Eosinophilic granulomatosis with polyangiitis (Churg–Strauss syndrome) masquerading as acute coronary syndrome

Authors: Peter Moore and Lin Thiri Toon

Case presentation
A 74-year-old man with a history of ankylosing spondylitis presented with a 5-day history of feeling generally unwell. He complained of burning retrosternal chest pain, cough productive of white sputum, shortness of breath, confusion, fevers and fatigue. He also mentioned seeing transient flashing lights. On examination, he had bibasal crackles on auscultation and splinter haemorrhages on his fingernails and toenails. Investigations revealed raised inflammatory markers, a raised white cell count (notably with a high eosinophilia), a raised troponin and D-dimer. Electrocardiography (ECG) showed incomplete right bundle branch block with left axis deviation and a chest X-ray was normal.

Initially, the patient was treated according to the acute coronary syndrome (ACS) protocol and was transferred to the coronary care unit. Following admission, he was investigated for infective endocarditis, but serial blood cultures were negative and echocardiography found no vegetations. Further investigations excluded parasitic infections and autoimmune conditions. The patient later developed slurred speech and decreased coordination. Computed tomography (CT) of his head showed a small low attenuation area in the right superior frontal lobe, reported as likely recently established ischaemic infarcts. CT of his chest/abdomen/pelvis excluded localised infections and occult malignancy, but showed a small pericardial effusion, reported as likely recently established ischaemic infarcts.

Conclusion
EGPA is a rare autoimmune condition with non-specific presentations and multi-organ involvement. Eosinophilia, raised inflammatory markers and raised pANCA can be the clues for diagnosis, but raised troponin and D-dimer tests are sometimes misleading.

Conflicts of interest
None declared.

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