Loeffler endomyocardial fibrosis

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A 58-year-old patient known for an idiopathic hyper-eosinophilic syndrome, previously treated with interferon, presented with severe dyspnoea and clinical signs of right ventricular (RV) failure. The transthoracic echocardiography (TTE) confirmed the RV systolic dysfunction with severe tricuspid valve (TV) regurgitation and an apical fibrotic infiltration of both ventricles (Panel A). The suspected infiltrative cardiomyopathy was confirmed by cardiac catheterization with biventricular haemodynamic restrictive pattern secondary to the hyper-eosinophilic syndrome (Panel B). Despite optimal medical treatment, the RV failure worsened and the patient was urged for palliative TV reconstruction associated with cavo-bipulmonary shunt with an aim to unload the failing RV (Panel C). Post-operative right catheterization confirmed the patency of the cavo-bipulmonary shunt (Panel D). In the follow-up, the peripheral oedemas, the dyspnoea, and the eosinophilic disease, under tyrosine kinase inhibitor improved and the patient left the hospital in improved conditions. Three months later, the patient suffered from a pulmonary oedema due to irreversible cardiac disease 5 months later the diagnosis of Loeffler endomyocardial fibrosis.

Panel A. Fibrotic left ventricle (LV) apical infiltration (arrow). LA, left atrium.
Panel B. Left ventriculography showing the amputated LV apex (arrow).
Panel C. TV (white arrow); diffuse RV fibrotic infiltration (black arrow).
Panel D. Contrast medium in the superior cava vein (black arrow) descending through the right pulmonary artery (white arrow).