by the OAT study and the new subgroup analysis. The relatively disappointing results in this analysis by Menon et al. underscore once again the importance of achieving early reperfusion in ST-segment elevation myocardial infarction (STEMI), and support continued efforts to reduce the large numbers of patients who still fail to achieve this.

Conflict of interest: none declared.

References

Giant calcified cardiomegaly

Anas Babiker, Jose Alberto de Agustín*, and Pilar Jiménez-Quevedo
Cardiovascular Institute, San Carlos University Hospital, C/ Profesor Martin Lagos s/n, 28040 Madrid, Spain
* Corresponding author. Tel: +34 696 228 197, Fax: +34 915 610 674, Email: albertutor@hotmail.com

A 65-year-old male, ex-smoker, with previous extensive anterior myocardial infarction 18 years ago and NYHA functional class III, presented to the emergency room with diarrhoea and vomiting associated with epigastric pain and acute renal failure. Myocardial enzymes were markedly elevated with an ECG evidence of an old anterior myocardial infarction. Chest X-ray showed an enlarged and calcified cardiac silhouette (Panel A). Transthoracic echocardiogram revealed a large ventricular anteroapical aneurysm occupied by a huge mural thrombus (Panel B). Coronary angiography showed an occluded proximal left anterior descending artery without any evidence of collateral circulation (Panel C). Left ventriculogram demonstrated a large calcified ventricular aneurysm (Panel D) and cardiac magnetic resonance (Panel E and F) revealed left ventricular end-diastolic and end-systolic volumes of 873 and 821 mL, respectively. The left ventricular ejection fraction was only 6%. The patient was rejected for cardiac resynchronization, therefore underwent cardiac defibrillator implantation and was referred for consideration of cardiac transplantation.

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