P1481

Embolic infarct in a known coronary artery disease patient

Ali AH.[1]; Alnuaimi U.[2]; Lacau SI.[3]; Badiu C.[4]; Popescu AC.[1]

[1]Elias Emergency Universitary Hospital, Cardiology, Bucharest, Romania
[2]Elias Emergency Universitary Hospital, Radiology, Bucharest, Romania
[3]Sanador, Radiologie, Bucharest, Romania
[4]Spitalul Monza, Bucharest, Romania

A 60 y/o diabetic and hypertensive lady with previous anterior infarction treated by primary PCI with stenting of the proximal LAD (2011) and CABG for stent thrombosis, presented for chest pain. Admission ECG showed ST segment elevation in II, III aVF, ST segment depression in V1-V2 (A). Urgent coronary angiography was performed. It showed non-significant lesions on RCA and LCX, occlusion of the proximal LAD stent, patent LIMA to LAD and first diagonal with non-significant stenosis of the distal anastomosis (B). Transthoracic echocardiography (C) showed calcific mass involving the mitral annulus and posterior mitral leaflet, moderate mitral regurgitation, hipokinesia of the basal segment of the inferior wall with preserved LV ejection fraction. Transesophageal echocardiography (D) confirmed the calcified mass involving the mitral annulus and the posterior mitral leaflet. There was no significant mitral stenosis, and mitral regurgitation was moderate. Thoracic CT showed massive mitral calcification and a possible thrombus attached to it. (E)

Myocardial infarction was confirmed by troponin rise and fall. The patient was discharged on dual antiplatelet therapy, ACE-I, betablocker and statin. At one month follow-up transthoracic echocardiography the central area of the mitral mass became hypoechogenic, and a bilobated hypermobile structure was seen attached to the ventricular side of the mass (F). Blood cultures were negative and there was no inflammatory syndrome. Cardiac magnetic resonance (H) confirmed myocardial infarction and showed massive calcification of the posterior mitral annulus. TEE performed after another month showed a very long hypermobile structure attached to the mitral annulus calcification, which was entering the left ventricular outflow tract reaching the plane of the aortic valve (G). The patient underwent surgical mitral valve replacement and redo CABG and the mass was excised. The pathologic aspect of the excised material was cazeous and friable (I).

The initial presentation was presumably an embolic infarct with cazeous material.

Abstract P1481 Figure.