Most cerebral embolic events in young patients are of cardiac origin. Atrial thrombus accounts for about half of cardiac embolism cases. Cardiac myxoma, the most frequent cardiac tumor, is rare cause but an important etiology of stroke in young patients. It is difficult to distinguish myxoma from thrombus due to similar echocardiographic features on TTE in patients with atrial fibrillation associated with rheumatic mitral valve disease. TEE is helpful to discriminate between myxoma and thrombus.

**Video 1.** TTE revealing mobile homogeneous mass in the left atrium.

**Video 2.** 2-D TEE showing highly mobile homogeneous pedunculated mass arising from the anterior interatrial septum.

**Video 3.** 3-D TEE showing highly mobile mass.

A giant left ventricular pseudoaneurysm presenting with transient ischemic attack 7 years after acute myocardial infarction: A deep investigation via multiple imaging modalities

Left ventricular pseudoaneurysm (LVPA) develops when myocardial rupture is contained by pericardial adhesions and thrombus formation. We present a unique case report of LVPA with illustrative and demonstrative images. A 75-year-old male patient was admitted to emergency department with a complaint of temporary verbal aphasia. Seven years earlier, the patient had suffered an inferior myocardial infarction that was treated with left anterior descending artery (LAD)-saphenous vein graft (SVG) and right coronary artery (RCA)-SVG bypass surgery. His symptoms were completely resolved before admission and neurological examination was normal. Cranial multi-detected computed tomography (MDCT) revealed location of ischemic stroke at chronic stage in left occipital lobe (white arrow).
chronic stage in left occipital lobe (Fig. 1). His electrocardiogram showed ST segment elevation and deep Q waves in leads D3 and aVF (Fig. 2). Echocardiogram revealed presence of large (max. dimensions: 67x75 mm; entrance size: 38 mm) thrombosed LVPA of the inferior wall (Fig. 3, Videos 1–3). Coronary angiography demonstrated normal functioning of LAD-SVG and left circumflex artery, and total occlusion of RCA. RCA-SVG stump was not visualized. Contrast-enhanced-cardiac-MDCT confirmed LVPA exiting the inferior wall (max. dimensions: 65x71x85 mm) and total occlusion of RCA-SVG from the origin (Figs. 4–7). In consultation with cardiovascular surgical team, decision was made for urgent surgery. However, the patient denied the therapy. Therefore, anticoagulation medications warfarin and enoxaparine were administered. After reaching target level, the patient was discharged and called for a check-up after a month. Echocardiogram revealed the persistence of thrombus inside LVPA.

Figure 2. Electrocardiogram shows ST segment elevation and deep Q waves in lead D3 and aVF, consistent with left ventricular aneurysm.

Figure 3. (a) Transthoracic echocardiography (TTE) with apical modified 4-chamber view shows near-normal examination. (b, c) TTE with para-sternal short-axis view shows giant (67x75 mm) and partially thrombosed left ventricular pseudoaneurysm directly communicating with left ventricular chamber through 38 mm breach.

Figure 4. (a–c) Horizontal, sagittal, and coronal cardiac computed tomography scans show thrombosed left ventricular pseudoaneurysm with thin outer layer.
Video 1. Transthoracic echocardiography with parasternal long-axis view shows left ventricular pseudoaneurysm.

Video 2. Transthoracic echocardiography with parasternal short-axis view shows left ventricular pseudoaneurysm.

Video 3. Transthoracic echocardiography with parasternal short-axis view shows left ventricular pseudoaneurysm and color inflow.

Muhammed Keskin, Taha Keskin1, Muhsin Nuh Aybay2
Department of Cardiology, Dr. Siyami Ersek Thoracic and Cardiovascular Surgery Training and Research Hospital; İstanbul-Turkey
1Department of Medicine, Albert Einstein College of Medicine, Yeshiva University; New York, NY-USA
2Department of Radiology, Konya Training and Research Hospital; Konya-Turkey

Address for Correspondence: Dr. Muhammed Keskin
Dr. Siyami Ersek Hastanesi Tibbiye Cad. No:25, Üsküdar, İstanbul-Türkiye
Phone: +90 216 542 44 44 Fax: +90 216 337 97 19
E-mail: drmuhammedkeskin@gmail.com
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