A case of myocarditis associated with Toxocara Canis

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Toxocara canis (T.canis), a common dog roundworms, is one of the causative agents of visceral larva migrans. The clinical manifestations in toxocariasis varies widely from asymptomatic to severe organ injury. Human can be infected by ingestion of encapsulated larvae of T. canis in the tissues of a paratenic host. A few cases of myocarditis associated with T.canis have been reported. We report a rare case of myocarditis associated with eosinopilia caused by T. canis. A 45-year-old female was admitted due to chest pain, recurrent loss of consciousness and general fatigue. Echocardiography showed small amount of pericardial effusion and myocardial wall thickening, and left ventricular ejection fraction was normal. On admission, laboratory finding was normal. However, blood eosinophil count was elevated (3,178/µL) on admission day 2, and which increased up to 3,178/µL on day 7. Systemic corticosteroid was administrated. The antibody titer against T.canis was detected in her serum by enzyme-linked immunosorbent assay, and she had a history of ingestion of raw cow’s stomach 2 month ago. Finally we diagnosed myocarditis caused by T.canis. She was treated with a combination therapy of albendazole and prednisolone. Three days later, the eosinophil count and pericardial effusion decreased, and the patient made a full recovery.

Key words: eosinophilia, toxocara canis, myocarditis

Two cases of right middle lobe syndrome due to eosinophilic mucus in adults

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Right middle lobe syndrome (RMLS) is defined as a recurrent or chronic collapse of the middle lobe of the right lung by certain pathologic conditions. RMLS is a relatively uncommon condition having multiple etiologies and various clinical presentations. Here, we report two cases of RMLS due to the eosinophilic mucus. The first case was a 57-year old female visited our clinic because of non productive cough for 3 weeks developing after upper respiratory tract infection. A chest X-ray showed a persistent consolidation in the right middle lobe despite of treatment with antibiotics over two weeks. The second case was a 52-year old female transferred to our clinic for the treatment of pneumonia. Her respiratory symptoms and radiologic abnormalities were gradually resolved after the administration of antibiotics but still remained RML infiltration on the x-ray. In both cases, chest CT scans showed RML obstruction and bronchoscopic findings were the RML bronchus obstruction by thick and yellowish materials. Pathologic findings showed mucus with many eosinophils and Charcot-Leyden crystals. They had no history of bronchial asthma. Pulmonary function tests were normal as well as negative bronchodilator responses. They showed negative responses to fungal allergens such as Alternaria, Aspergillus, Cladosporium, and Penicillium in both skin tests and specific IgE antibodies using ImmunoCAP. However, they had eosinophilia in blood and bronchoalveolar larvage fluid and elevated total IgE levels. Once the mucus plugs removed, their symptoms and x-ray were normalized. In conclusion, eosinophilic mucus should be considered as one of the causes in patients with RMLS regardless of typical asthmatic symptoms.