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Clinical Image
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A Silent Case of Endomyocardial Fibrosis: Pay Attention to ECG (Even at these Latitudes)

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Clinical Image

A 50-year-old Caucasian man with a history of allergic asthma, favism and eosinophilia on blood tests, and deep negative T waves from V2 to V6 (A), was referred to cardiac magnetic resonance. He presented obliteration of the LV apex (maximum total thickness of 18 mm (B)) and a subtle subendocardial hyperintensity in the distal segments of the LV in T2-weighted imaging (C), as signs of sub-endocardiac edema.

In EGE images, a subendocardial hypointensity was highlighted in the apical segments (D) and in the LGE T1-GRE-IR images, subendocardial enhancement was found at LV lateral wall and at level of all distal segments, compatible with fibrosis. A 6-millimeter hypointense formation adhering to the area of apical fibrosis compatible with apical thrombotic stratification was highlighted (E). In 2023 a control MRI showed overlapping findings but the thrombotic formation was no longer evident (F): The patient has never taken anticoagulant therapy and manifested no symptoms.

Even in non-tropical regions endomyocardial fibrosis should be suspected in case of apical hypertrophic phenotypes and characteristic ECG findings.

CMR can differentiate EMF and apical HCM, as the former shows typical abnormal subendocardial fibrosis on LGE and apical thrombi formation (three-layered "V sign"), while the latter shows LV apical myocardial thickening with heterogenous enhancement on LGE. Differentiation from advanced eosinophilic heart disease relies mostly on clinical history (exclusion of hematologic neoplasms, parasitic infections and vasculitis).

Even if prognosis is usually poor, due to the increased risk of arrhythmias and sudden cardiac death, it can present sometimes as an incidentaloma.

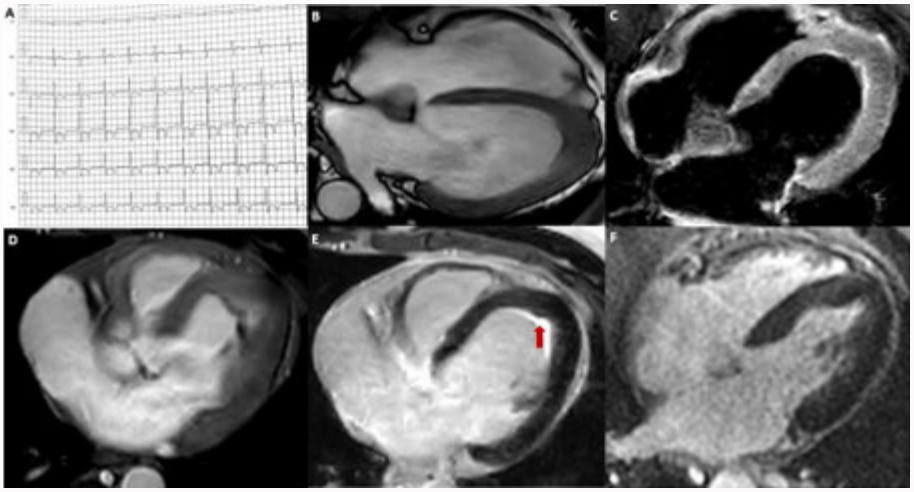

Figure 1: Endomyocardial fibrosis.

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