

Giant thrombus occupying the right cardiac chambers in a cancer patient: An unusual and incidental discovery 🎥

A 76-year-old woman with existing uninvestigated chronic hepatitis B presented with resting dyspnea and bilateral leg swelling. The patient was hemodynamically stable with a significant tricuspid murmur. Laboratory findings highlighted important hepatic cytolysis, moderate anemia, and increased D-dimers. Transthoracic echocardiography revealed a large, well-defined echogenic mass (30/80 mm) with hypoechoic central areas that occupied the right atrium (RA) almost entirely, protruded into the right ventricle (RV), and significantly obliterated the tricuspid valve (Fig. 1, Panel A, Supplementary Video S1). The mass also extended into the RV outflow tract with some smaller fragments protruding into the pulmonary artery (PA) (Fig. 1, Panel B). The subcostal view revealed that the mass seemed to originate from the inferior vena cava (IVC), which suggested a thrombus (Fig. 1, Panel C). Computed-tomography (CT) consistently showed subsegmentary pulmonary embolism and revealed that the mass had completely filled the IVC. Additionally, multiple heterogenous, hypervascular liver nodules (Fig. 1, Panel D) associated with significant abdominal lymphadenopathy were observed, which are highly consistent with a

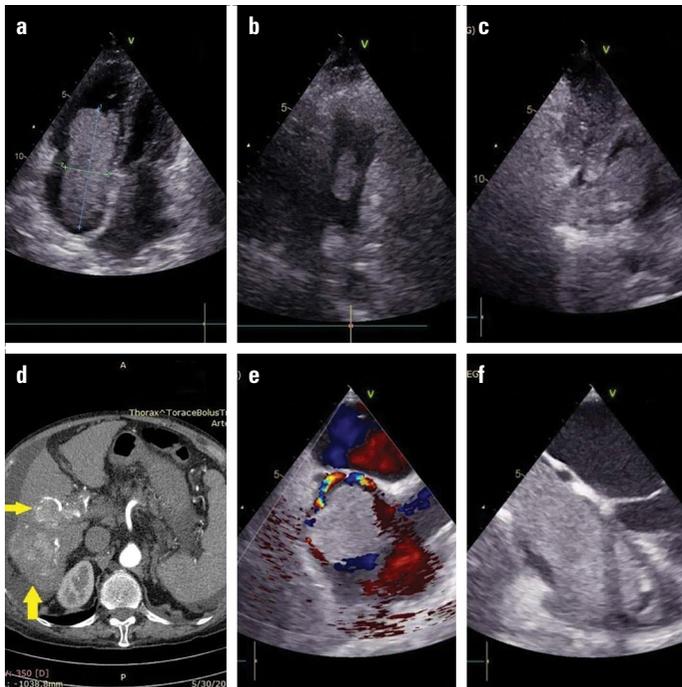


Figure 1. Panel figure. (a) Well-defined giant mass occupying the right atrium (RA), protruding into the right ventricle (RV), and significantly obliterating the tricuspid valve; (b) protrusion in the pulmonary artery (PA); (c) origin site in the inferior vena cava (IVC); (d) highly typical CT for hepatocellular carcinoma diagnosis (arrows); (e, f) transesophageal echocardiography revealing a giant mass occupying the right chambers

diagnosis of hepatocellular carcinoma (HCC). Transesophageal echocardiography from both midesophageal bicaval view (Fig. 1, Panel E, Supplementary Video S2) and four-chamber view (Fig. 1, Panel F) highlighted the highly mobile mass that occupied the right chambers and extended into the PA and therefore, blocked both the RV inflow and outflow tract. However, few hours after admission and despite the attempted rescue thrombolysis, the patient experienced sudden cardiac arrest. HCC patients are known to have an increased risk of thrombosis; however, a giant metastatic thrombus that extends from the IVC to the PA is still considered an unusual presentation of HCC.

Informed consent: The informed consent was obtained from the patient.

Supplementary Video S1. Transthoracic echocardiography, subcostal view: giant mass occupying the right atrium (RA), protruding into the right ventricle (RV), and significantly obliterating the tricuspid valve.

Supplementary Video S2. Transesophageal echocardiography, midesophageal bicaval view revealing highly mobile mass occupying the right chambers.

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Near complete resolution of nonbacterial thrombotic endocarditis in a patient with antiphospholipid antibody syndrome 🎥

A 64-year-old woman with a medical history significant for cirrhosis, portal vein thrombosis on rivaroxaban, cerebrovascular accident, antiphospholipid antibody syndrome (APLS), and streptococcus mitis endocarditis with complete resolution underwent a routine screening transthoracic echocardiogram, which demonstrated new mitral valve vegetations on both the anterior and posterior leaflet tips with moderate-severe mitral valve regurgitation. A transesophageal echocardiogram dem-