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Ecmo as bridge to recovery in a case of fulminant myocarditis

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A 41 year old female Caucasian patient, with no past medical history visited the emergency department of a peripheral hospital complaining of 3-day fever, nasal congestion and fatigue. During her evaluation the ECG showed diffused ST elevations, elevated troponin levels and reduced ejection fraction (LVEF 35%). She was admitted in the cardiology department and a few hours later became haemodynamically unstable (BP 60/40 mmHg, HR 120bpm) and anuric. Noradrenaline and dobutamine were started with no significant improvement and the decision was made to get the patient transferred to our centre for further treatment. On her admission, the patient was intubated, hypotensive and tachycardic on high doses of both dobutamine and noradrenaline, with cold extremities, non palpable peripheral pulse and anuric. Her ECG showed diffused ST segment elevation and the bedside ECHO displayed global hypokinesia (LVEF<20%), no pericardial effusion and no significant valvular pathology. We immediately inserted an intra-aortic balloon pump and performed a coronary angiogram that was normal as well as a myocardial biopsy. The biopsy specimen was indicative for active myocarditis. As the patient on IABP was not improving we decided to support her with ECMO. The patient remained on ECMO for 10 days with progressive improvement of her haemodynamic status as well as the function of the left ventricle. 10 days later, ECMO was removed and the patient needed only small doses of inotropes. She was transferred to the ward for further rehabilitation and inotrope weaning.

On exit, the patient had fully recovered and her LVEF was normal.

In conclusion, we describe a case of fulminant myocarditis successfully treated with ECMO as a bridge to recovery.