PERTH
CARDIOVASCULAR
INSTITUTE

PRIVATE AND CONFIDENTIAL

26th October 2023

Dr Praveen Vasantharao
Beechboro Family Practice
2/130 Bridgeman Dve
BENNETT SPRINGS WA 6063

Dear Praveen

RE: **Adam Siwek DOB: 21/9/1984**
18 Turtledove Way
BENNETT SPRINGS, WA 6063

Diagnoses/Problem List

1. Ongoing chest pains since myocarditis in 2021 - cause uncertain.
2. mRNA vaccine induced myocarditis December 2021.
   2.1 Cardiac MRI - December 2021 - subepicardial LGE involving septal walls consistent with myocarditis. No significant functional impairment.
   2.2 Transthoracic echocardiogram. Normal LV size with inferoapical akinesis and lateral apical hypokinesis with preserved ejection fraction.
   2.3 Coronary angiogram - normal coronary anatomy with non-specific findings with potential spasm and unlikely to be related to MRI findings.
   2.4 Peak troponin 1100.
3. Stress echocardiogram September 2022. Normal LV function with no inducible myocardial ischaemia.
4. Cardiac MRI March 2023 - normal LV size and function with mid ventricular fibrosis consistent with previous myocarditis and no evidence of ongoing myocardial oedema or fibrosis.
5. AV malformation - treated in March with radiotherapy and doing well from this.

Thank you for referring this 39-year-old gentleman whom I saw with his wife in my Midland Clinic today. He underwent COVID vaccination with Pfizer vaccine on 15 September 2021. Following this he developed a number of symptoms including headaches and recurrent epistaxis. He then had a further vaccination on 15 October 2021 and following this had further episodes of headaches and epistaxis and then developed pain in his chest on exertion but also consistent with myopericarditis i.e. worse lying flat and relieved by lying forward. He eventually presented to Sir Charles Gairdner Hospital on 09 December feeling unwell and clammy and in summary had investigations consistent with myocarditis. His troponin rose to 1180 and there were T-wave changes on his ECG. An initial coronary angiogram ruled out significant coronary artery disease, a CT aortogram ruled out dissection, an echo showed some subtle wall motion abnormalities and an MRI scan showed changes consistent with myocarditis. Following that initial presentation he has had ongoing symptoms of chest pain which are non-specific. He has been investigated with stress tests which have been normal. I understand he has had two episodes of COVID-19 infection since that time

both of which have made things slightly worse. He continues at the moment with ongoing symptoms of non-specific chest pain worse on exertion, can be made worse by breathing and do not really appear to be helped with analgesics. He had a repeat MRI study earlier in the year which has shown normal LV size and function, evidence of the previous myocarditis but no evidence of ongoing issues. He is a non-smoker, drinks alcohol at weekends socially. There is no significant family history of heart disease and he has no known drug allergies.

Clinical examination today was normal with no clinical signs of hyperlipidaemia. His pulse was 66 regular, blood pressure of 148/88, normal heart sounds, clear chest, no tenderness across the chest wall and no ankle swelling.

Resting ECG was within normal limits.

Management Plan

This gentleman has an almost certainly had vaccine induced myopericarditis and is summarised well in other correspondence from the immunology team. With regard to the ongoing symptoms of chest pain I have seen quite a few patients in recent months with almost identical symptoms and I have never really been able to give a specific cause for these. They have all occurred either after COVID-19 or vaccination. In general these things do tend to settle given some time though an exact timescale is not possible. I have reassured him and his wife with regard to this today. They also asked whether I would be happy to sign their COVID-19 vaccine claim scheme medical certificate and I have done so.

Yours sincerely,

Electronically approved by Dr Andrew Epstein
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