itself induced immune activation is considered to independently contribute to CVD and may partially explain the higher cardiovascular mortality in this patient group. Moreover, cART via associated dyslipidaemia or insulin resistance may further enhance cardiovascular risk. Therefore, careful selection of antiretroviral drugs as well as cardiovascular risk management is necessary to counter balance the increased cardiovascular morbidity in this patient population and close attention towards multiple complex drug—drug interactions between HIV therapy and commonly used cardiovascular drugs is mandated. With regard to developing countries, dynamic socioeconomic, and lifestyle factors characteristic of an epidemiological transition appear to have positioned the urban community also at risk for traditional CVD. In this context, cardiovascular risk assessment of HIV patients needs to become a critical element of care similar to developed countries. Also, access to first and second line cART with little or no impact on lipid and glucose metabolism will become of importance to reduce CVD in HIV in the future.

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

Cusp thrombosis after transcatheter aortic valve replacement detected by computed tomography and echocardiography

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An 86-year-old male underwent transcatheter aortic valve replacement (TAVR) for severe aortic stenosis with an Edwards Sapien 29 mm XT valve and percutaneous coronary intervention simultaneously. Periprocedural transoesophageal echocardiography (TOE) showed good positioning and expansion of the prosthesis with only minor paravalvular insufficiency. Routine post-TAVR computed tomography angiography (CTA) performed 7 days after implantation revealed a crescent shaped, hypoattenuating structure adherent to the prosthesis cusp located in the former native left-coronary cusp position (Panels A–C). Rigidity of the cusp was displayed by 4D-cine CT imaging and confirmed by TOE (Panels D and E; Supplementary material online, Videos S1 and S2), suggestive of cusp thrombosis. Despite restricted cusp movement, the mean pressure gradient (9 mmHg) was normal. Post-interventional anticoagulation therapy had consisted of daily aspirin and clopidogrel, while heparin had been paused from Day 4 to 7 post-intervention due to perianal bleeding complications. After restoring coumadin therapy, the patient had received for 3 years due to a history of pulmonary embolism and which had been paused prior to TAVR, 10-week follow-up CTA (Panel F) and TOE showed complete disappearance of the initial finding, underlying the diagnosis of cusp thrombosis. As to our knowledge, this is the first report of a cusp thrombosis of a transcatheter aortic valve detected by computed tomography.

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