghan, who thought that the ECG changes could fit Myopericarditis/IHD..
The patient should have a diagnostic angiogram (+/- PCI) later today, then review.

Angiogram –normal



What is the final diagnosis?

Answer: Viral Myopericarditis

How would you manage this patient?

Stop Clexane, aspirin, Beta-blockers, Ace inhibitors
Administer NSAID if pain recurs
Review tomorrow;- home if settled without any follow up.

Day 4

Patient was pain free and mobilising. His observations were stable, therefore he was able to be discharged home. He was advised to refrain from work for 1 week and to attend follow up in 6 weeks time.

Key learning points

1. Always bear in mind patients' who present with chest pain who also complain of vague cold/flu like symptoms as this may mislead the diagnosis.
2. Are Troponin results accurate enough to be relied on to make an accurate diagnosis ?
(to be investigated with Chemical pathology dept.)

References / Links

<http://www.cdc.gov/mmwr/preview>
<http://www.mamashealth.com/myocarditis>
<http://home.coqui.net/myrna/virus.htm>
<http://www.infectiousdiseaseneews.com>
<http://www.nlm.nih.gov/medlineplus>
<http://www.emedicine.com>
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