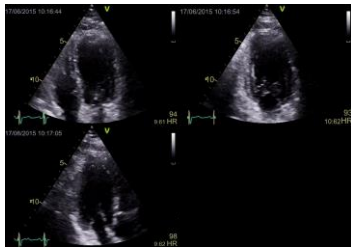


LV case

Stephen Glen

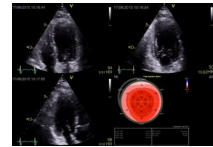
65 yrs, female

- Lymphoma (full remission) following stem cell transplant 1996, chemotherapy including carmustine, etoposide, melphalan, and previously CHoP (cyclophosphamide, hydroxydaunorubicin, oncovin / vincristine, prednisolone), and chest radiotherapy
- Transient transfusion related iron overload
- Presents with syncope / dyspnoea



What do you think has caused LV dysfunction?

1. Chemotherapy
2. Radiotherapy
3. Coronary artery disease
4. Takotsubo reaction
5. Iron overload



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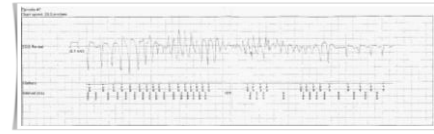
65 yrs, female

- Lymphoma (full remission) following stem cell transplant 1996, chemotherapy including **carmustine, etoposide, melphalan**, and previously CHoP (**cyclophosphamide, hydroxydaunorubicin, oncovin / vincristine, prednisolone**), and **chest radiotherapy**
- Transient transfusion related **iron overload**
- Presents with syncope / dyspnoea

Recurrent syncope

- No warning
- Loss of consciousness for seconds
- No chest pain or palpitations
- Infrequent
- Attended MGH after flight to Boston
- Implantable loop recorder

Advanced Echo 2018



Multiple drug intolerances, stabilised on bisoprolol after slow dose titration

ICD implanted

EP assessment to consider VT ablation

Advanced Echo 2018

Clinical progress

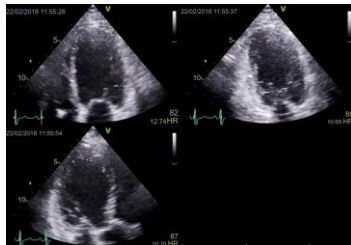
- Major psychological issues requiring formal support
- Condition stabilised
- No further VT or syncope
- Exercise capacity slowly improved again

Advanced Echo 2018

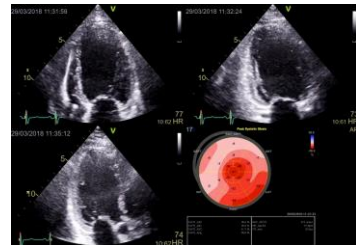
Progress

- Flu like illness March 2017
- Non-specific myalgia, fatigue, dyspnoea
- Haematuria
- New diagnosis - renal mass, confirmed as primary renal cell carcinoma with multiple metastases
- Chemotherapy - carboplatin, gemcitabine

Advanced Echo 2018



Advanced Echo 2018



Advanced Echo 2018

