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Daniel Z. Hodson, BA; Samuel W. Reinhardt, MD; Christopher L. Moore, MD

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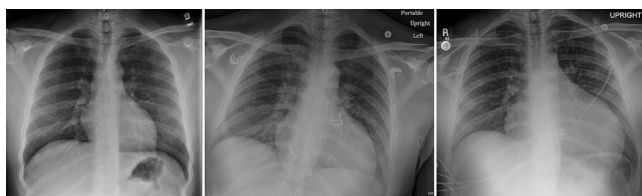
<https://doi.org/10.1016/j.annemergmed.2020.10.026>

Figure 1. Chest radiographs from baseline in 2019 (left panel), at presentation with COVID-19 infection in May 2020 (middle panel), and at presentation in late July (right panel) demonstrated recently enlarged cardiac silhouette.

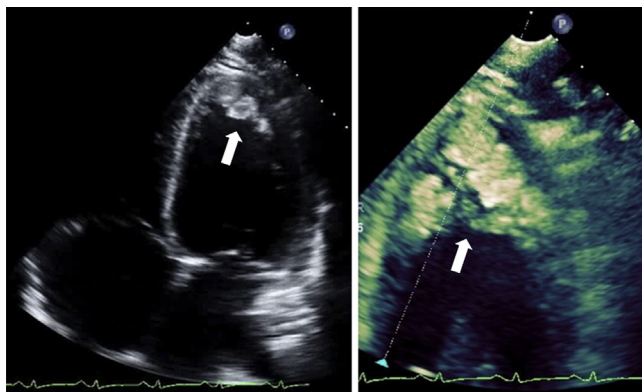


Figure 2. Transthoracic echocardiography while inpatient showed severe global hypokinesis, severely reduced right and left ejection fraction, and biventricular thrombi, including multiple large thrombi in the left ventricular apex (arrows).

[Ann Emerg Med. 2021;77:500.]

A 29-year-old man with a history of asthma presented twice to the emergency department in July with shortness of breath and exercise intolerance. In May, he had been admitted for confirmed coronavirus disease 2019 (COVID-19). Compared with baseline (Figure 1, left panel), chest radiography in May (Figure 1, middle panel) showed new patchy opacities in the right base, as well as mild enlargement of the cardiomeastinal silhouette on which the dictated report did not comment. Echocardiographic imaging was not obtained, and the patient was discharged after 1 night. He next presented in mid-July with dyspnea, and the cardiomeastinal silhouette was noted to be within normal limits. On presentation in late July, he was tachycardic with wheezing, and chest radiography showed a markedly enlarged cardiac silhouette (Figure 1, right panel). Focused bedside echocardiography found a dilated left ventricle with severely decreased function.

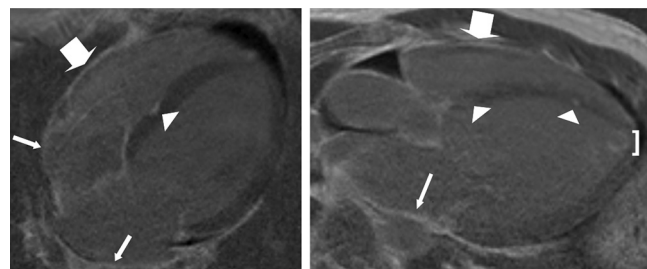


Figure 3. Cardiac MRI revealed global hypokinesis with a left ventricular ejection fraction of 13%, large biventricular thrombi, and foci of pericardial/myocardial fibrosis in a nonischemic pattern consistent with myopericarditis. Four-chamber (left panel) and left ventricular outflow tract (right panel) views with delayed enhanced images demonstrated focal enhancement in the bilateral atria (thin arrows), interventricular septum (arrowheads), and pericardium (thick arrows), suggesting a non-coronary artery disease pattern of scar and fibrosis. A left ventricular thrombus is also visible (bracket). Imaging was limited by tachycardia and poor compliance with breath holding.

For the diagnosis and teaching points, see page 558.

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CORRECTION



Correction to 'The Rock, Paper, Scissors Contest of "Surprise" Medical Billing' [Annals of Emergency Medicine 77 (2021) 13A–16A/8895] by Alan Huffman

The authors regret that the word "Action" was left off of "Families USA Action" in 2 places.

The authors would like to apologize for any inconvenience caused.

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IMAGES IN EMERGENCY MEDICINE

(continued from p. 500)

DIAGNOSIS:

Suspected COVID-19–related myopericarditis. Once the patient was admitted, transthoracic echocardiography (Videos E1 and E2, available online at <http://www.annemergmed.com>) and cardiac magnetic resonance imaging (MRI) confirmed severely decreased right and left ventricular function and revealed biventricular thrombi (Figure 2 and Video E3, available online at <http://www.annemergmed.com>). Cardiac MRI was consistent with myopericarditis (Figure 3).

COVID-19 has been associated with myopericarditis in case studies,^{1–4} and myocardial injury has been associated with increased morbidity and mortality.^{5,6} Large studies using biopsy, histologic examination, and molecular-based testing for the severe acute respiratory syndrome coronavirus 2 genome in cardiac tissue are needed to illuminate the potential role of COVID-19 in myopericarditis. To help identify cardiac complications, the threshold should be low for using bedside echocardiography in patients presenting both during and after possible COVID-19 infections.

Author affiliations: From the Section of Emergency Ultrasound, Department of Emergency Medicine (Hodson, Moore), and Section of Cardiovascular Medicine, Department of Internal Medicine (Reinhardt), Yale University School of Medicine, New Haven, CT.

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