several cardiac diseases. Echocardiography and CMR are the imaging modalities of choice for imaging the right heart. In most patients, both techniques provide complementary information and can be used in combination for almost complete evaluation of the RV. Multidetector computed tomography and nuclear imaging technique are valuable alternative modalities and add important additional information in selected cases, particularly in RV ischaemic disease. Emerging new technologies such as 3D echocardiography, TDI, speckle tracking as well as new CMR sequence are enlarging the spectrum of the pathophysiologic information obtained, but are still confined to investigational use and need further clinical validation. Table 5 summarizes the use of all these imaging modalities for assessing the different RV parameters in various diseases, and may serve as guide for multimodality imaging.

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References

The list of references is available in the online version of this paper.

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**CARDIOVASCULAR FLASHLIGHT**

**An unusual cause of embolic myocardial infarction**

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A 35-year-old female presented with acute inferior ST-elevation myocardial infarction and underwent emergency cardiac catheterization. Diagnostic images revealed an occlusive filling defect at the first bifurcation of a large dominant circumflex artery (Panel A). The other epicardial coronary arteries were normal. Aspiration thrombectomy removed a significant volume of thrombus and angiography then demonstrated the circumflex to be angiographically normal and no stenting was required (Panel B). Transoesophageal echocardiography (TOE) demonstrated a 0.4 × 0.6 cm mobile echodensity on the atrial aspect of a thickened anterior mitral valve leaflet. No other intracardiac abnormalities were identified. The patient was systemically well with no episodes of pyrexia. Inflammatory markers were not raised (C-reactive protein 7 and erythrocyte sedimentation rate 35) and blood cultures did not identify a bacteraemia. Thrombophilia screen was remarkable for a positive lupus anticoagulant (RVVT norm% correction 48.6%) and a positive anticardiolipin antibody (ACA IgG 44 U/mL). An anti-nuclear antibody was positive for both the nucleolar and homogenous patterns. A diagnosis of Libman–Sacks endocarditis (LSE) was made and the patient was commenced on intravenous heparin. On follow-up TOE, several days later, the mobile echodensity was no longer visible, though the anterior leaflet tip remained thickened (Panels E and F). She was commenced on warfarin and has remained well with no unplanned hospital admissions.

Libman–Sacks endocarditis comprises sterile verrucose lesions of the valvular and mural endocardium and most commonly affect left-sided valves on the upstream side of the valve leaflets. The presence of LSE and concurrent anti-phospholipid syndrome promotes thrombus formation on the abnormal valve surface. This most often leads to cerebrovascular phenomena, with documented myocardial infarction secondary to thrombo-embolism from LSE exceptionally rare.