Absolutely! Here is a re-written case report abstract in the same format as your provided example, but featuring an entirely different (fictional) medical scenario. Please note, this example is meant to serve as a template for your own writing and should not be used for actual patient data.

Title:
Acute Myocarditis Presenting as Refractory Ventricular Arrhythmia in a Young Athlete

Authors:
Rebecca L. Monroe, M.D.(1), Samuel T. Lin, M.D., Ph.D.(1), Priya Krishnan, D.O.(2), Marcus Lee, M.D.(3)
(1) Department of Cardiology, Riverside University Medical Center
(2) Department of Emergency Medicine, Riverside University Medical Center
(3) Department of Internal Medicine, University of California Health System

Introduction:
Acute myocarditis is an inflammatory condition of the myocardium that is frequently underdiagnosed in otherwise healthy young adults.1 Presentation varies from asymptomatic cases to life-threatening arrhythmias and heart failure.2 Early identification is crucial, particularly in young athletes, because exercise-induced stress can exacerbate myocardial injury and arrhythmic risk.3 Here, we report an unusual case of acute myocarditis manifesting solely as refractory ventricular arrhythmia in a collegiate athlete, highlighting the importance of suspicion for myocarditis in atypical presentations.

Case Presentation:
A previously healthy 21-year-old male collegiate basketball player presented to the emergency department after a syncopal episode during practice. He reported palpitations and lightheadedness but denied fever, chest pain, or respiratory symptoms. His medical history was unremarkable, and there were no recent illnesses or medication use.

On arrival, his vital signs were notable for a heart rate of 130 bpm and blood pressure of 128/72 mm Hg. Cardiovascular examination revealed frequent premature ventricular contractions (PVCs) but was otherwise normal. Neurological and respiratory exams were unremarkable.

Initial ECG showed frequent multifocal PVCs with runs of non-sustained ventricular tachycardia (VT). Laboratory workup revealed normal electrolytes and troponin I just slightly above the upper limit of normal. Chest X-ray was unremarkable. Transthoracic echocardiogram showed preserved ejection fraction without structural abnormalities. Over the next several hours, the patient developed sustained VT requiring chemical (amiodarone) and electrical cardioversion with transient success. Cardiac MRI demonstrated diffuse myocardial edema and late gadolinium enhancement, confirming the diagnosis of acute myocarditis. Viral serology was positive for recent coxsackie B infection.

The patient agreed to hospital admission and was managed with antiarrhythmic medications and supportive care. Over the following week, arrhythmias resolved and repeat imaging showed

improvement in myocardial inflammation. He was advised to refrain from strenuous activity for six months.

Discussion:

This case underscores the importance of early consideration of myocarditis in young patients presenting with unexplained ventricular arrhythmias, even in the absence of typical symptoms such as chest pain or viral prodrome. Literature review reveals that while arrhythmias are not uncommon in myocarditis, isolated sustained VT as an initial manifestation is rare.4 Early use of cardiac MRI allowed for noninvasive confirmation of the diagnosis and timely management. This case is distinctive in that the patient was a high-performance athlete, reinforcing the need for pre-participation screening and close monitoring after syncopal events. In future similar cases, rapid cardiac imaging should be considered, and return-to-play decisions must be cautious and individualized.

References

(*References would be added here in a formal submission*)

Let me know if you'd like a rewrite for a specific scenario, specialty, or focus!

1. https://ppl-ai-file-upload.s3.amazonaws.com/web/direct-files/attachments/88649493/bf14a0cc-6e35-4dba-8883-51bff5fee9c5/CaseReportExample.pdf