SMGroup

SM Journal of Cardiology and Cardiovascular Diseases

Case Report

Diary of a Myocardial Infarction: A Case Report

Kaufeld T*, Fleissner F, Cebotari S, Schmitto J, Kühn C, Mollitoris U, Haverich A and Martens A

Department of Cardiothoracic, Transplant and Vascular Surgery, Hannover Medical School, Germany

Article Information

Received date: Apr 10, 2018
Accepted date: Apr 24, 2018
Published date: Apr 26, 2018

***Corresponding author**

Tim Kaufeld, Department of Cardiothoracic, Transplant and Vascular Surgery, Hannover Medical School, Carl-NeubergStrasse 1, 30625 Hannover, Germany,
Fax/Tel +49(0)511 532 2255;
Email: kaufeld.tim@mh-hannover.de

Symptoms of acute myocardial infarction may vary and occur with manifold qualities. Due to this reason many patients may misinterpret their subjective perception. One drastic case was documented by a 69 year old patient himself, on his private typewriter starting at December 24, Christmas.

Instead of consulting a physician this patient had documented his suffering in a personal diary. He handed his diary to the emergency doctor at the time of his admission. Here we would share the translation of the letter as it was written by the patient.

"My stomach reacts to stress immediately and I constantly have some air-burping and swallowing difficulties. So at Christmas Eve, I felt severe oppressive pain behind my breastbone. We have had lots of fatty foods, alcohol and baked goods to eat. Due to the fact that I have had a myocardial infarction 1999 and the fact that I frequently feel angina pectoris in stressful times, I took two tablets of diazepam combined with a small glass of caraway-flavored liquor for relief. All physical complaints disappeared at first. At the third day however, the 26th of December, the pain had increased so badly that I felt like jumping out of the window because of the discomfort. At the same time my belly hardened unbelievably, as if cramping. Mucus moved up to my esophagus, my vocal chords felt coated and my tongue seemed strangely transformed, so white and covered with mucus. It was clear to me, that this was due to my stomach problems. I didn`t eat for the next two days. Furthermore I suffered from excruciating pain in both arms, in my hands and up to my ears.

From Dec 29th on, the pain was only bearable when I consumed some oatmeal gruel, aloe vera gel and silicic acid gel. There was no nausea, no vomiting, no black defecation, normal urine color, no flatulence or fever. As a precaution though, I took ¼ tablet of Bisoprolol (beta blocker) and ¼ tablet of Ramipril (ACE inhibitor).

***Problem:** After a period of 10 days my weight had decreased to 63 kg and I could barely move at all. When I drank some hand-warm water my arms started to burn followed by massive pain behind my breastbone. I worry about my kidneys.*

***Current Status**: At 174 cm my weight decreased to 62 kg. I feel dehydrated. I wake up in the morning with fast and irregular pulse associated with mild pain in my arms. If I don`t have prompt defecationin this situation, the pain behind my breastbone increase at once. When I consume some oatmeal gruel I feel better instantly. My stool seems to be greenish. My tongue fells more sensitive and tingling. Once a day I develop some kind of dry cough. To avoid further pain I have to take in food every 4-5 hours. The most unpleasant sensation is my physical weakness, I don`t want to stand up at all and feel totally exhausted".*

The patient was admitted to our hospital two weeks after he first documented his suffering. He was in a cardiogenic shock and was treated at our intensive care unit for further 6 weeks. The initially performed echocardiography could verify a Left Ventricular Ejection Fraction (LVEF) of 16% (a.Simpson) as well as a severe mitral valve insufficiency. The first ECG showed no ST-changes. Blood chemistry proofed an elevation of cardiac muscle enzymes. An immediately implemented coronary angiogram showed a total occlusion of the Circumflex artery (CX) and severe stenosis of the left main coronary artery and the right coronary artery. A coronary artery bypass graft and a mitral valve replacement were performed as a case of emergency. Due to failed weaning from extracorporal circulation and increasing need of inotropes the patient required Veno-Arterial (VA) Extracorporal Membran Oxygenation (ECMO) support. Haemodialysis was induced right after surgery. Despite VA-ECMO treatment the left heart chambers remained dilated so that an additional Impella Pump support was established at the first postoperative day for left ventricular unloading against venoarterial ECLS. Extensive anticoagulation caused a haematothorax with the need of a re-sternotomy just one day after. Five days following the CABG no further improvement of the global

left ventricular ejection fraction was visible so the decision was made for the implantation of a Left Ventricular Assist Device (LVAD). VA-ECMO and Impella support were removed during LVAD implantation. In the ongoing course the patient remained under stabile conditions. Tracheotomy was performed two weeks after LVAD-Implantation. High dose catecholamines were consistently administered. Nearly one month after admission the patient required an emergency - laparotomy due to laceration of his liver, possibly due to the anticoagulation and pre-existing cholezystolithiasis. Subsequent to this procedure two further laparotomies were needed. As a result of the severe complications the patient developed a severe right-heart failure with application of a right – heart bypass using a transjugularvenous – pulmonary artery ECMOsystem.

Despite of these 6 weeks of extensive intensive care treatment our patient died of multi organ failure. This tragic case undermines the importance of educating our patients with cardiovascular risk factors to consult a physician early on, especially if symptoms are unspecific and refractory.