Fear of COVID-19 leading to late presenting myocardial infarction complicated by cardiogenic shock due to ventricular septal rupture

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SUMMARY
Post myocardial ventricular septal rupture (VSR) is one of the most fatal complications of acute myocardial infarction (AMI) in spite of percutaneous and surgical closure. With the advancement of percutaneous coronary interventions in a timely manner, incidence of post MI VSR has declined remarkably. However, the COVID-19 pandemic-related late hospital presentations with AMI increases the possibilities of a potential upward shift in the incidence of post MI VSR. This case report aimed to increase awareness of negative contributions of the current pandemic to AMI and its fatal complications.

BACKGROUND
Since the emergence of the COVID-19 pandemic, there have been about 275 million confirmed cases and more than 5.3 million deaths globally according to the WHO.1 While the virus causes severe and life threatening hypoxaemic respiratory failure, there have been ample reports of extrapulmonary manifestations including venous and arterial thrombembolism, myocardial dysfunction and arrhythmia, acute kidney injury, dermatological and neurological complications.2 Not only have there been reports of medical adverse events, COVID-19 has resulted in significant psychosocial stress and delay in patients seeking medical care for emergencies like acute myocardial infarction (AMI).3 Recent data indicates almost 40% decline in catheterisation for ST-elevation myocardial infarction (STEMI) during the early phase of the pandemic in the USA which will likely continue to contribute to morbidity and mortality.4 This case report aimed to increase awareness about negative contributions of the current pandemic to the leading cause of death in the globe and its fatal complications.

CASE PRESENTATION
A man in his 60s, a lifetime non-smoker with a medical history notable for hyperlipidaemia and severe peripheral vascular disease who presented to the emergency department with reports of progressive dyspnoea and generalised weakness for a week. On further questioning, he reported that he had several episodes of self-limiting chest discomfort 2 weeks prior to the presentation day. During these episodes, the patient did not seek any medical attention due to fear of contracting COVID-19. On presentation, the patient was hypotensive with a blood pressure of 60/40 mm Hg, tachycardic with a heart rate of 140 beats per minute and hypoxic with an oxygen saturation of 85%. Other vitals were within normal limits. Physical examination was remarkable for jugular vein distention, a holosystolic murmur on the left sternal border, bilateral crackles at lung bases, cold and clammy extremities. ECG in the field was consistent with acute inferior STEMI and ventricular tachycardia (figure 1). Blood work on presentation was as follow: Blood urea nitrogen 49 mg/dL, creatinine 1.89 mg/dL, aspartate aminotransferase 239 U/L, alanine transaminase 135 U/L, venous lactic acid 11.4 mM/L, troponins 13.4 ng/mL and B-type natriuretic peptide 173 pg/mL. Presenting ECG and rhythm in the field are shown in figures 1 and 2. Left ventriculogram (LVG) showed findings suggestive of ventricular septal rupture (VSR) (videos 1 and 2). Coronary angiogram showed a total occlusion of the right coronary artery (RCA) at the mid portion. The other coronary arteries had non-obstructive stenosis (figures 3–5). Transthoracic echocardiogram (TTE) revealed a large VSR with regional wall motion abnormalities and moderately reduced left ventricular systolic functions (figures 6 and 7).

Differential diagnosis includes acute coronary syndrome, acute aortic syndrome, stress-induced cardiomyopathy and acute myocarditis. In the presence of STE in the inferior leads on 12-lead ECG and ventricular tachycardia in a pre-elderly man, inferior myocardial infarction is the most likely diagnosis. Additionally, haemodynamic instability and abnormal examination findings indicating reduced tissue perfusion are suggestive of acute cardiogenic shock. Moreover, pansystolic murmur in the left sternal border on auscultation raises suspicion for AMI-related complications such as post MI VSR or papillary muscle rupture. Therefore, LVGs in the right anterior oblique and left anterior oblique projections were immediately performed that showed the basal, mid and distal inferior wall hypokinesis with evidence of shunt from the left ventricle to the right ventricle at systole. TTE confirmed the defect in the mid portion of the interventricular septum (IVS). Bilateral selective coronary angiogram revealed a total occlusion of the RCA at the mid-level that was the culprit lesion for AMI.

Overall, the patient’s presentation was consistent with cardiogenic shock due to complicated AMI. Given ventricular tachycardia leading to haemodynamic compromise, a successful cardioversion was performed. In addition to intravenous vasopressors, intra-aortic balloon pump (IABP) was inserted...
for the purpose of percutaneous mechanic circulatory support (PMCS) due to cardiogenic shock. The case was discussed with the cardiothoracic surgery team and emergent repair of VSR was declined due to high-risk features. Therefore, the decision was made to proceed with percutaneous coronary intervention (PCI) for the culprit lesion. After pre-dilatation of the index lesion, two drug-eluting stents were inserted to the mid RCA with no complications.

On the first day post cardiac catheterisation, he remained in cardiogenic shock and pulmonary oedema despite intravenous vasopressors, IABP counter-pulsation therapy and mechanical ventilation. Given severe upper and lower peripheral vascular disease, percutaneous mechanical circulatory support with axial or centrifugal flow was not feasible at our institution. The patient was eventually transferred to a larger centre for advanced PMCS and surgical closure of the VSR. He was placed on veno-arterial extracorporeal membrane oxygenation (VA ECMO) on arrival at the accepting centre and underwent surgical closure on VA ECMO 4 days after the transfer. Over the next several days, VA ECMO was successfully decannulated. However, the patient continued to require increasing pressure support and oxygen requirements that eventually progressed to persistent hypotension on maximum pressure support. The patient eventually had a cardiac arrest and expired within 10 days of surgery.

GLOBAL HEALTH PROBLEM LIST

The incidence of the COVID-19 has been up trending globally with increasing morbidity and mortality since the outbreak was officially confirmed in 2019.

The overall mortality rate has risen worldwide, especially in the USA which was 20% higher between March and August 2020 in comparison with all-cause mortality from previous years since 2014.

Since public health measures have been announced globally to mitigate the spread of the COVID-19, late presenting cases from cardiac and non-cardiac conditions became more prevalent due to the inability to reach designated healthcare centres on time for multitude of reasons including the contagious nature of the virus, stay home orders, strict hospital policies for preventing the spread of COVID-19 pandemic as well as overburdened healthcare systems.

This global pandemic has a likely positive correlation with the increased proportion of late presenting fatal cardiac emergencies especially mechanical complications post AMI.
GLOBAL HEALTH PROBLEM ANALYSIS

Post MI VSR results from a complete occlusion of a coronary artery supplying blood to a territory of the IVS. Latham first recognised VSR as a complication of AMI in an autopsy report in 1847. Although, the incidence reported is somewhere between 1% and 3% historically, the current data has shown a marked decrease in incidence by about 10-fold primarily due to the advancement of early reperfusion strategies for the last few decades. Despite the advent of percutaneous and surgical techniques in the closure of post MI VSR, it still remains a devastating complication with grim prognosis. In the published series, the mortality rate varies at 18.4% with the delay of surgery up to 7 days, 58.4% with emergent repair and 94% if left untreated by day 30 post presentation. Therefore, high index of suspicion is required for early recognition and treatment optimisation in a timely manner.

Universal risk factors of this fatal complication are advanced age, female gender, history of stroke, ST-segment elevation on ECG, elevated cardiac markers, higher heart rate, lower blood pressure, higher Killip classification and delayed or lack of reperfusion. The data also shed light into a negative correlation between the presence of atherosclerotic risk factors and post MI VSR. Our case was classical for the late presentation of acute inferolateral MI complicated by VSR. Traditional cardiovascular risk factors were relatively less present which was consistent with the current data.

The anterior IVS is supplied by the left anterior descending (LAD) artery as opposed to a dominant RCA generally provides a blood supply to the inferior IVS. As a result, apical VSRs are seen in the presence of total occlusions of the LAD whereas infarcted dominant RCAs usually result in basal VSRs. Moreover, RCA-related VSRs are more likely to be large and associated with intra-myocardial dissection and involvement of the free wall. In our case, the defect interestingly was located in the mid portion of the IVS. This may be explained by the RCA being dominant and supplying such a large territory in the IVS from the base to the mid portion.

When it comes to timing of surgery, the mortality rates have been reported lower in patients with delay of the closure than those who underwent early repair within 1 week or treated conservatively. Despite medical treatment, PMCS and a successful PCI of the infarct-related artery with an optimal door-to-balloon time, cardiogenic shock remained persistent. Our patient remained on ECMO for 10 days and underwent a surgical closure of the VSR on day 10. He transiently recovered from shock but unfortunately developed cardiac arrest and expired in the same hospitalisation.

Since the global health organisations announced the COVID-19 pandemic in 2019, the whole world has started...
it could be provided in a timely manner, with an expert team outfitted with PPE in a dedicated cardiac catheterisation laboratory (CCL). In order to prevent late door-to-balloon time in STEMs, several actions have been recommended by cardiac societies across high-impact regions in the USA. These actions include a quick screening for COVID-19, the use of ultra-rapid COVID-19 testing if available, rapid classification of patients with STEMI into COVID-19 positive/probable or COVID-19 possible groups and transferring COVID-19 positive or probable STEMs to dedicated CCLs.

The impact of the COVID-19 pandemic to AMI and its complications is largely unknown since the data are lacking. Additionally, large delays from diagnosis to treatment in this context have become ordinary during the pandemic and it is unclear the amount of impact on morbidity and mortality rates due to increased risk of developing post-MI complications. Moreover, patients who had an AMI who chose not to seek medical attention could probably have been affected the most.

Our case signals a potential shift in the characteristics of patients who had an AMI with regards to the pandemic. It also highlights the importance of educating our patients and the population in general about the devastating complications from acute medical emergencies and the essence of timely presentation to the hospital to avoid such complications.

Learning points

► Late presenting myocardial infarction (MI) cases increase due to COVID-19 outbreak.
► High index of suspicion for MI-related complications especially post MI ventricular septal rupture (VSR).
► Physical examination is the crucial step to suspect post MI VSR.
► Use of percutaneous mechanic circulatory support to bridge surgery if feasible.
► The importance of optimal timing of surgery in the management of post MI VSR.

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Case reports provide a valuable learning resource for the scientific community and can indicate areas of interest for future research. They should not be used in isolation to guide treatment choices or public health policy.

REFERENCES


