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## Masquerading acute myelogenous leukemia

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We present a case of a 48-year-old male who presented with worsening pleuritic chest pain for two days. He also complained of fever, malaise, headache and severe neck pain. On admission, electrocardiogram (ECG) showed ST segment elevation in leads I, II, aVL and V5 with PR elevation and ST depression in aVR. Troponin-I was 14.8 ng/ml. Based on the ECG changes, elevated troponin and family history of early coronary artery disease, patient was emergently taken to cardiac catheterization lab. Angiography showed non-obstructive coronaries, mild hypokinesis of mid inferior and anterolateral wall with ejection fraction (EF) of 40-45%. Based on the above presentation and angiographic findings, the diagnosis of acute myopericarditis was made. He was started on colchicine and ibuprofen. Other workup to determine the etiology of myopericarditis was negative (shown in detail in the presentation). Given the history of fever, headache and worsening neck pain, we became suspicious of meningitis. Lumbar puncture was performed which was negative. On the day of admission, he was found to have blasts on complete blood count and peripheral smear. Bone marrow biopsy and flow cytometry confirmed the diagnosis of acute myeloid leukemia (AML). He received induction and salvage therapy. Repeat bone marrow confirmed complete remission and normal cytogenetics. Although pericardial or myocardial biopsies are unavailable for our patient, in the absence of other causes, it does appear that his acute myopericarditis was secondary to AML. Our case highlights pericarditis as an initial manifestation of AML which is a rare phenomenon.

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