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A 44 year old male presenting as ST elevation myocardial infarction in Kawasaki disease: Case report

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Introduction: Kawasaki disease is a form of vasculitis that is self-limiting and usually occurs in children. Its incidence is high in Japan and in Korea. Several causes have been inflicted as a trigger to Kawasaki but some studies mentioned toxins such as fungal toxin or bacterial super antigen. In children, it is easy to diagnose by using the clinical criteria such as persistent fever of more than 5 days, lymphadenopathy, strawberry tongue, rash and conjunctivitis. However, this criteria has not been widely accepted in adults. In Kawasaki disease, 25% of them may present with coronary artery aneurysm. It is defined as dilatation of more than 1.5 times of the patient's largest coronary.

Case: This is a case of a 44-year old male, hypertensive, smoker, physician who came in due to sudden onset of chest pain. The pain was described to be chest heaviness, continuous, not relieve by rest, VAS 7/10. His family had no history of premature coronary artery disease. He had recurrent rhinitis and conjunctivitis during his childhood. On examination, he was stable with the following vital signs: blood pressure of 120/70, heart rate of 70 beats per minute, a respiratory rate of 18 cycles per minute, temperature of 36.8 C. He weighs 90 kg with a BMI of 21. His electrocardiogram revealed an ST segment elevation over the inferior leads (leads II, III and aVF). Initial troponin showed normal result but there was a 20% increment on the repeat troponin determination. Two dimensional echocardiography showed preserved ejection fraction of 75% with adequate wall motion and contractility. With the presentation of classic angina and electrocardiogram result, he was brought to the catheterization laboratory for an emergency double set up. Emergency coronary angiography was done and revealed an ectatic right coronary artery with a large aneurysm over the distal segment and thrombus within its lumen. Aspiration thrombectomy was done hoping that the lumen would be free from thrombus but none was aspirated. Intracoronary Tirofiban was also administered. There was regression of the ST elevation. The patient was admitted for 5 days and was maintained on dual antiplatelet and anticoagulation. Currently, he is asymptomatic, ongoing rehabilitation with stable vital signs.

Conclusion: Although atherosclerosis is the most common cause of Acute Coronary Syndrome, we should be mindful to the feasibility of unwonted causes of angina like dissection, inflammatory or autoimmune diseases. As a cardiologist, we should be wary with high index of suspicion of these rare entities as a cause of angina.

Biography

Francis Carl L. Catalan MD is presently an Adult Interventional fellow at Cardinal Santos Medical Center. He had his premedical major in Bachelor of Science in Physical Therapy. Following a completion of his Internal Medicine residency at the East Avenue Medical Center and Adult Cardiology training in Philippine Heart Center. To further augment his acquired clinical expertise and skills, he worked and acquainted himself in various hospital settings for 3 years. His competence as a doctor is not only existent in a clinical setting. But holistically, he exhibited competency in research and scientific presentations. He is duly recognized by various renowned research committees in Hong Kong, and Dubai. He is also interested in interventional and experimental cardiology.

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