

Loeffler endocarditis in a patient with non-Hodgkin's lymphoma

Zapalenie wsierdza Löfflera u pacjenta z chłoniakiem nieziarniczym

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A 61-year-old Caucasian man, with medical history of stage IV non-Hodgkin's lymphoma diagnosed 3 years previously, presented with hypereosinophilia, lymphocytosis, and adenopathies and was treated with two chemotherapy regimens (CHOP and ESHAP) plus immunotherapy (alemtuzumab). He was free of treatment for 16 months. The patient was admitted to the hospital with a presentation of sepsis. During hospitalisation, a transthoracic echocardiogram (TTE) was performed, which revealed a bulky and mobile heterogeneous mass, size 63.70×38.33 mm, occupying the apex and the majority of the left ventricular (LV) cavity, with no ventricular wall invasion. LV had normal dimensions and preserved systolic function, with no abnormalities in segmental contractility. TTE did not show any other significant alterations (Fig. 1). He underwent cardiac magnetic resonance imaging, which confirmed the presence of an expansive lesion in LV with no mitral valve or outflow tract involvement (Fig. 2). During this exam, the patient entered respiratory arrest and focal neurologic signs appeared. After successful advanced life support, the TTE revealed an almost complete disappearance of the LV mass, with small residual masses located on the apex and on the middle of the LV cavity (Fig. 3). There was a complete regression of neurological signs, and no ischaemic lesions were documented on the brain computerised tomography (CT) scan. A search for systemic embolism showed splenic infarction, ischaemic colitis, and psoas muscle ischaemia on thoracoabdominal CT. The patient developed inferior limb ischaemia with severe rhabdomyolysis (creatinine kinase 25505 U/L) and acute kidney injury requiring renal replacement therapy and surgical thromboembolctomy of the aortic bifurcation. The histological examination of the surgical piece identified an organised thrombus with no evidence of neoplastic cells. Anticoagulation with unfractionated heparin and prednisolone 80 mg/day were started. Prednisolone dose was gradually tapered to 5 mg/day, and oral anticoagulation was initiated before discharge. Nine months later, a TTE was performed, which revealed endocardial fibrotic thickening of the ventricular apex, with no extension to subvalvular apparatus, or restrictive pattern on pulsed-wave Doppler (Fig. 4). The final diagnosis was Loeffler endocarditis secondary to non-Hodgkin's lymphoma with hypereosinophilia.

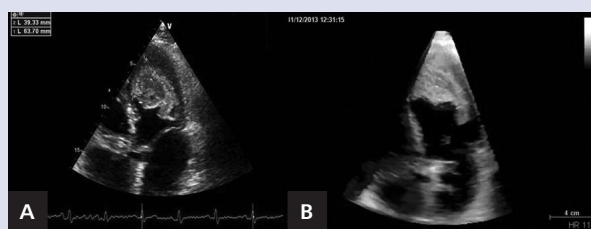


Figure 1. Two- (A) and three-dimensional (B) transthoracic echocardiogram in a four-chamber apical view showing the mass in the left ventricular cavity

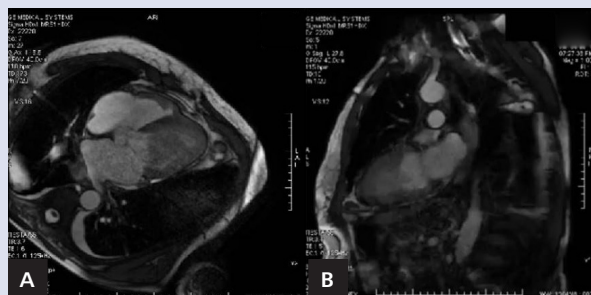


Figure 2. Axial (A) and sagittal (B) view of magnetic resonance imaging showing an expansive lesion in the left ventricle

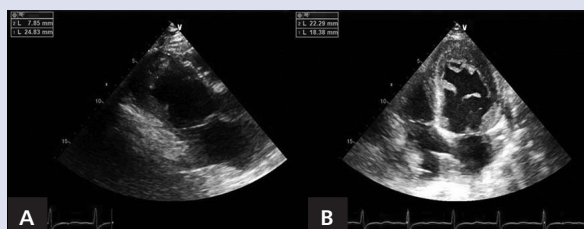


Figure 3. Transthoracic echocardiogram performed after advanced life support; A: Two-chamber apical view showing residual mass on the apex; B: Four-chamber apical view showing residual masses in the middle of the left ventricular cavity

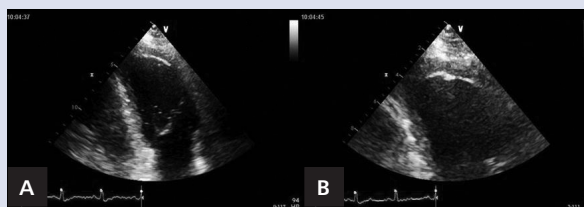


Figure 4. A: Transthoracic echocardiogram in a four-chamber apical view showing endocardial fibrotic thickening of the left ventricular apex; B: Amplified view

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Conflict of interest: none declared

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