



Berlot, B., Harries, I., & Bucciarelli-Ducci, C. (2019). The connection between the heart and the gut. *Heart*. <https://doi.org/10.1136/heartjnl-2019-314832>

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The connection between the heart and the gut

B. Berlot^{1,2}, I. Harries^{1,2}, C. Bucciarelli – Ducci^{1,2,3}

¹Bristol Heart Institute, University Hospitals Bristol

²Bristol Medical school, University of Bristol

³Bristol NIHR Biomedical Research Centre, University Hospitals Bristol NHS Trust and University of Bristol, Bristol, United Kingdom.

CLINICAL PROBLEM: A 45-year old male with ulcerative colitis was admitted with bloody diarrhoea and chest pain. Inflammatory markers and high-sensitivity troponin were elevated (CRP 57 mg/L, WBC 10.65 10⁹/L, Neutrophil 6.6 10⁹/L, TnI 663 mmol/L). The electrocardiogram (ECG) showed inferior ST- elevation. Urgent coronary angiography revealed unobstructed coronary arteries. Inpatient cardiovascular magnetic resonance (CMR) was arranged to determine the aetiology of the myocardial infarction with non-obstructive coronary arteries (MINOCA). The imaging protocol at 1.5 T included balanced steady state free precession (bSSFP) cine images, T2-weighted oedema sequences, early and late gadolinium enhancement (LGE). Native T1 and T2 mapping images provided advanced tissue characterisation.

QUESTION: What is the most likely diagnosis based on the MRI findings?

- A) Multiple embolic myocardial infarctions in the right coronary artery territory
- B) Acute autoimmune myocarditis
- C) Cardiac sarcoidosis
- D) Stress (Takotsubo) cardiomyopathy
- E) Multiple embolic myocardial infarctions in the left circumflex coronary artery territory

ANSWER: B) Multiple patchy, mid-myocardial, high-intensity signal areas in the inferolateral wall on T2 weighted images (B) and increased T2 mapping values on the short axis images (G) are highly specific for oedema. These areas have high-signal intensity on early (C) and late (D,H) sequences, suggesting hyperaemia with capillary leakage and increased extracellular space, respectively. Furthermore, increased native T1 mapping values in all layers but predominantly in the subepicardium of the entire lateral wall (F) are in keeping with extensive myocardial injury. Taken in combination, these findings meet the updated Lake Louise criteria for acute myocarditis (1). Despite extensive oedema, stress (Takotsubo) cardiomyopathy (Option D) can be excluded by ventricular morphology and presence of LGE (2), and multiple embolic myocardial infarctions (Option A and E) are excluded by the non-ischemic pattern of LGE (3). Finally, based on the CMR, cardiac sarcoidosis (Option C) cannot be easily distinguished from acute autoimmune myocarditis. However, the clinical presentation and absence of pulmonary changes make the latter diagnosis the most likely (4). Cardiac biopsy might definitively differentiate, but is not routinely performed due to associated procedural risk. The patient was treated with corticosteroids and monoclonal antibodies and responded well. The pathophysiological mechanisms underlying cardiac manifestations of inflammatory bowel disease are incompletely understood but may occur in up to one third of patients with inflammatory bowel disease (5).

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Acknowledgment

CBD is in part supported by the NIHR Biomedical Research Centre at University Hospitals Bristol NHS Foundation Trust and the University of Bristol. The views expressed in this publication are those of the author(s) and not necessarily those of the NHS, the National Institute for Health Research or the Department of Health and Social Care.

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