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## Case report

# “Acute coronary syndrome” and heart failure caused by a large hiatal hernia

Jiří Holý<sup>a,\*</sup>, Pavel Červinka<sup>a</sup>, Nedal Omran<sup>a</sup>, Ján Koscelanský<sup>b</sup>

<sup>a</sup> Clinic of Cardiology, Krajska zdravotni, a.s., Masaryk Hospital Usti nad Labem, o.z., Czech Republic

<sup>b</sup> Clinic of General Surgery, Krajska zdravotni, a.s., Masaryk Hospital Usti nad Labem, o.z., Czech Republic

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## ABSTRACT

Upside down stomach (UDS) as a severe form of hiatal hernia has various clinical scenarios. Patients could be asymptomatic or present with haemodynamic collapse due to mechanical compression of the mediastinum.

We herein present a case of 71-year-old woman referred to our clinic due to acute coronary syndrome with acute onset of heart failure, which was treated accordingly. Throughout the diagnostic and therapeutic process, a diagnosis of an incarcerated UDS was established as a trigger of her symptoms. An acute surgery was performed. Despite complications in the post-op period the patient recovered successfully and was referred to a rehabilitation facility for further therapy.

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## Introduction

Upside down stomach (UDS) is herniation of most of the stomach into the posterior mediastinum and according to literature represents up to 5% of all hiatal hernias. It is caused by the rise of intraabdominal pressure, shortening of oesophagus and widening of oesophageal hiatus. The risk factors for its occurrence are pre-existing damage of oesophageal hiatus and connective tissue disorders [1,2].

Clinical manifestation of UDS can vary from postprandial nausea, vomiting, pyrosis, dysphagia to substernal and

epigastric pain [1–4]. In the literature, however, several reports described UDS with symptoms mimicking acute coronary syndrome [3–5]. Thirty per cent of patients presenting with UDS are prone to chronic and acute gastrointestinal bleeding, gastric perforation, incarceration or volvulus, which in turn increase their mortality rate [1–4].

The treatment of choice for patients with symptomatic UDS is urgent surgical intervention so potential complications associated with such a pathological situation could be minimalized, whereas asymptomatic patients can be scheduled for conservative therapy without the need of surgery. Authors of this paper describe a unique case of a 71-year-old lady who presented herself with signs of an acute coronary

\* Corresponding author at: Clinic of Cardiology, Masaryk Hospital, Socialni pece 3316/12A, Usti nad Labem 40113, Czech Republic.

E-mail address: [jiri.holy@kzcr.eu](mailto:jiri.holy@kzcr.eu) (J. Holý).

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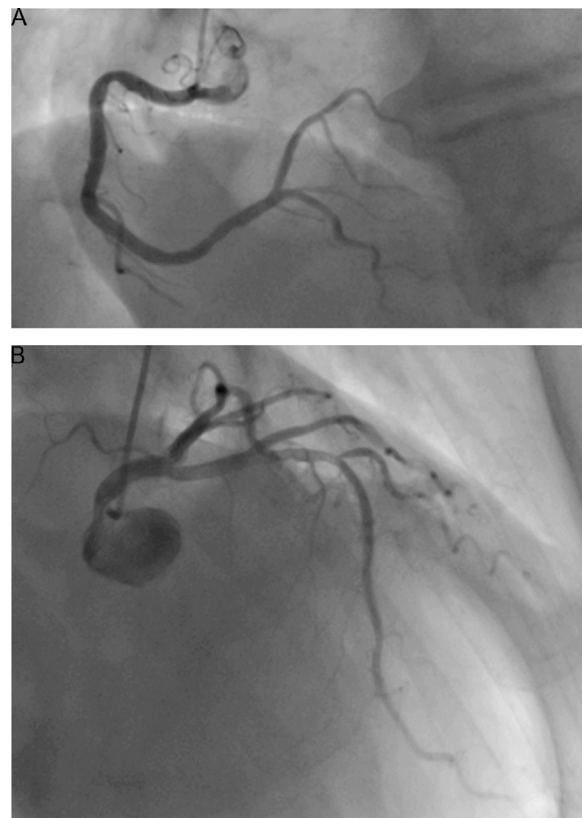
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syndrome along with acute onset of heart failure, caused by extra-cardiac mechanical compression from an extremely large hiatal hernia.

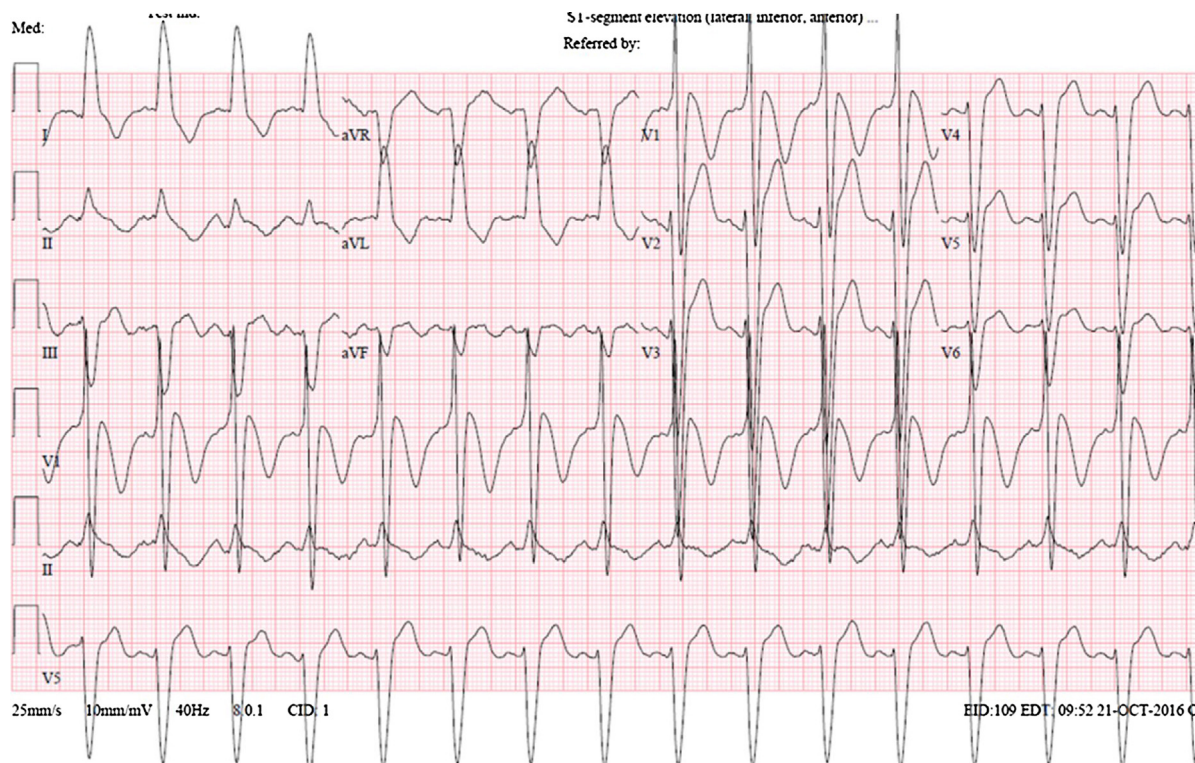
### Case report

A 71-year-old-lady with a history of hypertension was admitted to our department because of sudden onset of anterior stabbing chest pain lasting over the past few hours. At presentation, the patient was short of breath, her blood pressure was 150/110 mmHg, her heart rate was 98/min and blood oxygen saturation was 94%. The patient was not aware of abdominal discomfort or dyspepsia. Physical examination showed weakened breathing sounds above the basal third of her left hemithorax with dulled percussion, other physical findings were within normal. The initial blood tests showed leucocytosis ( $17.6 \times 10^9$ ), elevated level of NT-pro BNP (18,268 ng/L), and high sensitive troponin T level (259 ng/L). Her electrocardiogram (ECG) showed left bundle branch block with atypical morphology in the precordial leads (R wave in V1 S wave in V6) (Fig. 1).

An acute coronary syndrome was highly suspected, so a coronary angiography was performed, which excluded obstructive stenosis of the coronary arteries (Fig. 2A and B). Left ventriculography showed severe hypokinesis of the antero-apical and the adjacent basal region of the left ventricle with severe hypertrophy. The overall ejection fraction of the left ventricle was 40%. During the fluoroscopy a large hiatal hernia was noticed (Fig. 2B). After the coronary angiography the patient was admitted to the coronary intensive care unit for



**Fig. 2 – (A) Angiogram of the right coronary artery with insignificant atherosclerosis. (B) Angiogram of the left coronary artery with insignificant atherosclerosis. Hydro-arteric formation is apparent.**



**Fig. 1 – Electrocardiogram presenting left bundle branch block with atypical morphology in precordial leads (R wave in V1 S wave in V6).**

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