Cardiac Sarcoidosis

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Authors:
Ryan Rohan Sanni
Medical Student, Windsor University School of Medicine, Cayon, Saint Kitts and Nevis

Frederick M. Tiesenga, MD
Chairman of Department of Surgery, West Suburban Medical Center, Oak Park, Illinois

Charles Bradley Schubert, MD
Vascular Surgeon, West Suburban Medical Center, Oak Park, Illinois

Juaquito M. Jorge, MD
Bariatric Surgeon, West Suburban Medical Center, Oak Park, Illinois

Sandeep Mellacheruvu, MD, MPH
Director of Clinical Research, Loretto Hospital, Chicago, Illinois, and Associate Dean of Clinical Sciences, Windsor University School of Medicine

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A 64-year-old African American woman presented to the emergency department (ED) with constant unremitting sharp pain in the epigastric region, which she rated as 10 of 10 in severity. The pain had been present for the past 24 hours and had progressively become more severe within the past 12 hours, with radiation to the upper thoracic spine. She also described having increasing hemoptysis for the past 24 hours, filling one 12-oz cup in the ED.

She also reported having a history of nonresolving and difficult to manage cardiac arrhythmias, including Mobitz type 1 and type 2 second-degree atrioventricular (AV) block.

Results of laboratory testing in the ED were significant for a critically low hemoglobin level of 6.7 g/dL (reference range, 12.0-16.0 g/dL). Findings of chest radiography performed in the ED showed bilateral hilar lymphadenopathy with dilation of the ascending thoracic aorta (**Figure 1**).

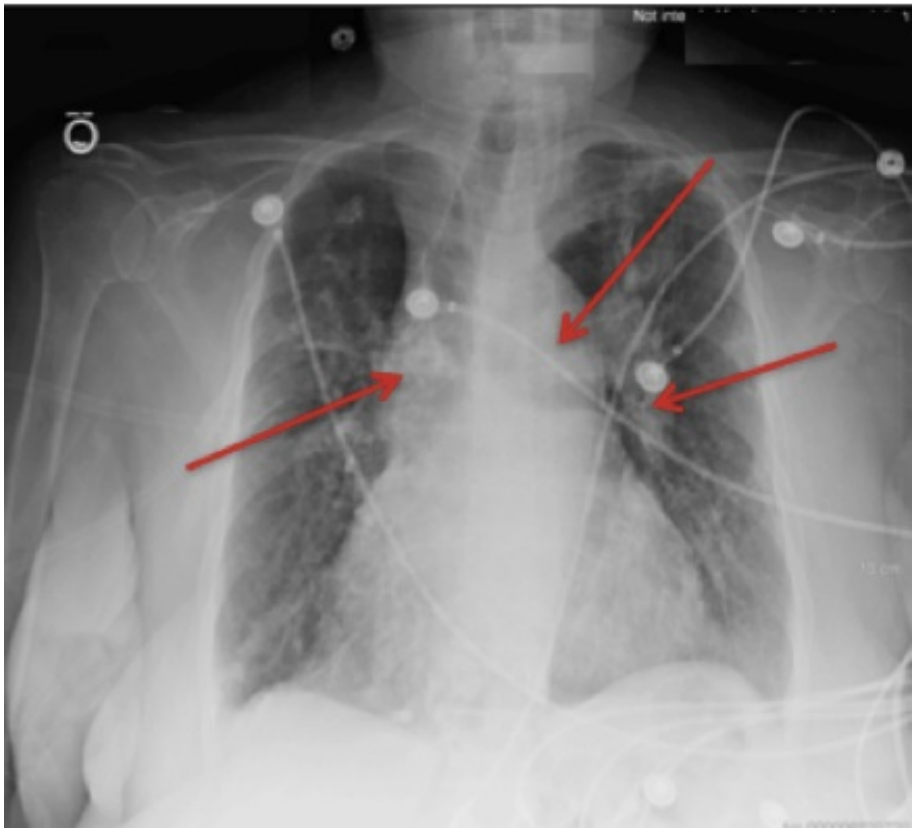

Figure 1. *Chest radiograph with the 2 arrows on either side of the sternum pointing to an enlarged hilar lymph node and the central arrow pointing to aneurysmal dilation of the ascending aorta.*

The patient underwent transfusion with packed red blood cells in the ED as a life-saving measure and was admitted to the internal medicine service for further evaluation.

While further test results, including brain natriuretic peptide (BNP), were pending, electrocardiography (ECG) monitoring on telemetry showed paroxysms of atrial fibrillation with rapid ventricular rate and atrial flutter with 2-to-1 AV block (**Figure 2**).

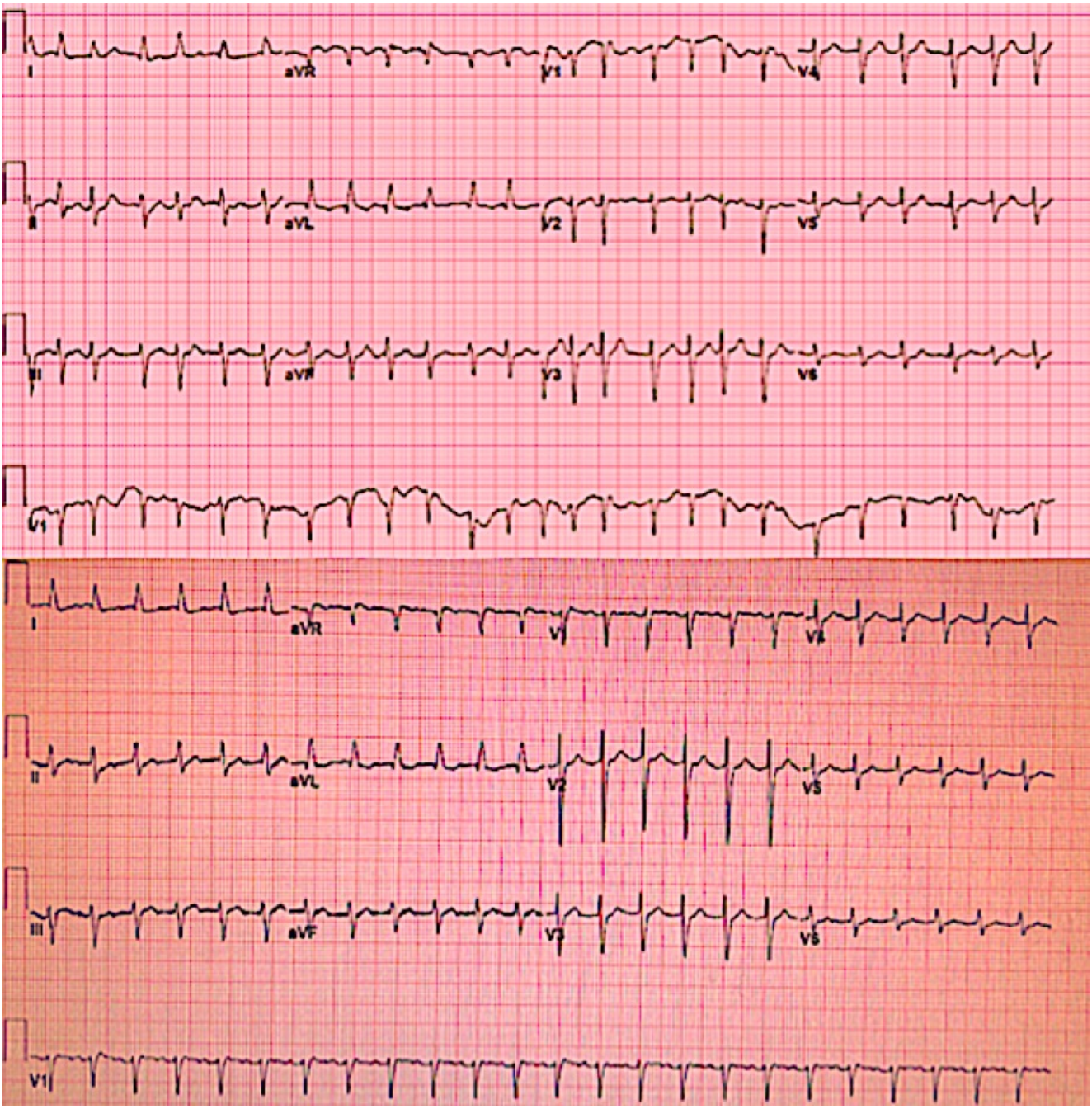

Figure 2. *The ECG tracing on the top shows atrial fibrillation with a rapid ventricular rate. The ECG tracing on the bottom shows fluctuating atrial flutter with 2-to-1 block.*

BNP test results came back elevated at 328 pg/mL (reference value, <100 pg/mL), indicating heart failure (HF) secondary to cardiac dysfunction.

NEXT: Further Diagnostic Tests