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Real case – from data to practice

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President, Heart failure Society of Serbia

Case presentation

- Male, 33y, tennis player

- **Respiratory infection, productive caugh, followed by dyspnea, fatigue, fever up to 39 °C**
- **Hospitalization in regional hospital: EDDLK 7.3cm, EF 20%, ascites, right side bronchopneumonia on Chest X-ray**
- **Tx : antibiotics i corticosteroids**
- **Worsening HF, transferred to University clinic on milrinon**
- **NYHA II-III on admission to our department**

Case presentation

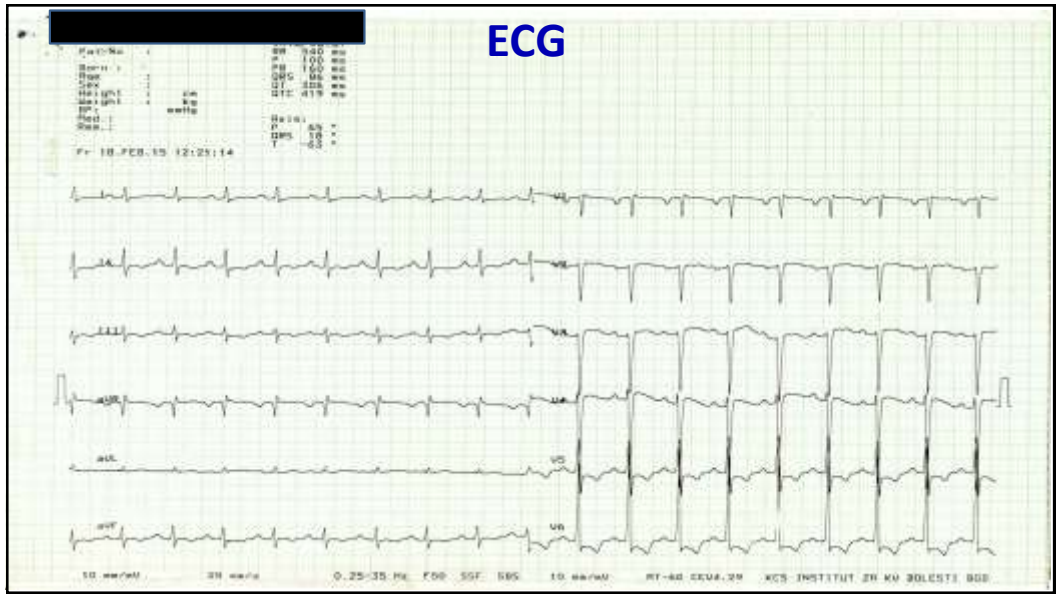
Personal hystory:

- **Frequent bronchitis with fever in past history**
- **Risk factors: smoker (3y, 1pack/d), familly history (father CMP, uncle AMI in 60y).**
- **No allergies, no alchocol or drug abuse**

On admission:

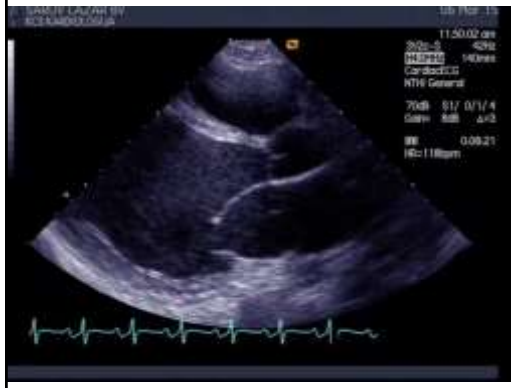
- **Afebrile, no signs of cyanosis and icterus, mildly dyspnoic, musculous**
- **(170cm, 53kg)**
- **Normal lung sound**
- **Systolic murmr on apex 2/6, BP- 100/70mmHg**
- **No no lymphadenopathy, hepatosplenomegaly or peripheral oedema**

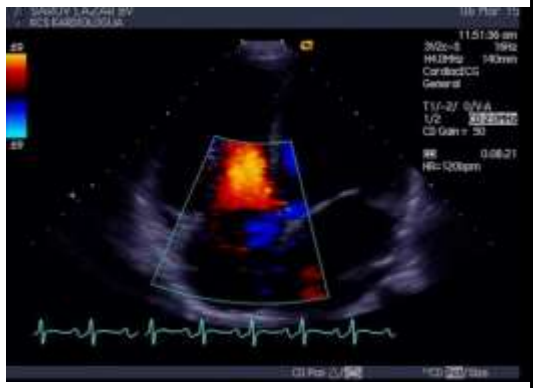
BNP-500



TT Echo exam

February 2016.

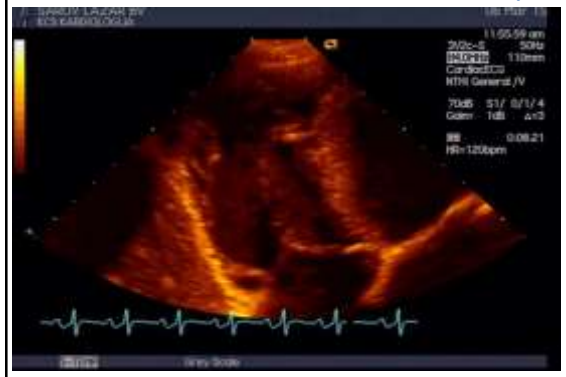


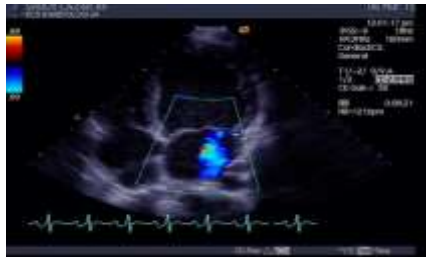


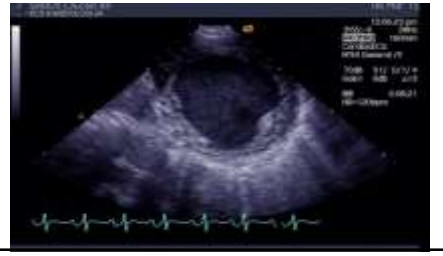
Dilated CMP
LVEF: M mod 8.5%, biplane 12.5%

TT Echo exam

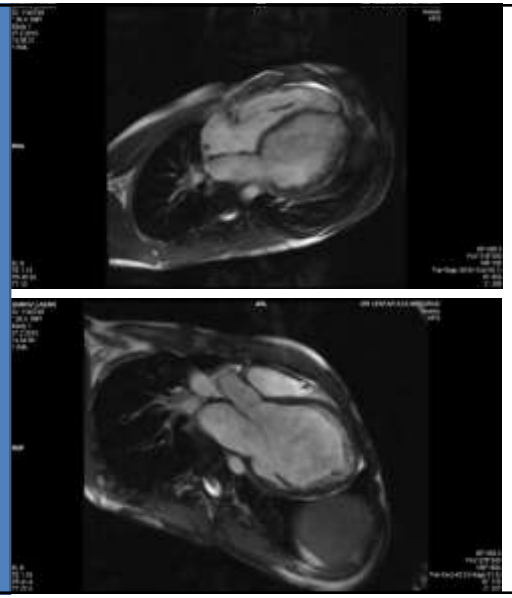
February 2016.







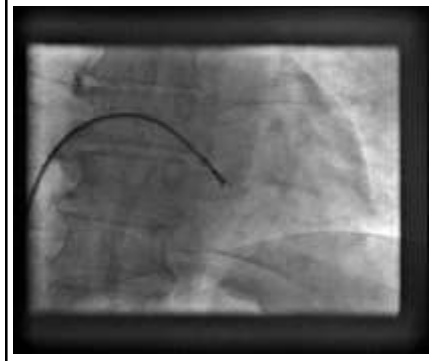
LK apical rocking (intraventrikular asychrony)
MR 2-3+ i TR 2-3+, PR 2-3+, AR 1+, RVSP 45mmHg, RV 2.5cm, FAC 32%, TAPSE 1.99
Possible to implant LVAD, and CRT?!

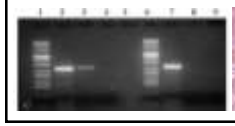


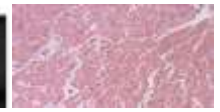
NMR

- Lateral LV wall oedema, no late enhancement change in signal intensity
- Diffferential dg: myocarditis

Right heart catheterization and endomyocardial biopsy







- PCWP 15mmHg, mPA 22mmHg, RVSP 38mmHg, CO 4.07l/min, SAR 1375, PAR 176
- Pathohystology: non specific finding of lightly dilated myocardium, not enough criteria for myocarditis
- PCR: no viruses detected

24h Holter ECG

- s.r., fr 84-125/min (average 103/min)
- 15 single focus monomorphic VES
- 14 SVES, 1 string 5 SVES
- No pauses detected

Control TT Echo exam

March 2016.

- Dilated CMP, larger motion amplitude for mitral and tricuspid valve, other findings as before – not candidate for LVAD
- Ao 2.7cm, AR1+, MR 2+, LA 3.8x4.7x6.0cm, LK 6.9/6.3cm, EF 18%, RV 2.7cm, TAPSE 2.45cm, FAC 18.7%, TR 2-3+, SPDK 48mmHg, VCI 2.0-1.2cm.

March 2016

Discharge from our department

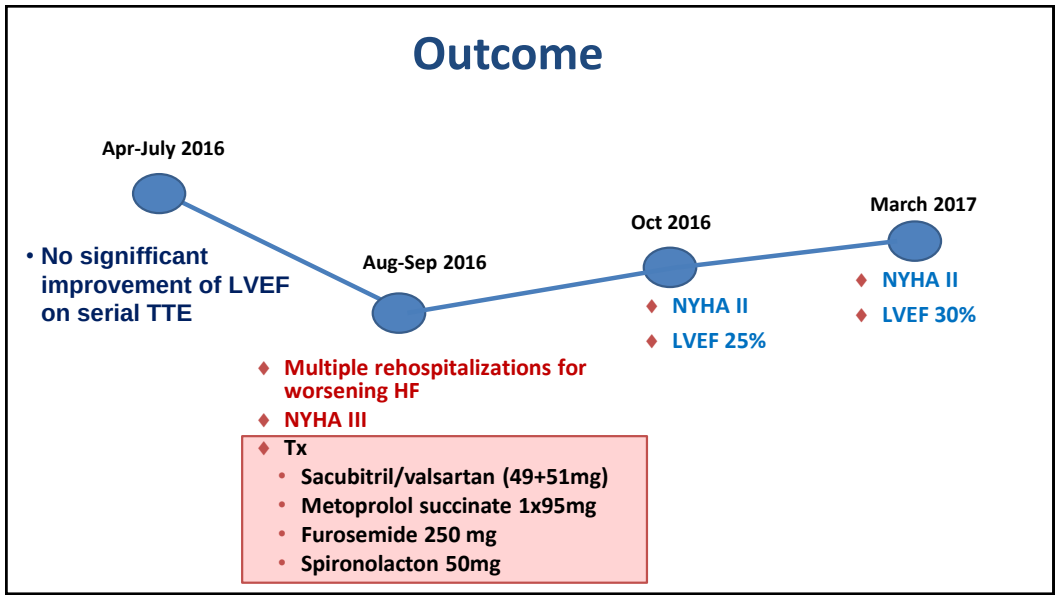
- NYHA II
- Compensated (BP 120/70mmHg, HR 70/min)

Tx:

- Ramipril 2.5mg
- Metoprolol succinate 95mg
- Furosemide 125 mg
- Spironolacton 50mg

- Conclusion: control TEE and ergospyrometry in one month, decision for ICD/CRT implantation

Outcome


Apr-July 2016
• No signifficant improvement of LVEF on serial TTE
Aug-Sep 2016
♦ Multiple rehospitalizations for worsening HF
♦ NYHA III
♦ Tx
• Sacubitril/valsartan (49+51mg)
• Metoprolol succinate 1x95mg
• Furosemide 250 mg
• Spironolacton 50mg
Oct 2016
♦ NYHA II
♦ LVEF 25%
March 2017
♦ NYHA II
♦ LVEF 30%