Case of Pheochromocytoma Presenting with Combined Cardiovascular Manifestations

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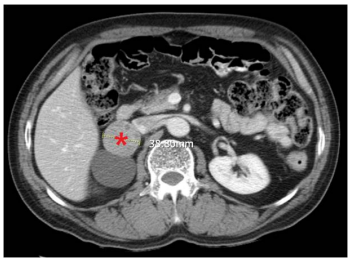
Excess level of catecholamine in pheochromocytoma can cause various clinical manifestations. Hypertension, palpitation, anxiety, headache and nausea are common manifestations of pheochromocytoma ever reported. There are few reports of pheochromocytoma presented with catecholamine-induced myopathy after mild stress and the case of the disease relating non-occlusive stroke is more uncommon.We report a case of pheochromocytoma manifestated repeated stress-induced cardiomyopathy after mild stress featuring fulminant myocarditis and combined non-occlusive stroke. A 56-year-old man admitted presenting with cardiac enzyme elevation, regional left ventricular (LV) wall motion abnormality and pulmonary edema. However, coronary angiography was normal. LV function was totally recovered at discharge, suggesting fulminant myocarditis. During the hospital stay, he also developed acute non-occlusive stroke but resulted in no neurologic sequelae. After 3 years, he readmitted because ventricular tachycardia and severe LV systolic dysfunction (EF=15%) were developed after mild stress. 3 days of applying percutaneous cardiopulmonary bypass system, the patient was completely recovered. Suspicious of pheochromocytoma, considering the repeated cardiomyopathy developed after stress, we checked 24 hour urine VMA and metanephrine and abdomen computed tomography, which revealed pheochromocytoma. After laparoscopic adrenalectomy, 24-hour urine catecholamine level were normalized and he was finally diagnosed with catecholamine-induced cardiomyopathy due to pheochromocytoma.



Coronary artery aneurysm with thrombotic occlusion resulting in MI after warfarin interruption

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ABSTRACT: A 44-year-old man with large coronary artery aneurysm visited us with myocardial infarction. The patient had been diagnosed with myocardial infarction caused by coronary thrombosis previously. Thereafter, the patient had been receiving warfarin for 12 months. Four months prior to the visit, the medication had been changed to aspirin. Coronary angiography showed that a large thrombus occupied the region extending from the middle right coronary artery to the ostium of the posterior descending coronary artery. The patient received both combined pharmacotherapy containing clopidogrel, heparin, abciximab and urokinase and mechanical intervention containing thrombo-suction. On hospitalization day 2, the patient experienced recurrence of chest pain and underwent coronary angiography, which revealed distal embolization of large thrombus to the posterior lateral branch. It showed the same findings as the coronary angiography conducted 1 year earlier. Thrombus aspiration was again performed several times using a thrombo-suction catheter. Coronary artery flow was improved. This case emphasizes the mandatory need for combined pharmacotherapy and mechanical intervention for myocardial infarction with coronary thrombosis due to a large coronary aneurysm. Patients should also receive lifelong anticoagulation therapy with warfarin to prevent ischemic thromboembolic events.