Ulcerative colitis-induced myocarditis

Barbara Gruenhagen, M Chadi Alraies, Kairav P Vakil, Shamane K March

Department of Cardiology, University of Minnesota, Minneapolis, Minnesota, USA

Correspondence to Dr M Chadi Alraies, alraies@hotmail.com

Accepted 23 April 2014

DESCRIPTION

A 24-year-old man presented with a 2 h history of substernal chest pain radiating to both arms with associated dyspnoea, diaphoresis and dizziness. He also reported a 3-week history of abdominal cramping with multiple loose bloody bowel movements. His vital signs were stable and general examination was unremarkable. He had similar abdominal symptoms about 3 months prior for which he sought medical attention and was given a preliminary diagnosis of colitis but never followed up. A chest CT scan was performed and ruled out pulmonary embolism. A 12-lead ECG revealed J-point ST elevation in the inferolateral leads, and cardiac troponin-I was elevated at 0.211 μg/L (ref <0.034). Cardiac catheterisation revealed normal coronary arteries and left ventricular systolic function. Troponin-I levels peaked at 12 h (1.57 μg/L), then trending down the following day. Given the clinical presentation and ECG changes in the setting of normal coronary angiography, a diagnosis of acute myocarditis was suspected. Cardiac MRI showed myocardial oedema with delayed gadolinium enhancement in the subepicardial apical inferior (figure 1, left panel) and mid-apical inferolateral myocardial segments (figure 1, right panel) consistent with acute myocarditis.1 2 Given the history of altered stool consistency and frequency, he also underwent a flexible sigmoidoscopy that showed active ulcerative colitis. Daily oral prednisone and mesalamine therapies were instituted which led to resolution of both cardiac and gastrointestinal symptoms.3 At a 1-month clinic follow-up, the patient reported no cardiac or abdominal symptoms.

Learning points

▸ Myocarditis is a common, but underdiagnosed disease due to its inconsistency in presentation.1
▸ Careful workup of young patients presenting with myocarditis is warranted especially for systemic inflammatory disorders including IBD.1 2
▸ Control of the underlying disease is often associated with myocarditis resolution and prevention of recurrence.3

Competing interests None.

Patient consent Obtained.

Provenance and peer review Not commissioned; externally peer reviewed.

REFERENCES


Figure 1 Cardiac MRI showing myocardial oedema and delayed gadolinium enhancement in the subepicardial apical inferior (left panel) and mid to apical inferolateral myocardial segments (right panel).