

Rheumatic Heart Disease-A Case Study

An 18yr female was brought to our hospital on 7/04/03. Her old reports diagnosed at PGI & Superspeciality Hospital Nagpur, as a case of Rheumatic Heart disease- MR (Severe) + AR (mod)+ PH.

She came with c/o -

1. Breathlessness (N.Y.H.A Gr III) < exertion, < sitting position and palpitations.
2. Chest pains-Sensation of constriction in the precordium, radiating to the back, > by slight massage on chest.
3. Cough with copious jelly- like expectoration. < lying down, night. No haemoptysis.
4. Swelling over the feet.

H/O Orthopnoea +. No H/O Paroxysmal Nocturnal Dyspnoea, Syncope, fever, joint pains, rashes, haematuria or convulsions. No Bowel or bladder complaints. All complaints were present since 3 years but increased in intensity steadily since 7 days, after the patient picked up a bucketful of water. She was taken to a private physician who prescribed certain medications (Inj Lasix) and then referred to our hospital.

O/E GC not satisfactory. Conscious,

Thin built, Short stature, afebrile

Pulse-reg 120/min, good vol, mildly

collapsing, Resp Rate-28/min,

BP -100/60mmHg,

Pallor+. No Icterus. Cyanosis or Clubbing.

Tongue clean and moist. Throat- mild congestion +

Signs of CCF+-JVP raised, Edema feet +

Skin-no rheumatic nodules/rashes.

Spine-mild scoliosis +. Joints normal & mobile

P/A-liver/ spleen-not palpable. No evidence of free

fluid in abdomen.

Sounds in all 4 quads +.

CVS-Precordium bulging, Apex beat-left 6th intercostal space. palpable P2 & thrill at apex, dancing carotids +. no parasternal heave.

HS 1- muffled, P2- loud, S3 gallop +.

Pan-systolic murmur at apex, crescendo-decrescendo, gr V, radiating to back Ejection diastolic murmur at A2, Gr III increased on breath held in expiration.

RS-Trachea central, Air entry - decreased at bases, billateral coarse crepts+.

CNS-N.A.D.

7/4/03 Blood sent for investigations

POP & O2 inhalation @ 2L/min

7.10pm Adv ECG, X-ray Chest PA, ECHO/Doppler. *Stroph* Q 10dr 2hrly

10.10pm Hb-9.6gm%, TLC-10,200/cu mm, P-70%, L-28%, E-2%, Rx ct all

ESR-30mm, B. Urea- 42mg %, S. Creat- 1.3 mg %, S. Na-140mEq/l, S.K- 3.5mEq/l, T. Prot-7.2 gm%, S. Alb-2.4gm%, S. Bil-0.6 gm% , S.AST-44 U/L, S.ALT- 36 U/L, CRP-+ve.

X-Ray Chest PA-Cardiomegaly +, Increased Bronchovascular markings bilaterally/L

USG abd-WNL,

ECG-HR 120/m, NSR, axis-45deg, P 0.08sec,

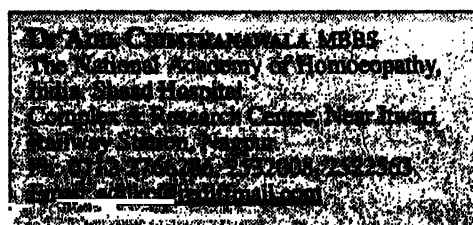
PR 0.12 sec, QRS 0.06 sec, Global T inv, LVH +.

2D ECHO. Both MV Leaflets mod thick. No subvalvular crowding or calcification, MV valve non stenotic shows III/IV MR. Aortic Leaflet thickened. Aortic valve complete.

Doppler shows Gr III/IV AR. Tricuspid/ Pulm valves normal LA/LV dilated. Other cardiac chambers normal in dimensions.

No Pericardial effusion, Fair LV systolic & diastolic func, LVEF - 50%, No intracardiac clot / mass.

8/4/03 Pt.dyspnoenic & uncomfortable. P-130/m, reg, Omit *Strophanthus*



8am R-24/m, BP- 90/60 mmHg, pallor +,
Laurocerasus Q 10dr 2h
 S/o CCF+ RS-bil coarse crepts +
 POP/O₂ inhalation
 CVS-HS 1- muffled, P2- loud, No S3 gallop.
 PSM at apex, EDM at A2, CNS/Abd NAD
 4pm Dyspnoea less. Urine output 1100cc since adm
 ct. all
 Vitals stable. Systemic same.
 ECG- HR 100/m, NSR, axis -40deg, P/PR/QRS N,
 Global T inv, LVH +
 9.10pm Pt. much better. ASO titre 110 TU
 O2 SOS
Laurocerasus Q 2h
 9/4/03 Pt slept well, Dyspnoea less, cough/ expect
 ++, *Lauro* Q 10 dr 4h
 8.30 am Passed stool. Urine N, No chest pain
 Light diet.
 P 96/m, R 20/m, BP-110/60 mmHg,
 Pallor ++, S/o CCF+ edema feet decreased
 RS- bilateral fine crepts+
 CVS-HS 1-muffled, P2- loud, No S3 gallop.
 PSM at apex, EDM at A2, CNS/Abd NAD
 7.30pm Mobilized. Urine N, No chest pain
Lauro Q 10 dr BD.
 P 90/m, R 20/m, BP-110/70 mmHg, Rest ct all.
 Edema feet less, RS-bilateral fine crepts+
 CVS-HS 1-muffled, P2-loud, No S3 gallop.
 10/4/03 Pt. feeling better. No Dyspnoea reduced.
Lauro Q 10 dr BD
 Cough with expectoration +, vitals stable SL TDS
 crepts reduced. ECG same
 11/4/03 Pt. >, Dyspnoea / chest pain >
Lauro Q 10 dr BD
 Cough with expectoration persistent SL BD
 No Crepts, Urine/stools/diet/sleep N
 12/4/03 Pt. discharged on request. *Lauro* Q 10 dr BD
 Adv. Medicines to be ct. SL BD
 2/7/03 Pt. visited after Double valve replacement at
 SSH & PGI Nagpur.
 On allopathic drugs/ Inj Penidure every 21 days.

But not willing to ct allopathic injections.
 Called for detailed interview after 1 week
 9/7/03 Patient's mother stated - "Sir, we are from a
 middle class family. My husband, my son, aged 15
 years, daughter and me. My son too has got Rheu-
 matic Heart disease. His Balloon Mitral Valvotomy was
 done 4 years ago. My husband is serving in a bank.
 My daughter is our first child & was detected to have
 RHD 3 years ago. She was on Inj Penidure and was
 advised surgery then. Since the last acute episode we
 became very disturbed hence went in for surgery. Now,
 we wish that the Inj Penidure which she has been ad-
 vided for life be discontinued. Also she has other com-
 plaints too. She stopped schooling for lack of interest
 & concentration in studies and physical weakness. She
 is a very obstinate, sensitive girl and weeps on every
 little matter even at this age. She is basically restless
 and the continuous moving of feet really irritates us. Even
 after her surgery she feels that she will never recover.
 Sir, she has menstrual troubles. Her menses are pro-
 fuse, passes clots with intense abdominal pain and are
 offensive > lying on the stomach. She passes thin white
 discharge with itching over genitals." During the entire
 interview the patient hardly spoke.

- o Ambithermal
 - o Appetite-Normal.
 - o Desires salty foods, chilled drinks
 - o Thirst+++
 - o Sweat-scanty
 - o Urine/stool-normal. H/o Pinworms ++, scratches
 in the anal region at night.
 - o Sleep-sound. Prefers sleeping in prone position.
 Dreams-not specific.
 - o PSM at apex, EDM at A2, CNS/Abd NAD
- PERSONAL HISTORY** - 1st child of a non-consanguinous
 marriage. H/o severe anaemia in mother during preg-
 nancy, Premature delivery at 36 wks with birth weight
 of 1.8kg was kept in an incubator for jaundice. Vacci-
 nated till date. All milestones normal. Hobbies- loves
 music. In school - average student.
 P/H-RHD + MR(Sev) + AR(mod)+ PH since 3 years.

Repeated hospitalizations for the same. On Inj Penidure & was Advised surgery.

F/H-Brother-RHD: MS, PH (BMV done), Father - Urethral stricture (rec dilations), PGF-Renal stones, Rheumatoid Arthritis(died), PA- RHD,

9/7/03

Medo 1m 3d. Sac lac BD x 1mth. Psychotherapy 4/8/03

Pt much better, Depression >>, SL 1 TDS x 1 mth. Sensitivity / obstinacy >>, Counseling done. Menses- 6 days ago. Avg flow. Dysmenorrhoea > Adv to resume studies. Leucorrhoea ++ thin serous discharge, itching+. No Chest pain, dyspnoea, Vitals stable. Chest clear. HS - valvular click at apex, ECG-WNL

1/9/03

No complaints. No depression. Sac lac ct. Confidence of pt good. Pt. started studies and was Re-admitted in 9th std. Menses 3/29 days, avg flow. No dysmenorrhoea. Leucorrhoea + >, No itching. Hb = 11 gm%, TLC- 9,700/cu mm, P56%, L40%, E3%, M 1%, ECG -WNL. 2D ECHO- All valves normal. LV mildly dilated. Other cardiac chambers normal in dimensions. No Pericardial effusion, Good LV systolic and diastolic func, LVEF-65%, No intracardiac clot / mass/ vegetations.

8/10/03

Pt still under follow-up. Improving. No complications of replaced valves reported.

DISCUSSION

1. *Strophanthus-hisp Q* was given as a short acting remedy for controlling the Left Ventricular failure or cardiac asthma manifested by severe dyspnoea, congestion of lungs, swelling over the feet, tachycardia, angina and anaemia. Although S3 gallop which is the clinical evidence of Severe LV failure disappeared but there was no special relief to the patient.

2. *Laurocerasus Q* was administered after *Strophanthus* did not ameliorate to satisfaction. *Digitalis*, *Adonis-v*, *Kalmia* and *Convalraia* were thought of but

finally *Laurocerasus* was given as a pathological prescription to control the LVF on the basis of Breathlessness < exertion < sitting, palpitations, S/of constriction in the precordium > by massage on the chest. Cough with copious jelly- like expectoration < lying down, night. Edema feet. Valvular disease - Mitral & Aortic regurgitation. The patient improved to a great extent and her failure was controlled.

3. *Medorrhinum* - the multipolycrest missile was the constitutional remedy, the true Similimum in this case. It was decided on the basis of the detailed case history. Mentally patient had lack of interest and concentration in studies while physically she was stunted and short statured. Fidgety feet, Very obstinate, sensitive with weeping tendency. Hopeless of recovery. Menstrual troubles- profuse, clots dark offensive, stains difficult to wash, dysmenorrhoea > lying on the stomach. Leucorrhoea - thin white, with intense vulval itching. Desires salt, icy cold drinks, Thirst - ++++. Anal itching with pinworms. Sleep - sound. Sleeps on the stomach. P/H - RHD, F/H of Brother & PA - RHD, Father - Urethral stricture, PGF- renal stones, Rheumatoid Arthritis.

Within a month itself the patient responded positively. She became mentally calm and her menstrual complaints reduced although the elimination continued i.e. leukorrhoea increased initially but then gradually decreased. The patient is still under regular follow-up and has started her studies again.

4. **POP/O₂ inhalation** were essential tools in managing the acute scenario along with medicines (F.N aph 67, 6th Ed Org). Psychotherapy & Counseling have also played a very important role in the management of the entire case. □

“Do not regret growing older.
It is a privilege denied to many.”