Septicaemia induced acute heart failure with elevated Trop I – a case report in Fourniers gangrene.

Introduction: Infection induced acute heart failure is sometimes remained undiagnosed cause of death in hospital admission. Any sort of initial systemic infection caused greatly increased oxygen consumption, decrease microvascular circulation and decrease oxygen delivery to heart, causing release of Trop i in systemic circulation. Severe Sepsis with acute heart failure inprevious healthy heart patient has mimicking raised troponin like acute MI.

Abstract: A 42 yrs Diabetic, H/O healthy cardiac status male patient presented as scrotal abscess admitted in surgery ward and debridement done as a case of Fourniers gangrene under regional anaesthesia. Patient had symptoms of cough, dyspnoea, frothy secretions , high color urine and episodes of desaturation preoperatively. 4 hours following debridement patient develops marked dyspnoea, chest heaviness with increased frothy secretions and shifted to intensive care unit. In critical care comprehensive management patient symptomatically improved after 3 days of ICU care and shifted to ward.

Keywords: Acute heart failure, Severe sepsis, elevated trop I, Fourniersgangrene .

Case report : A 42 yrs Male, Diabetic had a history of 3 days of pain in lower scrotum and perineal area. On admission patient diagnosed as scrotal abscess and underwent surgery with regional anaesthesia .on exploration it was gangrenous and labeled as Fourniers. Preoperatively patient was febrile, mild dyspnoeic, frothy secretions and high colored urine. Peroperatively patient was desaturated and managed with high flow of oxygen. Following 4 hrs of Wide local excision and debridement of devitalised tissues, patient status was deteriorated , worsening dyspnoea, frothy secretions and restlessness. Immediately shifted for intensive care and parameters reveals ABG-mild respiratory alkalosis,markedy raised TLC(20,140/cumm) , CRP(157 mg/l),chest x ray non significant, HBA1C(12.7). D dimer-6928.21 ng/ml.pro BNP -2905 pg/ml (high probability of heart failure> 450). his urinary ketones also was positive. Trop i 27.2ng/ml(<19 ng normal and acute MI >100) and dyselectrolytaemia. Screening echocardiogram was non significant. By comprehensive critical careincludingEnoxaparin , mild diuretics and collaboration of surgery team , patient status improved gradually and shifted to ward.

Discussion : In Hospital admitted patient morbidity and mortality review , sepsis induced acute heart failure is a great contribution though we sometimes overlook. In critically ill patient with sepsis the results are difficult to interpret and in evolutionary medicine. Pulmonary edema and fluid overload, pulmonary embolism is a major part in perioperative period eventful recovery. Previous healthy

individual suddenrespiratory complaints with severe sepsis , acute heart failure should kept in mind even in remote thinking.

Conclusion: Infection induced acute heart failure should kept In mind in treating sepsis. fluid overload , Pulmonary embolism is also not always for respiratory complains in perioperative sepsis. Definitive pathophysiology of acute heart failure in infection will provide basis for furtherdefinitive therapeutic strategies. Elevated trop I is always not the cause of acute MI in sepsis.

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