reaching the age-dependent work capacity would qualify for a substantial rebate on their health insurance rates. Exceptions would have to be made, of course for patients with physical handicaps. In addition, as recently stated by Joyner in an editorial comment, deconditioning should become a recognized syndrome or diagnosis. This would definitively facilitate the education of the general population as well as the medical community about the beneficial effects of ET as treatment options for several diseases.

In conclusion, physical activity is one of the most fundamental factors necessary for maintaining health and warding-off risk factors; long-term compliance, however, is poor in the vast majority of patients. Until today, all strategies to improve adherence significantly have failed and long-term trends seem to point the wrong direction. New concepts need to be contemplated, borrowing from successful fights against other risk factors.

Conflict of interest: none declared.

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

CARDIOVASCULAR FLASHLIGHT

Unusual complication after infective endocarditis: pseudo-aneurysm of the left ventricle

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A 37-year-old female, with a history of drug abuse (including cocaine), was admitted with fever and malaise. Transoesophageal echocardiography demonstrated infective endocarditis of the native mitral valve, and the patient underwent antibiotic treatment for 6 weeks. On 1 year follow-up trans-thoracic echocardiography, a large cavity with flow adjacent to the left ventricle was seen (Panel 1A). Further workup with magnetic resonance imaging confirmed the presence of a pseudo-aneurysm (83 × 60 × 76 mm, Panel 1B), with a small neck at the latero-apical aspect of the left ventricle, with no wall motion abnormalities. Coronary angiography ruled out any atherosclerotic lesion with normal anatomy (Panel 1C). After this episode, the patient was temporarily lost to follow-up due to a relapse into drug abuse, but presented again two years later with chest pain and dyspnoea. The patient finally consented to surgery for aneurysm resection. Intra-operatively, the pseudo-aneurysm was opened revealing an oval defect (20 × 40 mm, Panel 2) in scarred myocardium. This defect was closed using a double Dacron patch and prolene sutures. The post-operative echocardiogram demonstrated good left ventricular dimensions with reasonable function and no signs of local dyskinesia. Diagnosis of a pseudo-aneurysm was confirmed on pathology. Recovery was uneventful and the patient was discharged on the 10th post-operative day. We suspect that the pseudo-aneurysm was caused by a local septic embolism or abscess from the infective endocarditis or due to coronary artery spasm occurring with cocaine usage, rather than by ischaemic vessel disease. This case emphasizes the usefulness of echocardiography in the follow-up after infective endocarditis (Supplementary Material online, Video S1).

Supplementary material is available at European Heart Journal online.

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