Case report

Takotsubo cardiomyopathy triggered by SARS-CoV-2 infection in a critically ill patient

Fadi Taza, Mary Zulty, Arjun Kanwal, Daniel Grove

SUMMARY

COVID-19 became a global pandemic in early 2020. While well known for its pulmonary manifestations, the virus also has a number of cardiac manifestations as well. Takotsubo syndrome has scarcely been reported in patients with COVID-19, but it is possible that the cytokine storm associated with the infection can trigger Takotsubo syndrome in patients with underlying risk factors for Takotsubo (emotional distress, physical distress, history of psychiatric disorders).

BACKGROUND

COVID-19, also known as severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), which originated in China in late 2019, has spread rapidly resulting in a global pandemic. The cardiovascular complications remain under investigation. Here, we present a case of Takotsubo syndrome in a patient with COVID-19 infection.

CASE PRESENTATION

History of present illness

A 52-year-old man presented to the emergency department with shortness of breath. He was altered, febrile, tachypneic and hypoxic. Lung auscultation revealed bibasilar crackles and cardiac examination was normal. Laboratory tests were significant for an elevated C-reactive protein (276 mg/L), elevated D-dimer (3.45 μg/mL) and normal troponin I (<0.015 ng/mL). In the emergency room, he underwent endotracheal intubation due to acute hypoxic respiratory failure and altered mental status, and admitted to the intensive care unit. On the evening of hospital day 2, he became haemodynamically unstable and noted to have ST segment elevations on the telemetry.

Medical history

The patient is a nursing home resident with history of schizophrenia, diabetes mellitus and hypertension. He was recently diagnosed with SARS-CoV-2 by reverse transcription PCR of a nasopharyngeal swab at his nursing home.

INVESTIGATIONS

ECG revealed ST segment elevations in the inferior leads (II, III, aVF; figure 1). Laboratory testing demonstrated normal levels of cardiac troponin 1 (<0.015 ng/L; reference range (RR) <0.045 ng/L). He underwent emergent coronary angiography due to haemodynamic instability, which revealed non-obstructive coronary arteries (figure 2) and apical ballooning on ventriculography (figures 3 and 4), consistent with Takotsubo syndrome. The estimated left ventricular (LV) ejection fraction was 45%.

DIFFERENTIAL DIAGNOSIS

The differential diagnosis includes acute inferior wall infarction, pericarditis, myocarditis, vasospasm (Prinzmetal’s syndrome) and Takotsubo syndrome.

Based on the ECG changes, acute myocardial infarction was possible. The patient had ST elevations in II, III, aVF, signalling a right coronary artery infarct. Pericarditis was possible, however, less likely given the distributional pattern of ST segment elevations, rather than a diffuse pattern. The patient never had cardiac MRI; however, myocarditis was unlikely given ventriculogram findings and negative troponin. The most likely diagnosis remains Takotsubo syndrome based on the patients apical ballooning on ventriculogram and patent coronary arteries on angiography.

TREATMENT

Treatment was started with colchicine and methyprednisolone 1 mg/kg/day given elevated serum inflammatory markers: C-reactive protein (217 mg/L; RR <3 mg/L), ferritin (1427 mg/mL; RR 28–365 mg/mL), erythrocyte sedimentation rate (84 mm/hour; RR 0–20) and interleukin-6 (IL-6; 67 pg/mL; RR ≤5 pg/mL). He was also started on intravenous continuous hepatic infusion for anticoagulation in the setting of his elevated D-dimer (2.40 μg/mL; RR ≤0.52) and concern for SARS-CoV-2-induced thrombophilia. On day 2, tocilizumab was administered for IL-6 inhibition based on evidence of a hyperinflammatory state and likely cytokine storm. He clinically improved and on hospital day 6, he was extubated and downgraded to a medical floor.

OUTCOME AND FOLLOW-UP

He clinically improved and on hospital day 6, he underwent endotracheal extubation and downgraded to a medical floor. The patient finished 3 days of methylprednisolone (40 mg two times per day) and remains on intravenous continuous heparin infusion for anticoagulation. His oxygen requirements decreased to 2 L/min of nasal canula with oxygen saturations between 95% and 98%.

He was eventually discharged to outpatient rehabilitation without medical symptoms.

**DISCUSSION**

COVID-19, also known as SARS-CoV-2,\(^1\) which originated in Wuhan, China in late 2019, has spread rapidly resulting in a global pandemic. The cardiovascular manifestations and clinical outcomes of patients with COVID-19 who develop myocardial injury during hospitalisation remain under investigation. Here, we report a case of a patient who developed Takotsubo syndrome in the setting SARS-CoV-2 infection. There were no signs of cardiac injury or myocardial involvement on presentation as demonstrated by normal ECG and absence of troponin I elevation.

Takotsubo syndrome or stress cardiomyopathy is a syndrome characterised by transient regional systolic dysfunction of the LV and ECG changes that mimic acute myocardial infarction in the absence of angiographic evidence of obstructive coronary
It is hypothesised that SARS-CoV-2 elicits an exuberant systemic immune response with a cytokine release syndrome (CRS) characterised by elevated inflammatory markers. It is hypothesised that CRS triggered by COVID-19 with a subsequent rise in catecholamines may play a role in the pathogenesis of Takotsubo syndrome in patients with COVID-19 infections.

Learning points

- COVID-19 remains an ongoing global health emergency with varied clinical manifestations besides primary pulmonary symptoms.
- Caregivers must remain vigilant towards cardiac manifestations of COVID-19 syndrome as these could be potentially serious and life threatening.
- Cytokine storm induced by COVID-19 infection may play a significant role in stress cardiomyopathy.

Twitter Fadi Taza @faditaza and Arjun Kanwal @arjun.kanwal

Contributors All authors contributed to this manuscript. FT was responsible for creation of manuscript. AK was responsible for consent and editing of manuscript. MZ was responsible for writing and editing manuscript. DG was responsible for editing manuscript and retrieving images.

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patient consent for publication Obtained.

Provenance and peer review Not commissioned; externally peer reviewed.

Open access This is an open access article distributed in accordance with the Creative Commons Attribution Non Commercial (CC BY-NC 4.0) license, which permits others to distribute, remix, adapt, build upon this work non-commercially, and license their derivative works on different terms, provided the original work is properly cited and the use is non-commercial. See: http://creativecommons.org/licenses/by-nc/4.0/.

ORCID iD Arjun Kanwal http://orcid.org/0000-0002-6370-289X

REFERENCES

1. WHO. Naming the coronavirus disease (COVID-19) and the virus that causes it. World Health Organization, 2020.