A 68-year-old man with left-sided facial palsy was referred for cardiac search for embolic source. He had been on parenteral nutrition after surgery for colon cancer, and his paralysis had been preceded by 3-week long-remittent fever despite exchange treatment and supportive care, the patient died several days later because of over-

The pulse rate was 94 bpm and blood pressure was 96/49 mmHg. The head, chest, and abdominal computed tomography revealed multiple lesions in the brain, right kidney, and spleen consistent with infarctions. Transthoracic echocardiography revealed an oval mobile mass occupying the left ventricle with dimensions 3.5 × 4.7 cm (Panel A). Systolic function and dimensions of left ventricle were preserved within normal limits. No vegetation were present on the valves and no thrombi in the other cardiac chambers. Colour Doppler imaging showed no valvular insufficiency. Methicillin-resistant Staphylococcus aureus was isolated from blood cultures. According to the clinical course, a cardiac mass was considered as endocarditis. Despite antibiotic treatment and supportive care, the patient died several days later because of over-

Intracardiac infection involving non-valvular structures are often secondary to valvular vegetations, regurgitation, prosthetic valve, and congenital shunt. This case is unusual because of isolated huge mural vegetation attached to the left ventricular apex, suggesting that non-valvular infectious endocarditis could be occurred primarily in compromised patients.

(A) Echocardiography showed an oval mobile mass occupying the left ventricle (arrow).
(B) An excised mass included multiple abscesses with thick capsules (arrows).
(Histology showed bacteria clumping with fibrosis (haematoxylin–eosin).)

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