

**PP 25**  
**DENGUE PERIMYOCARDITIS;**  
**HYPOVOLEMIC VS CARDIOGENIC**  
**SHOCK?**

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**INTRODUCTION**

Cardiac involvement such as functional myocardial impairment, arrhythmia and myocarditis is not uncommon in dengue infections but it may have been frequently under-reported because it usually manifests as a mild and self-limiting condition. Dengue perimyocarditis is rare with only few cases reported worldwide. Nevertheless, more cases of dengue with cardiac involvement, which progress to acute heart failure, cardiogenic shock and death have been increasingly described.

**CASE REPORT**

A 16 years old boy, diagnosed dengue in defervescence phase with compensated shock, was transferred to emergency department (ED) from a primary care clinic. Upon arrival to ED, he had just completed 10ml/kg/hour normal saline infusion. In ED, patient was still in shock and blood gas analysis showed metabolic acidosis. Hence, 20ml/kg/hour gelafusine infusion was initiated. 12 lead ECG was performed upon noticing ST elevation in lead II on cardiac monitor and revealed saddle shape ST elevation in lead I, II, aVL, V2-V6. Bedside echocardiography showed poor cardiac contractility and presence of pericardial effusion. Patient had a cardiac arrest an hour after arrival in ED. Initial CPR (for 8 minutes) was successful but second cardiac arrest began 20 minutes later. Prior to

second cardiac arrest, triple inotropes support was commenced. During second CPR, blood transfusion was started and intravenous dexamethasone was given. Despite the resuscitation efforts, patient was pronounced dead after two hours upon arrival in ED.

**DISCUSSION AND CONCLUSION**

In addition to circulatory shock due to plasma leakage and occult bleeding, the persistent shock in the above patient can be attributable to cardiogenic shock caused by myocarditis or pericarditis. Therefore, care should be taken not to cause iatrogenic fluid overload. Using echocardiography in dengue patient with features of heart failure and ECG changes, may help clinician to guide fluid resuscitation, identify patients at risk of fluid overload and allow early use of inotropes or use of other alternative therapies.

**PP 26**  
**HEART STOPPER!**

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**INTRODUCTION**

Brugada syndrome is a cardiac sodium channelopathy associated with one of several ECG patterns characterized by incomplete right bundle-branch block and ST elevations in the anterior precordial leads. Autosomal dominant inheritance is found in 50% of case. It affects young males with structurally normal hearts who are prone to develop ventricular tachyarrhythmias leading to syncope, cardiac arrest, or sudden cardiac death.