CASE REPORT

We wish to report on an unusual presentation of syncope in patients with hypertrophic cardiomyopathy—postprandial syncope. This was exemplified by a 55-year-old white male who presented with four episodes of unexplained syncope over the course of 10 years, all of which occurred immediately after eating. His only past history was hypertension on treatment with diuretics and angiotensin-2 receptor blockers. He had a normal examination without a murmur at rest or during the strain phase of the Valsalva maneuver. He was subsequently found to have moderate basal septal hypertrophy of 1.6 cm without outflow tract obstruction either at rest or during an exercise test. However, a repeat examination was performed immediately after eating a large meal and he developed a loud 5/6 systolic ejection murmur with an echocardiogram showing severe dynamic outflow tract obstruction with systolic anterior motion of the mitral valve, an outflow gradient of 110 mmHg, and severe posteriorly directed mitral regurgitation. The patient was subsequently taken off his diuretic and AT2 receptor blocker, started on a beta blocker. Follow-up has been obtained 10 years after evaluation and he has done well without further symptoms.

Syncope in patients with hypertrophic cardiomyopathy is usually related to neurally-mediated syncope or an arrhythmia [1]. It has been recommended that there be consideration of an automatic defibrillator for patients who present with syncope, especially those younger patients with a recent episode of syncope. Our patient is an example of syncope from a hemodynamic consequence which occurred after a large meal, presumably due to a reduction in preload from pooling of blood in the splanchnic circulation [2,3]. Treatment is aimed at preventing the occurrence of a dynamic left ventricular outflow tract obstruction rather than implantation of a defibrillator. Thus, a careful history should always be an important part of the work-up for patients with hypertrophic cardiomyopathy and this pathophysiology should be considered in patients who present with postprandial syncope.

REFERENCES