The patient’s laboratory findings were as follows: neutrophil-to-lymphocyte ratio higher than 3 (reference range, 1–3), elevated levels of high-sensitivity cardiac troponin T, from 72 ng/l to 102 ng/l (reference range <14 ng/l), dynamically evolving C-reactive protein levels, from 1.2 mg/l to 1.8 mg/l and 94 mg/l (reference range <6 mg/l), elevated levels of N-terminal fragment of the prohormone brain natriuretic peptide, 2451 ng/l (reference range <125 ng/l), lactic acid dehydrogenase, 369 U/l (reference range, 80–240 U/l), D-dimers, 1.39 mg/l (reference range <0.5 mg/l), aspartate aminotransferase, 159 U/l (reference range <45 U/l), alanine aminotransferase, 163 U/l (reference range <35 U/l), but procalcitonin levels (reference range <0.05 ng/ml) were normal. Due to suggestive laboratory results, particularly in the light of the COVID-19 outbreak, a reverse transcription–polymerase chain reaction test for SARS-CoV-2 was performed on the sixth day of hospitalization and yielded a positive result. Consequently, the patient received a single 500-mg dose of azithromycin and a single 75-mg dose of oseltamivir. On day 7, he was transferred in good general condition to a COVID-19-specialized hospital for further treatment.

On day 17, the patient’s pharyngeal swab specimen was still positive for SARS-CoV-2 after the reverse transcription–polymerase chain reaction test, and the man presented no respiratory symptoms.

Cardiac magnetic resonance imaging, performed with a 1.5 Tesla scanner, revealed left atrial enlargement and global left ventricular hypokinesia with ejection fraction of 20%. The T2-weighted sequence did not show myocardial edema (Figure 1A–1C). In contrast, imaging with the use of late gadolinium enhancement...
demonstrated a large, patchy, and linear non-ischemic pattern of fibrosis localized subepicardially and intramurally in the basal, mid-cavity, and apical segments of the inferior and inferolateral wall (arrows) demonstrated a large, patchy, and linear non-ischemic pattern of fibrosis localized subepicardially and intramurally in the basal, mid-cavity, and apical segments of the inferior and inferolateral wall (Figure 1D–1G).

As shown in this case, SARS-CoV-2 may cause, apart from COVID-19-related pneumonia, acute myocardial injury meeting diagnostic criteria for clinically suspected myocarditis.9

**SUPPLEMENTARY MATERIAL**
Supplementary material is available at www.mp.pl/paim.

**ARTICLE INFORMATION**

**CONFLICT OF INTEREST** None declared.

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FIGURE 1  Cardiac magnetic resonance imaging in a patient with severe acute respiratory syndrome coronavirus 2 infection: G – late gadolinium enhancement in a 4-chamber view showing a nonischemic pattern of fibrosis localized subepicardially and intramurally in the mid-cavity and apical segments of the anterolateral and lateral wall (arrows)


REFERENCES