CLINICAL SNAPSHOT

Dressler Syndrome in Anterior Myocardial Infarction Due To Traumatic Coronary Artery Dissection

A 36-year-old male physician presented to our emergency department with back pain after a fall while exercising on a trampoline. A fracture was excluded by X-ray and the patient was discharged. Two weeks later the patient presented again, this time with progressive fatigue, a temperature of up to 39.3°C, and thoracic pain on respiration. Clinical chemistry found elevated parameters of inflammation (leukocytes 16.9/nL, C-reactive protein [CRP] 159 mg/L). Echocardiography revealed a 3-cm pericardial effusion and an apical hypokinesia with left ventricular thrombus; computed tomography showed corresponding morphological findings. After pericardiocentesis, cardiac catheterization demonstrated traumatic dissection of the left anterior descending coronary artery with older thrombi, which was then treated by implantation of a stent. Inflammatory markers normalized under antiphlogistic therapy. The patient was discharged after 2 weeks with mild exercise dyspnea.

Dressler syndrome is an autoimmune-mediated pericarditis that rarely occurs nowadays but was observed in around 3% of post-infarction patients a few weeks after the myocardial damage before the advent of modern reperfusion treatment.

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Figure

a) Axial contrast-enhanced computed tomography showing serous pericardial effusion (20 HU) and left ventricular apical thrombus (arrowheads).

b) Coronary angiography (postero-anterior caudal) with longitudinal narrowing of the lumen of the left anterior descending artery (arrowheads). Bottom left: Optical coherence tomography (OCT) showing coronary dissection as a result of the blunt thoracic trauma.