Recurrent Embolism Due to Thoracic Aortic Thrombus Detected by Transoesophageal Echocardiography. Which Treatment Is Currently the Most Appropriate?

To the Editor:

We present the case of a 50-year-old woman whose only signs of cardiovascular risk were smoking and morbid obesity (body mass index = 53). The patient was admitted for vascular surgery due to acute arterial ischaemia in the left lower extremity and obstruction of the external iliac artery was observed. The patient was treated with intra-arterial fibrinolysis, which was efficient initially but early reocclusion followed.

With the aim of localising possible sources of embolism, a transoesophageal echocardiography was carried out which showed a complex aortic atheroma with mobile thrombus at the thoracic aortic level behind the exit of the left subclavian (Figure 1). The thoracic computerised tomography showed an extension of the thrombus to the infradiaphragmatic aorta, reaching close to the coeliac trunk (Figure 2).

Surgical treatment was offered as the first therapeutic option, which the patient rejected, so oral anticoagulation treatment was initiated. Subsequent development was marked by peripheral recurrent embolisms in the same extremity despite adequate therapeutic INR values. Amputation of the extremity was eventually required.

Thrombi in the thoracic aorta are an uncommon condition associated with atherosclerotic lesions, ulcers, or aortic dilations and they are a potential source of embolisms.

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The use of transoesophageal echocardiography provides excellent spatial resolution and allows for the detailed visualisation of the intimal surface.\(^1,2\)

Treatment of floating thrombi in the aorta is currently a controversial subject and it has only been looked at in retrospective studies.\(^3\)

There are various therapeutic options, such as anticoagulation,\(^1\) thrombolysis, thromboaspiration, balloon catheter thrombectomy,\(^4\) open thrombectomy, thromboendarterectomy, or prosthetic aortic replacement.\(^5-7\) The exclusion of the thrombus via implantation of an aortic endoprosthesis is under development.

Some authors recommend starting anticoagulation with heparin for 2 weeks, with subsequent reassessment of thrombus development via transoesophageal echocardiogram. If the issue is resolved, chronic oral anti-coagulation is initiated; if it persists, heparin treatment is continued, and surgery is reserved for cases of recurrent embolism.

Other authors (as in the case mentioned, given the physical characteristics of the thrombus and premature reocclusion following arterial fibrinolysis) advocate for a more aggressive treatment once the diagnosis has been made, rather than deterioration at a later stage.

Currently under development is endovascular treatment with thrombus exclusion and coverage of the aortic wall with endoprosthesis, to thereby treat the mobile thrombus and the underlying cause (atheromatous plaque, aortic ulcer, etc).\(^8\) In this way recurrences are avoided and subsequent management with anti-aggregation is possible which avoids anti-coagulation.

Despite the lack of randomised tests (given the small number of cases) and in view of the rare complications and good results obtained (in large measure avoiding embolism recurrence), invasive strategies via exclusion of the floating thrombus with the implant of a vascular endoprosthesis has to be considered as an early treatment measure, thrombus location permitting.

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Incidental Finding of Coronary Embolism During Valve Surgery

To the Editor:

Embolisms from valvular warts form part of the clinical spectrum for presentation of endocarditis. Although in theory they can affect almost any vascular area, presence in the coronary territory is particularly infrequent thanks to the anatomical and haemodynamic properties of the cardiovascular system. We present the case of a 36-year-old man, an ex-intravenous drug addict, HIV positive, hepatitis C positive, with pulmonary hypertension and 2 episodes of mitral endocarditis caused by Enterococcus faecalis 61 months earlier, and mitral and tricuspid endocarditis caused by Staphylococcus aureus 16 months earlier, for which he received the relevant antibiotic treatment with good clinical development. Following an NYHA III cardiologic study, severe mitral and tricuspid insufficiencies were found and referred for surgical intervention with double reparative valvuloplasty. The arrow in Figure 1 shows the lesion described below, which corresponds to the intraoperative image taken from the position of the anaesthetist at the patient’s head-end (the larger image shows this in detail).

Intraoperatively an epicardial lesion measuring 0.5 × 0.5 cm was found, with an erythematous surface located on the front free face of the right ventricle, in a tributary region of vascularisation with collateral branches from the right coronary artery, in view of the interruption arising from one of these vessels. Prior to any cannulation procedure or opening of cavities, faced with the superficiality of the lesion and its potentially septic nature despite previous antibiotic treatments, extirpation was decided upon, with the aim of preventing subsequent endocardial contamination during the surgical procedure once the cardiotomy was carried out. Via the use of a haematoxylin-eosin stain, Figure 2 shows a longitudinal section of the lesion.