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Tricuspid Stenosis due to Cardiac Sarcoma

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Abstract

Primary cardiac sarcomas are a rare and aggressive tumour type with a high rate of recurrence, irrespective of treatment, and a poor prognosis. The age of presentation for cardiac sarcomas ranges from 1 to 76 years, with a mean age of around 40 years. Angiosarcoma and unclassified sarcomas account for approximately 76% of all cardiac sarcomas, of which angiosarcomas are the most common. Angiosarcomas are predominantly found on the right side of the heart, whereas osteosarcomas and unclassified sarcomas are predominantly found on the left side of the heart. Pericardial angiosarcoma is extremely rare.

Here we present a 32- year old male with Asian ethnicity, recently moved to the UK, with a history of non- specific symptoms including-abdominal pain, nausea and vomiting. On initial evaluation, everything pointed toward a gastroenterology (GI) aetiology, but increasing signs of right heart failure and an subsequent echo surprisingly revealed a right atrial mass extending into his right ventricle 8 x 3.7cm in size with an associated pericardial effusion. He was subsequently referred to both the cardiac surgical team and to local oncology once the diagnosis of primary cardiac sarcoma had been made. He has gone on to develop atrial flutter and severe left ventricular dysfunction and has thus been recently cardioverted. Presently, he is doing well and awaiting oncology and cardiology review. Although the diagnosis of primary cardiac sarcoma is rare, it should be considered in young patients presenting with non-specific symptoms and signs of right heart failure. Even with complete resection, most patients develop recurrent disease; hence median survival is typically less than one year.

Cardiac tumours need to be thought of in any young person presenting with decompensated heart failure or pericardial tamponade. This diagnosis is given more credence if there are associated features such as weight loss and anorexia.

Biography

My name is Mirza Baig, I am presently working as Cardiology Registrar in Bangor Hospital, North Wales UK. I am very passionate about working in Cardiology, I enjoy team work and make myself ready for challenges we face in our day-to-day practice. I have published one original research article and one case report.

I am delighted to present one more interesting case report which we came across in our hospital.

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Is there a relationship between atherosclerosis indices and mitral regurgitation in patients with mitral annular calcification?

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The most common accompanying valve disease of mitral annular calcification (MAC) is mitral regurgitation (MR). The relationship between the presence of mitral regurgitation and MAC burden has been tried to be clarified by many theories. It could not go beyond the presence of mitral valve coaptation defect and atherosclerotic load. The aim of this study is to compare atherosclerotic indices according to MR severity in MAC patients. Our retrospective cross-sectional observational study included 587 consecutive patients who applied to the cardiology clinic and underwent echocardiography between 2008 and 2020. A total of 71 patients who received lipid-lowering therapy within six months without echocardiography and who had an incomplete echocardiography report were excluded from the study. The remaining 516 patients were divided into two groups according to the presence of MR. Basic biochemical parameters, echocardiographic parameters, and atherosclerosis-related indices of 360 patients with MR and 156 patients without MR were compared. The Atherogenic indexes were calculated as follows (1):

Atherogenic Index of Plasma (AIP) = log (TG / HDL-c)

Atherogenic Coefficient (AC) = (Total cholesterol – HDL-c) / HDL-c

Castelli's Risk Index (CRI-II) = Total cholesterol / HDL-c

Castelli's Risk Index (CRI-II) = LDL-c / HDL-c

Among the echocardiographic parameters, the presence of aortic and tricuspid insufficiency, biatrial dilatation, and ventricular hypertrophy were significantly higher in the MR group (all p values <0.05). Hemogram and LDL-c, which are basic blood parameters, were significantly lower in the MR group (all p values <0.05). Among the atherosclerosis-related indices, AIP, AC, CRI-I and CRI-II, did not differ between the groups (all p values >0.05). Although MAC most commonly causes mitral regurgitation, it has a poorly defined pathogenesis (2). It has been tried to explain that the sphincter effect caused by MAC and the traction that occurs in the chordae leads to MR (2). Even if the underlying lipid accumulation indicates an atherosclerotic process, the presence of macrocalcification and bony formations in the biopsies taken away from the ordinary atherosclerotic process (3).

In conclusion, the pathogenesis of MR in MAC patients does not seem to be related only to atherosclerosis, but the management of MAC patients may be facilitated by adding additional theories in future studies.

Biography

Ferhat Dindaş, MD, PhD is an interventional cardiologist and assistant professor at Uşak Training and Research Hospital. He has experience in the field of percutaneous intracranial thrombectomy in the management of stroke patients with carotid artery atherosclerosis. Percutaneous valve implantation is the area where he wants to improve himself.

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Attempt to utilize Classification of Type2 Diabetes mellitus subgroups provided by Ahlqvist to generate individualized treatment methods based on the actions on insulin resistance & βcell function:A move forward to more effective diabetes control from start &avoid End StageDamage

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Type2 Diabetes mellitus(T2D) refers to a syndrome that by definition is secondary to numerous extents of βcells failure in addition to reduction in insulin sensitivity.Despite ,a lot of metabolic Impairment ,most patientsare classified as either presenting with T1D or T2D.Recently Ahlqvist etal.posited a new system of classification for adult onset disease ,keeping in view the heterogenic metabolic phenotypes of this disease.This new classification system might possess the potential for utilization for greater individualization of treatment depending on the underlying metabolic Impairments in this disease ,despite no existing mediation studies have developed data to validate this claim. Thus here we provide a brief introduction on the etiopathogenesis with regard to T2D as well as in patients acquiring Diabetes at adult age ,besides summarize the evolution of classification systems including one we had earlier provided. Subsequently we try to review the actions of various antidiabetic agents on insulin sensitivity along with β cell function in addition to the posited approaches for individualized therapy as per the various subgroups based on Ahlqvist etal's posit.Thus we conclude that the innovative T2D subgroups add to an intriguing model that could stimulate us to get better insight over the pathophysiology of this very wide group of T2D that aids in individualized treatment options on the basis of the underlying etiology of the disease.In these innovative T2D subgroups of adult onset disease that would aid in giving some antidiabetic agents that would prove be more advantageous for certain subgroups ,considering the major pathophysiology in addition to avoidance of endorgan injury .To start with it is just the initiation of trying to get in individualized therapy for T2D,along with studies that start performing evaluation of the current existence in addition to innovative drugs,prospectively in various subgroups possessing separate metabolic phenotypes to succeed in making therapy more individualized.

Key Words:

Type2 Diabetes mellitus; individualized treatment; classification of Diabetes mellitus; insulin sensitivity; βcell function ;SGLT2 Inhibitors;weight control

Biography

Dr Kulvinder Kaur is the scientific director of DR Kulvinder Kaur Centre For Human Reproduction, jalandhar,Punjab, India, where she manages the complicated cases of infertility .She graduated from LHMC Delhi in 1980 topping in medicine in all 3 medical colleges thereby getting the DR Devi Chand Gold medal from the late PM Smt Indira Gandhi&also topped in all the MBBS subjects prior to that eg anatomy, pathology, biochem etc making her basicssound &later she managed the endocrine clinic in PGI Chandigarh during her MD days .Following that she reported the 40th world case hydrometrocolpos working in Saudi Arabia &has been working in the field of neuroendocrinology of obesity. GnRH control along with role of kisspeptins,prokineticins in human reproduction,AIDS &Cancer –during this period she managed to successfully treat the first case of nongestational choriocarcinoma of uterine body in a young girl medically thereby preserving her fertility-the first case in world literature of its kind.Further she has over 300 publications mostly international in her name David J has completed his/herPhD at the age of 25 years from Duke University, USA. He/she is the director/professor of Duke University, USA. He/Shehas over 200 publications that have been cited over 200 times, and his/her publication H-index is 20and has been serving as an editorial board member of reputed Journals.

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The Role of Sleep in Stroke Recovery

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Despite advancements in understanding the pathophysiology of stroke and the state of the art in acute management of afflicted patients as well as in subsequent neurorehabilitation training, stroke remains the most common neurological cause of long-term disability in adulthood. To enhance stroke patients' independence and well-being it is necessary, therefore, to consider and develop new therapeutic strategies and approaches. We postulate that sleep might play a pivotal role in neurorehabilitation following stroke. Over the last two decades compelling evidence for a major function of sleep in neuroplasticity and neural network reorganization underlying learning and memory has evolved. Training and learning of new motor skills and knowledge can modulate the characteristics of subsequent sleep, which additionally can improve memory performance. While healthy sleep appears to support neuroplasticity resulting in improved learning and memory, disturbed sleep following stroke in animals and humans can impair stroke outcome. In addition, sleep disorders such as sleep disordered breathing, insomnia, and restless legs syndrome are frequent in stroke patients and associated with worse recovery outcomes. Studies investigating the evolution of post-stroke sleep changes suggest that these changes might also reflect neural network reorganization underlying functional recovery. Experimental and clinical studies provide evidence that pharmacological sleep promotion in rodents and treatment of sleep disorders in humans improves functional outcome following stroke. Taken together, there is accumulating evidence that sleep represents a "plasticity state" in the process of recovery following ischemic stroke. However, to test the key role of sleep and sleep disorders for stroke recovery and to better understand the underlying molecular mechanisms, experimental research and large-scale prospective studies in humans are necessary.

The effects of hospital conditions, such as adjusting light conditions according to the patients' sleep-wake rhythms, or sleep promoting

drugs and non-invasive brain stimulation to promote neuronal plasticity and recovery following stroke requires further investigation.Quality sleep has many benefits, especially for stroke survivors. Getting a good night's sleep supports neuroplasticity, the brain's ability to restructure and create new neural connections in healthy parts of the brain, allowing stroke survivors to re-learn movements and functions.People who got less than 7 hours of shuteye or 8–9 hours had no higher risk of stroke than those who slept 7–8 hours. Importantly, people who both slept for longer than 9 hours and napped for more than 90 minutes per day had an 85% higher risk of stroke than those who slept and napped moderately.

Biography:

Youssef Edwar Mounir Melek is a Egyptian Physiotherapist & Clinical Nutritionist. BPT from European University in Cyprus, DPT From Harvard medical school USA.Fellowship European Society of Cardiology in France.- Fellowship Egyptian Society of Shoulder Surgery in Egypt. - Fellowship American Clinical Nutrition Association in America.- Fellowship International Society of Orthopedic Surgery and Traumatology, New York, USA. - Fellowship American society of oncology - Fellowship American Pediatric Society, Assist prof At the British Academy, Assist prof at together Academy

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Non-endoscopic minimally invasive evacuation of intracerebral haematoma

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Spontaneous intracerebral haemorrhage has a high disability and mortality rate. In cases, when surgery is needed, minimally invasive approach is recommended.

A 59-year old patient was admitted due to progressive left sided arm and leg weakness. The neurological status started to deteriorate quickly. A computed tomography (CT) of the head revealed an ICH of 7cm in diameter with haematocephalus and cerebral oedema. The CT angiography was negative, classifying the haematoma as a primary one. Coagulation and aggregation values were deranged as a result of liver failure. The international normalised ratio (INR) and prothrombine time (PT) were lowered to 1.56 and 0.47, respectively. The platelet count was 33 and the platelet function tests were completely disturbed. Injections of fresh frozen plasma, recombinant coagulation factor VIIa, protrombin complex, vitamin K and platelet plasma were applied. As a result of extensive intracerebral bleeding and consciousness decline, surgery was recommended despite unfavourable laboratory results. A minimally invasive approach was chosen for the ICH removal. A burr hole of 1cm in diameter was made in the right temporal area. Under the microscope, the liquefied blood was evacuated with aspirator and bipolar. The ICP values remained normal during the course of treatment. The control CT scan showed successfully evacuated haematoma and normal width of the ventricles. The sedation was gradually discontinued after a week. The patient was awake with persistent left sided haemiplegia.

In case of patent with numerous risk factors and imminent operation, minimally invasive surgery for intracerebral haematoma is warranted.

Biography

Tomaz Velnar, MD, PhD is a neurosurgeon and assistant professor at Ljubljana medical centre. He is also active in research, cooperating regularly with the other two authors. They have started a multicentre study of vitamin D deficiency among older people.

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Cardiac tamponade as a cause for hyponatremia in patients with active malignancy

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Hyponatremia is the most common electrolyte imbalance managed by hospitalists. Although a rare entity, a relationship between hyponatremia and cardiac tamponade has been reported in a few published reports that highlight the normalization of sodium levels following pericardial drainage.

This is the case of a 57-year-old lady with rapidly progressive stage IV pulmonary adenocarcinoma who presented two months following diagnosis with findings of significant hyponatremia. Upon admission, she was afebrile, hypotensive and tachycardic. Her laboratory studies revealed a sodium level of 119 mEq/L, as well as hypokalemia and hypochloremia. Although her presentation was consistent with Syndrome of Inappropriate Antidiuretic Hormone, her hyponatremia did not improve despite adequate management with fluid restriction and salt tabs. During hospitalization, she was also found to have a large pericardial effusion with echocardiographic evidence consistent with tamponade physiology that required an emergent pericardial window. Her sodium levels normalized immediately following pericardial drainage, suggesting a correlation between her hyponatremia and cardiac tamponade.

A handful of published reports present a similar scenario in which pericardial drainage resulted in immediate resolution of the hyponatremia, particularly in patients with underlying malignancies. It is suggested that a decreased cardiac output stimulates antidiuretic hormone release and suppresses atrial natriuretic factor release, causing volume retention, increased heart rate and increased peripheral resistance. Following pericardiocentesis, there is marked diuresis and a normalization in sodium concentration. Cardiac tamponade should be included in the differential of hyponatremia in patients with active malignancy, since prompt management with pericardial drainage can result in marked improvement of hyponatremia.

Figures:

1. Chest CT with contrast on admission day #2 showing mild pericardial effusion and right sided pleural effusion

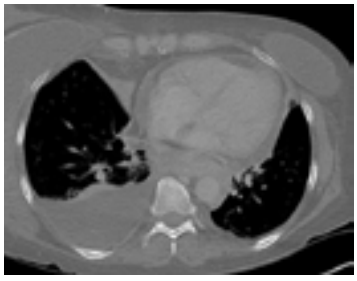
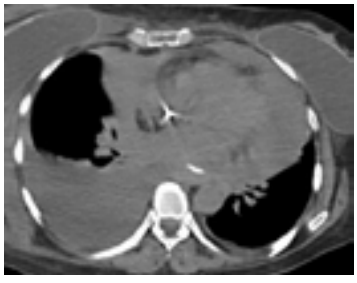


Figure 2. Chest CT on day #14 showing a severe pericardial effusion and recurrent pleural effusion



Biography

Paula Hernandez has completed her MD from the University of Puerto Rico Medical Sciences Campus. She is the currently in her first year of internal medicine residency at the University of South Florida Morsani School of Medicine in Tampa. She has published 4 papers in reputed journals and is currently engaged in diverse scholarly activities. She is interested in pursuing a cardiology fellowship and continuing research on imaging cardiology.

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