DISCUSSION & CONCLUSION

Pulmonary embolism in pregnancy is not uncommon and causes significant morbidity and mortality amongst pregnant women. Diagnosing PE can be challenging and involves the usage of echocardiography, laboratory, and clinical findings. Rapid and accurate diagnosis is vital because treatment must be initiated early before deterioration. However the treatment itself has potential complications. Most patients with DVT and/or PE can be safely and successfully treated with unfractionated or low-molecular-weight heparin for the duration of the pregnancy. But, in massive PE, thrombolytic or thrombolectomy must be decided fast to achieve a good outcome.

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"DON'T STREP ME!" – MYOCARDIAL ISCHAEMIA IN SEPTIC SHOCK

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INTRODUCTION

ECG findings in septic shock include loss of QRS amplitude, prolonged QTc interval, bundle branch blocks, Osborn waves. However ST segment elevation in septic shock is rare.

CASE REPORT

29 year-old gentleman presented with fever for 5 days, vomiting and diarrhea for 3 days. Patient was alert but blood pressure on arrival was 71/39mmHg, pulse rate was 114bpm. Patient has His peripheries were cold with right hypochondrial tenderness. Blood investigation showed leucocytosis 12.0x103/μL, thrombocytopenia 104x103/μL. ECG showed sinus tachycardia.

Dengue rapid test was negative. In view of history jungle trekking 2 weeks ago, patient was treated as leptospirosis with septic shock. Diagnosis was confirmed with positive leptospirosis rapid test. While commencing IV fluid resuscitation and IV noradrenaline infusion, noted there was ST elevation on cardiac monitor, blood pressure 101/59mmHg. Repeated ECG showed ST elevation in inferior and posterior leads, with reciprocal changes in antero-septal and right sided leads. Patient has no chest pain. Patient was treated as type 2 myocardial infarction (MI) and didn't proceed for thrombolysis. When the volume restored and vasopressor was weaned off, repeated ECG on the following day showed normalization of ST segment to baseline.

DISCUSSION

Type 2 MI, also known as supply/demand MI consisted of 3.5% of all MIs. In hypotension, reduced perfusion to coronary circulation can leads to imbalance between myocardial oxygen supply and demand, causing type 2 MI. In this case normalization of ST segment suggests a transient myocardial ischaemia. Adequate fluid resuscitation and judicious use of vasopressor will correct the supply/demand imbalance. Thrombolysis will not be helpful as the ischaemia is not due to coronary artery thrombosis. We need to treat the cause, not the ECG. Elevation of cardiac biomarkers can be due to septic shock itself, but elevated cardiac troponin directly related to mortality.