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IMAGE

Concomitant Myocardial and Coronary Injury in Systemic Lupus Erythematosus

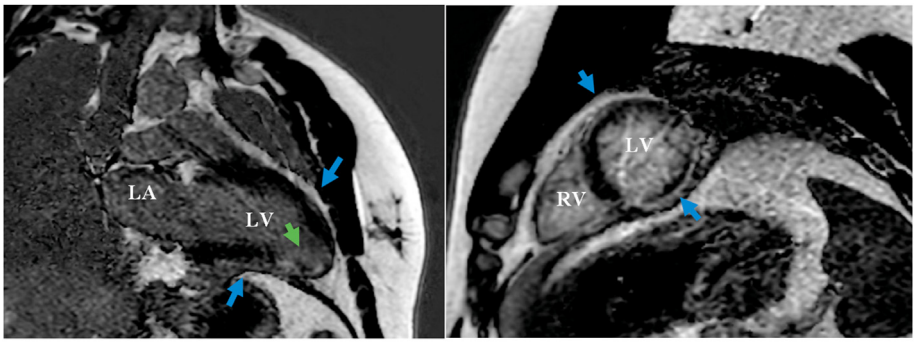
Amal Elouarradi*, Ilham Bensahi, Marwa Ghayate, Fatimazahra Merzouk, Mohamed Sabry

Department of Cardiology, Mohammed VI International University Hospital, Mohammed VI University of Health Sciences (UM6SS), Casablanca, Morocco

The prevalence of cardiac involvement in systemic lupus erythematosus (SLE) varies from 14 to 46%. It represents the main cause of mortality in SLE.

The case is a 42-year-old patient with severe SLE with a renal impairment. His medical history was notable for hypertension and diabetes, under immunosuppressant and corticosteroids. He presented an acute coronary syndrome with persistent ST-segment elevation in the inferior lead, the emergency coronary angiography reveals a thrombotic occlusion of the right coronary artery which was revascularized. Three weeks later, he presented with an acute chest pain, a ST shift in the anterolateral leads, and positive troponins. In the coronary angiography, the coronary arteries were without abnormality. However, the two-cavity slice (A) and short-axis slice (B) in the cardiac MRI revealed an aspect of acute myocarditis with diffuse subepicardial late enhancement (blue arrows) associated with subendocardial late enhancement (green arrows) testifying to the sequel of a myocardial infarction. After a 4 months follow-up, the patient is stable without recurrence of chest pain.

A concomitant coronary and myopericardial feature in SLE is possible, which is why it is mandatory to further explore any cardiac symptomatology in patients with lupus.



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* Corresponding author.
E-mail address: amal.elouarradi@gmail.com (A. Elouarradi).

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