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### An unusual presentation of an unusual disease: Myopericarditis

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**M**yopericarditis is an inflammation of both the pericardial sac and the myocardium. In clinical practice they usually co-exist. The clinical presentation is variable and depends on the area of myocardium involved. Symptoms range from mild to no chest pain to fulminant heart failure, syncope or sudden cardiac death. About 50% of the cases are idiopathic and the rest can be divided into infectious, neoplastic, autoimmune, metabolic, trauma, and drugs. The most likely etiology involves a viral infection –commonly Coxsackie B. 27 year old AAM with no past medical history came to the ED with abdominal pain. CT of the abdomen showed widespread pneumatosis, consistent with perforated viscus favoring a ruptured appendix. Patient was unstable and was emergently taken to the OR during surgery, large amount of purulent material was found in the peritoneal cavity, after which patient was transferred to the ICU. At this time patient troponin level was undetectable. Echo showed EF of 70% with no Wall motion abnormality (WMA). Despite being on appropriate antibiotics for two days, WBC was elevated with worsening LFT's, and creatinine. On day 3, new ST elevation were noted on telemetry mainly in leads II, III, avF and V5 with a troponin level of 57. Patient was started on ASA, and a heparin drip, though the suspicion for atherosclerotic disease was low (young age and no risk factors). Patient maintained his EF on the repeat echo and still did not have any WMA. Repeat CT of the abdomen showed multiple areas of loculated fluid, one of which was along the liver margin, directly underneath the right ventricle. The Next day, the patient was taken back to the OR for an abdominal washout. Subsequently, patient had resolution of ST elevations, heparin was discontinued, and troponins had normalized within 2 days. Myopericarditis can be diagnosed when there is an elevation of cardiac biomarkers in the presence or absence of chest pain or if there is myocardial inflammation seen on the cardiac MR or acute heart failure with reduced EF. Other common findings are ventricular arrhythmias, new bundle branch blocks and IVCD. It's very unique to have myocardial damage through a localized infectious source such as an abscess as in this case and present with STEMI. It's important to acknowledge the etiology because management of myopericarditis induced STEMI is very different from when there is an occlusive coronary artery disease. This patient was managed medically with ASA, blockers and Lisinopril as tolerated without activating the CATH lab. Understanding the pathophysiology can help with decision making when caring for patients with an unusual presentation.

### Poor lipid control among coronary heart disease patients receiving statins in India

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**Background and objective:** Lipid control to target is essential in patients with established Coronary Heart Disease (CHD). To determine prevalence of target oriented LDL cholesterol in patients with diabetes and CHD we performed a study.

**Methods:** Successive new patients presenting to cardiac out-patient department were enrolled in the study. The patients were classified into Group I- non-cardiac/non-diabetic, Group II- CHD without diabetes, and Group III- CHD with diabetes. Groups II and III were further stratified into those taking or not taking statins for at least 3 months. Descriptive statistics are presented.

**Results:** We enrolled 1032 patients, 123 (15.8%) in Group I, 403 (37.2%) in Group II and 506 (46.8%) in Group III. There were 40% females and 64% subjects were in age-group 35-50 years. In Group I, II and III respectively, mean total cholesterol was 176.8, 229.7 and 238.6 mg/dl, LDL cholesterol was 92.2, 132.4 and 159.0 mg/dl and HDL cholesterol was 56.8, 34.6 and 36.8 mg/dl (ANOVA  $p < 0.01$ ). In combined Groups II and III among patients on statins vs. not on statins only 26.4 vs. 6.1% had total cholesterol  $< 200$  mg/dl and 8.4 vs. 1.1% had LDL cholesterol  $< 100$  mg/dl ( $p < 0.05$ ). Revised target of LDL cholesterol  $< 70$  mg/dl was not achieved in any case.

**Conclusions:** There is dismal control of lipid levels in free-living patients with CHD in India.

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