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75-year-old mean with a broken heart survival of left ventricular free-wall rupture in completed myocardial infarction

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Heart rupture is a major lethal complication of acute myocardial infarction (MI), with an incidence as high as 5.6% in the pre reperfusion era, and 1.7% after the introduction of primary percutaneous coronary intervention (4 and 6). In a global registry performed among 60198 patients, 273 (0.45%) had heart rupture (4). In this study the incidence was 0.9% for ST-segment elevation myocardial infarction (STEMI), 0.17% for non-STEMI, and 0.25% for unstable angina. (4). Heart rupture is almost exclusively seen ST- elevation myocardial infarction (STEMI), very rare cases are reported for NSTEMI. Despite advances in diagnostic procedures and surgical techniques, hospital mortality remains high (80%) in patients with left ventricular free wall rupture. In this case, we present a 75 y/o male who had free wall rupture in the apex, which caused acute tamponade after completed myocardial infarction and survived this lethal complication. A 75-year-old man with past medical history of hypertension, type 2 diabetes mellitus, and hypothyroidism who presented to the emergency department complaining of severe oppressive retrosternal chest pain 10/10 in intensity for approximately 30 minutes duration, which radiated into his jaw and left arm, and was associated with nausea and diaphoresis. The patient also reported three episodes of chest pain earlier that day, each lasting approximately 10 min. A 12 lead electrocardiogram (ECG) showed Q waves and ST elevation in II, III, and aVF. Cardiac enzymes were elevated; CK-MB at 12.30 U/L, and troponin I 2.840 ng/L. Patient was treated with dual antiplatelet therapy, high dose statins, and anticoagulation was achieved with enoxaparin 1 mg/kg every 12 hours. On the second day following the myocardial infarction he arrived to our institution for coronary angiography, but before the procedure has started he developed mental changes, hypoxia, and persistent hypotension for which needed vasopressors. Physical examination revealed a man in obvious distress with a blood pressure of 70/40 mmHg and a sinus tachycardia of 110 beats/min. Physical examination showed muffled heart sound, bounding JVD, and lungs were clear to auscultation. Echocardiography was done and showed global thinning of left ventricle, diffuse global hypokinesia, large pericardial effusion, and cardiac tamponade physiology was diagnosed. Color flow Doppler imaging failed to identify an area of rupture. Patient was resuscitated with intravenous fluids and inotropes and an urgent cardiothoracic surgery was performed. Bleeding from a myocardial tear at the apex of left ventricle was identified with several blood clots at the rupture. Patient underwent emergency mediastinal exploratory, hematoma removal, and apex repair. The patient recovered well after surgery and was discharged home 12 days following the operation. This case demonstrated that left ventricular free wall rupture is not always fatal and that early diagnosis and high vigilance of clinicians to this condition can develop in a successful outcome.

Biography

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