Figure.3: peropertivly view: fistula between kidney and the second part of duodenum

References

1- Pumphrey J D Pyelo-Duodenal Fistula:A Case Report. Annals of Surgery 1963; 158: 260-62
2- Beverley N. Duodenorenal fistula. Pediatr Radiol 2004; 34: 343–347
3- Lang EK, Hanano A, Rudman E Pyeloduodenal fistula diagnosed on parenchymal excretory phase computerized tomography. J Urol. 2010; 184(1):334.

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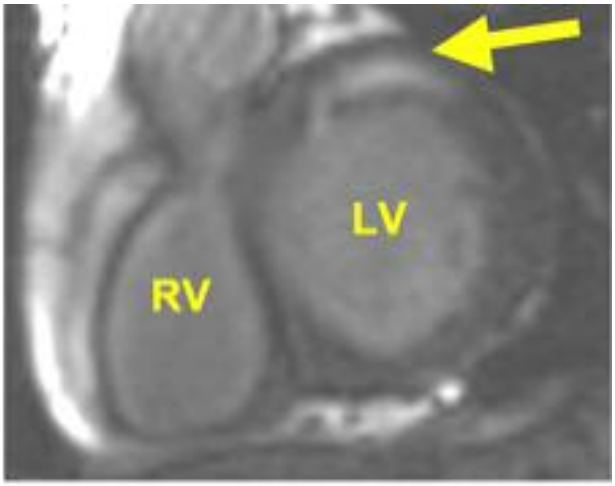
Myocarditis mimicking an acute coronary syndrome.

Myocarditis is an inflammation of myocardium usually secondary to a viral infection. Suspected myocarditis is currently confirmed using advanced non-invasive imaging and histopathologic examination of heart tissue. However, the diverse presentations of myocarditis and the lack of widely available, safe, and accurate non-invasive diagnostic tests remain major obstacles to early diagnosis and population based research(1). The clinical presentation of acute myocarditis is non-specific and mimics more common causes of heart failure and arrhythmias.Nevertheless, it may be difficult to distinguish between myocarditis and an acute coronary syndrome. Our case illustrates the usefulness of cardiac magnetic resonance imaging in such situation.

Case report

We report the case of a 42 years-old smoker man. He was admitted to our cardiology department for prolonged chest pain. Physical examination was normal. Electrocardiogram showed negative T waves in the anterior leads. Troponin dosage was positive. Echocardiography was normal without abnormal wall motion. The diagnosis of Non ST Segment Elevation acute coronary syndrome was considered and the patient received anti-ischemic treatment. Coronary angiogram was normal. A cardiac magnetic resonance (CMR) imaging has been performed. This exam showed a subepicardial late enhacement of the antero-septal wall (figure 1). The diagnosis of myocarditis was finally retained and the anti-ischemic treatment was stopped. After 6-month follow-up, the patient is still asymptomatic.

Figure 1: CMR: short-axis view showing subepicardial late enhacement in the antero-septal wall.
LV: Left ventricule, RV: Right ventricule.



Conclusion

Cardiac MRI is the gold standard for the diagnosis of myocardial infarction. It also allows easily the diagnosis of myocarditis. In some doubtful cases of chest pain, cardiac MRI could be a good alternative, avoiding an invasive strategy (2,3).

References:

1- Elamm C, Fairweather D, Cooper LT. Pathogenesis and diagnosis of myocarditis. Heart. 2012; 98:835-40.
2- Lurz P, Eitel I, Adam J, Steiner J et al. Diagnostic performance of CMR imaging compared with EMB in patients with suspected myocarditis. JACC Cardiovasc Imaging. 2012; 5:513-24.
3- Monney P, Locca D, Muzzarelli S, Hullin R, Jeanrenaud X, Schwitter J. Cardiac magnetic resonance in acute myocarditis: a new non-invasive diagnostic gold standard? Rev Med Suisse 2012 ; 8:1177-83.

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