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A case of amebic pericarditis precluding prompt diagnosis

Authors:
AS Saito¹, TA Asano¹, AM Mizuno¹, NK Komiyama¹, ¹St. Luke's International Hospital - Tokyo - Japan,

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71-year-old men came at emergency department presented epigastric pain last 2 weeks. His past medical history essential thrombocytosis treated with anagrelide. His ECG showed slightly ST elevation in V2 and PR depression in V5-6 (Figure 1). Chest-X-ray showed cardiomegaly and lung congestive (Figure 2). Laboratory test showed no elevation of myocardial enzyme and increased NT-pro BNP. Echocardiography showed normal left ventricle wall motion with small amount of pericardial effusion near left ventricular posterior wall. We diagnosed acute heart failure caused by anagrelide at that time and stopped anagrelide. On the 3rd admission day, the blood test showed white blood cell count and c-reactive protein increased 13500/µL and 8.04 mg/dl. Chest-X ray showed left pleural effusion (Figure 3). We performed thoracentesis at left side. The result showed exudative pleural effusion without and malignant cell. We changed the diagnosis to pleurisy and started ibuprofen. On the 7th admission day, he presented chest pain, dyspnea, hypotension (80/66mmHg) and tachycardia (104 bpm). Computerized tomography (CT) showed large amount of pericardial effusion (Figure 4). We performed pericardiocentesis for cardiac tamponade. The result also showed exudative pleural effusion without and malignant cell. We added colchicine as idiopathic pericarditis. Inflammatory marker decreased gradually, on the 13th day, he discharged the hospital. One month after the discharge, he presented fever. We took CT that showed new liver abscess (Figure 5). The serum antibody to Entameba is positive and Entameba PCR in the abscess and pleural and pericardial effusion is positive. We definitive diagnosis amebic pericarditis.