Complete recovery after near-fatal multifocal embolization of giant cardiac thrombus: importance of rapid cerebrovascular intervention

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A 59-year-old male patient was admitted with severe dyspnoea and weight gain of about 15 kg. Echocardiography revealed a global left ventricular hypokinesia and a 44 × 30 mm floating mass in the apical left ventricle. In view of the severely impaired patient condition, a decision against cardiac surgery for heart failure and anticoagulation treatment was made. We used intravenous unfractionated heparin and the activated partial thromboplastin time was kept at a ratio of 2.5. Diuretics and heart failure medication was initiated. Myocardial ischaemia was excluded by coronary catheterization. Under anticoagulation therapy, the cardiac mass decreased slightly in diameter (30 × 25 mm), indicating thrombus rather than myxoma. Ten days after admission, a sudden loss of consciousness occurred, which was accompanied by apnoea and pupil difference. The lower right extremity was cyanotic with no pulse palpable. A whole-body emergency CT-angiography revealed an embolic occlusion of the distal basilar artery as well as embolizations of the visceral and both popliteal arteries. The cardiac mass had completely disappeared from the left ventricle. An immediate intraarterial embolectomy was performed with a stent-retriever which succeeded in complete recanalization of the basilar artery within 90 min after start of symptoms. Blood flow of the lower legs could be restored by thrombectomy of both popliteal arteries.

In the following, the patient could be weaned from the respirator after 6 days on ICU. He presented only minor neurological symptoms which were completely reversible during the following weeks. By the time of this submission, the patient had resumed his occupation as a high school teacher.

Panels A–E. (A) Embolic occlusion of the distal basilar artery, (B) same region after intraarterial embolectomy with an implantation of a stent-retriever, (C) floating mass in the apical left ventricle revealed by echocardiography at the time of admission. Apical four-chamber view zoomed on the left ventricle. (D) Embolization to the superior mesenteric artery and embolus in the descending aorta, and (E) multiple embolic kidney infarctions.

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