

Case Report on Dressler's Syndrome

Jasmina Ek^{1*}, Lisa Mary Koshy² and Anjali Kuriakose³

Department of Pharmacy, National College of Pharmacy Kozhikode, Kerala, India

Abstract

Introduction: Dressler's syndrome (delayed pericarditis) is considered as a secondary form of pericarditis resulting in the inflammation of the sac surrounding heart (pericardium).

Case Presentation: A 56-year-old male was admitted to the cardiology department due to left sided chest pain associated with breathlessness, palpitation and sweating. patient had a past history of CAD-AWMI, moderate left ventricular(LV) dysfunction (diagnosed 2 months back). Percutaneous transluminal coronary angioplasty (PTCA) with stent to CAD done 2 months back. ECHO shows mild to moderate pericardial effusion, mild pulmonary arterial hypertension(PAH), moderate mitral regurgitation (MR), moderate LV dysfunction.

Conclusion: This reveals that the patient is diagnosed with Dressler's syndrome, a rare disease in the age of reperfusion therapy.

Keywords: Myocardial infarction; Pericarditis; Chest pain; Dressler's syndrome

Introduction

Dressler's syndrome also known as post myocardial infarction syndrome, is a form of secondary pericarditis with or without a pericardial effusion, that occurs because of injury to heart or pericardium [1]. It develops weeks to months after the initial infarction, and rarely within the first week post-MI. It is characterized by the development of inflammation of the pericardium as well as another serosa [2]. If left untreated, inflammation of the pericardium can lead to scarring, thickening, and muscle tightening of the heart, which can be life-threatening [3]. Dressler's syndrome is associated with an immune system response to heart damage [4,5]. This disease occurs mostly in 55 to 60 years of age [6]. Symptoms includes pericarditis, fever, chest pain, pleural effusion [7]. Your body reacts to the injured tissue by sending immune cells and proteins (antibodies) to clean up and repair the affected area. Sometimes this response causes excessive inflammation in the pericardium [1]. The treatment includes aspirin, ibuprofen, naproxen, corticosteroid and colchicine [8].

Case Presentation

A 56-year-old male admitted to hospital with complaints of left sided chest pain last night, which was associated with breathlessness, palpitation and sweating. He had similar episodes 2 days back. He had past history of CAD-AWMI, moderate LV dysfunction diagnosed 2 months back and Percutaneous transluminal coronary angioplasty (PTCA) with stent to CAD done 2 months back. Patient was on medication for DM and DLP. On arrival he was being treated with inj. morphine and paracetamol infusion. His investigation sheet shows ESR Level 121, HBA1C 11.4, decreased level of sodium (126) and Trop I found to be negative (0.01 ng/ml). The patient was well treated with T. Ticagrelor 90 mg, T. Rosuvastatin 20 mg, T. Aspirin 75 mg, T. Bisoprolol 5 mg, T. Trimetazidine 60 mg, T. Ranolazine 500 mg, Ivabradine 5 mg, T. Metoprolol 50 mg, T. Furosemide 40 mg, T. Pantoprazole 40 mg, T. Montelukast and levocetirizine. He was discharged 5 days post admission and remains free of symptoms.

Discussion and Conclusion

A young patient (56-year-old) with DM and DLP was admitted to cardiology department with complaints of chest pain. His ECHO shows mild to moderate pericardial effusion, mild pulmonary arterial

hypertension (PAH), moderate mitral regurgitation (MR), moderate LV dysfunction.

The incidence of this condition is declining with improved reperfusion therapy after myocardial infarction (5). The CKMB was almost normal (21.6 IU/L) and the troponin I shows negative (0.01 ng/mL). The echocardiogram showed evidence of pericardial effusion, which is mandatory for the diagnosis of pericarditis.

Dressler's syndrome, first described in 1956, is characterized by pleuritic chest pain, low grade fever and pericarditis, which may be accompanied by pericardial effusion. It is thought to be immune-mediate.

References

1. Foris LA, Bhimji SS (2017) Publishing Dressler's syndrome. In: StatPearls. Treasure Island: StatPearls.
2. Lawley C, Mazhar J, Grieve SM, Figtree GA (2013) Visualizing pericardial inflammation in Dressler's syndrome with cardiac magnetic resonance imaging. *Int J Cardiol* 168: 32-33.
3. Bonow RO (2015) Pericardial diseases. In: Braunwald's Heart Disease: A Textbook of Cardiovascular Medicine. (10th edn).
4. Adams JG (2013) Pericarditis, pericardial tamponade, and myocarditis. In: Emergency Medicine: Clinical Essentials. (2nd edn).
5. Sendon JL, Gurfinkel EP, Lopez de Sa E (2010) Factors related to heart rupture in acute coronary syndromes in the Global Registry of Acute Coronary Events. *Eur Heart J* 31: 1449-1456.
6. Figueras J, Alcalde O, Barrabés JA (2008) Changes in hospital mortality rates in 425 patients with acute ST-elevation myocardial infarction and cardiac rupture over a 30-year period. *Circulation* 118: 2783-2789.
7. Lawrence MS, Wright R (1972) Tamponade in Dressler's syndrome with immunological studies. *Br Med J* 1:665-666.
8. Tamarappoo BK, Klein AL (2016) Postpericardiectomy syndrome. *Curr Cardiol Rep* 18: 116.

*Corresponding author: Jasmina Ek, Department of Pharmacy, National College of Pharmacy Kozhikode, Kerala, India, Tel: 0495 229 7440; E-mail: jasminasafvan17@gmail.com

Received February 16, 2018; Accepted April 12, 2018; Published April 18, 2018

Citation: Jasmina Ek, Koshy LM, Kuriakose A. (2018) Case Report on Dressler's Syndrome. *J Clin Case Rep* 8: 1106. doi: 10.4172/2165-7920.10001106

Copyright: © 2018 Jasmina, et al. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.