CASE REPORTS

Rupture of left ventricle leading to pseudo-aneurysm formation

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A 55-year-old Asian man was admitted with a 24-h history of central crushing chest pain radiating to his left arm worse on the day of admission. He was known to have peripheral vascular disease, diabetes, previous right below knee amputation and hyperlipidaemia; he was also a long-term smoker. On examination he was haemodynamically stable with no evidence of cardiac failure or murmurs. His resting 12-lead electrocardiogram (ECG) revealed an acute anterior ST-elevation myocardial infarction. In view of his ongoing chest pains and ECG findings he was promptly transferred to the cardiac catheterisation laboratory for immediate primary angioplasty. Coronary angiography revealed an occluded proximal left anterior descending coronary artery with moderate disease in the left circumflex and dominant right coronary artery. The occluded vessel was opened and a stent was deployed in the proximal artery with a good result. Three days later he became hypotensive and a new murmur was audible on auscultation of his heart; he was not in overt cardiac failure. Transthoracic echocardiography revealed a dilated left ventricle with impaired systolic function with hypokinetic anterior and septal walls. A pseudo-aneurysm was noted at the apex of the left ventricle with myocardial rupture (Fig. 1); colour flow demonstrated flow into the pseudo-aneurysm (Fig. 2). He was treated medically and made a slow but steady recovery and was discharged home two weeks later. The patient was reviewed in the outpatient department two weeks later with repeat echocardiography revealing the pseudo-aneurysm was no bigger. The patient is under close follow-up and will require surgical intervention as the prognosis without surgery is poor and risk of rupture is high.

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Patients presenting with acute myocardial infarction who develop a new murmur should be promptly investigated with echocardiography to exclude myocardial free wall rupture, septal rupture or valvular incompetence.

Momentarily stuck in the foramen ovale

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Abstract An 80-year-old woman was admitted for a diagnosis of severe pulmonary embolism. A large serpentine thrombus stuck in a patent foramen ovale (PFO) completely resolved without the patient experiencing any manifestation. The right renal artery was the final destination. Three months later, the patient was diagnosed with a malignant melanoma and metastatic dissemination.

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