BSH Case Presentation
DCM - The Bigger Picture

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BSH Heart Failure Day for Revalidation and Training 2016

Presentation title: DCM The Bigger Picture

Speaker: Dr T Jackson

Conflicts of interest: Nil
GP referral – 21/5/14

- 42 year old
- 4/52 SOB & Cough
- Mild ankle oedema
- JVP elevated
- Chest clear
- HR 110, BP130/78
- Discussed with on call cardio Spr – start ramipril and β blocker
Seen in Heart Failure Clinic

- Orthopnoea – sleeping in chair for few hrs
- PMHx
  - Borderline HT
  - Duplex kidney
- FHx - Brother died in 20s from cardiac cause
- No etoh since 2004
- Smoker 20/day
- HR120, BP 120/90
- JVP to earlobes
- Chest clear, gallop rhythm
Echo
Plan

- Admit
- IV diuretics
- Oral diuretics 28\textsuperscript{th} May
- Discharged 30\textsuperscript{th} May on:
  - Bumetanide 2/1mg
  - Ramipril 1.25mg bd
  - Spiro 25mg od
  - Bisoprolol 1.25mg od
- CMR as OP
- HFN F/U
Clinic 18th August

- Much improved
- Working as a plasterer (2-4 hrs/day)
- Can walk 1 mile
- No oedema/Euvolaemic
- Some gynaecomastia
- HR 91, BP130/78
- Meds
  - Bisoprolol 3.75mg
  - Bumetanide 2/1mg
  - Ramipril 1.25 mg bd
  - Spiro 25mg
What would you do?

• Spiro to eplerenone
• Increase βB
• Repeat Echo and 24 Hr tape
  – EF 15-20%
  – LVEDD 9.2cm
  – SR with PACs, nocturnal sinus brady, very few VEs
• Consider ICD?
However...

- Other clinical findings
  - Daily headaches
  - Excessive sweating
  - (hypertension)
  - Huge hands
- Asked GP to refer to Endocrinology
Referred to Endocrinology

- **GP bloods:**
  - Prolactin 159 mu/l (55-276)
  - ACTH 14ng/l (0-46)
  - TFTs (TSH 0.72mu/L)
  - Non-fasting glucose 6.7mmol/l
- **Advised screening IGF-1**
  - 1431mcg/l (71-332)
- **Urgent GTT (fasting GH 19mcg/L with failure to supress), MRI Pituitary**
MRI Pituitary

- Pituitary macroadenoma with suprasellar extension and invasion of the right cavernous sinus and erosion of the clivus
Endocrinological Management

- Octreotide 50mcg s/c tds 1 day
- Then Lanreotide 60mg IM 4 weekly
- Repeat MRI at 6 months somatostatin analogue treatment - ?any shrinkage
  - Any implications for HF management?
- April 2016 – IGF-1 976mcg/L (from 1431)
- MRI improved – referred for endoscopic transsphenoidal surgery
- Pathology report:
  - “Sparsely granulated somatotroph adenoma with focal prolactin expression.”
HF clinic 10th December

- Exercise tolerance increased – now limited by hip pain
- No cardiac symptoms
- Working full time
- Drugs:
  - Bisoprolol 7.5mg, Bumetanide 1mg od, Eplerenone 25mg, Ramipril 5mg bd, Hydrocortisone 20mg (reducing dose)
- Euvolaemic
Echo
Summary

• Remember weird and wonderful causes of DCM
• Treat with regular neurohormonal therapy as well as underlying cause
• If considering device therapy ensure that the patient has had full OMT – including treatment of underlying cause
Many Thanks
Cardiac Manifestations in Acromegaly

Acromegalic Cardiomyopathy

- 4% of acromegaly presentations in 'overt CHF'
- Biventricular concentric hypertrophy
- Inters-al fibrosis
- Increased extracellular collagen deposition
- Myofibrillar derangement
- Areas of monocyte necrosis and lympho-mononuclear infiltration

3 Stages

1. Hyperkinetic syndrome with cardiac hypertrophy and increased contractility
2. Diastolic filling abnormalities and impaired cardiac performance on exercise
3. Impaired systolic and diastolic function with low cardiac output

Coexisting cardiac risk factors accelerate onset and progression of cardiac complications