

## IMAGE FOCUS

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## Acute coronary syndrome and endocarditis 20 years before: how do they match?

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A 33-year-old woman with a past history of mitral infective endocarditis in childhood was admitted in our department due to unstable angina. Transthoracic echocardiography (TTE) showed posterior mitral leaflet prolapse originating severe regurgitation and coronary angiography revealed an 80% stenosis of the proximal segment of left anterior descending artery (LAD). During the angioplasty procedure a calcification near the coronary lesion was found (Panel A). The cardiac magnetic resonance demonstrated two mycotic aneurysms, one at the anterior wall of the left ventricular outflow tract (LVOT) (Panel B) and a smaller one at the sub-mitral area, in left ventricle antero-lateral wall (Panel C). A multislice computed tomography showed a LVOT aneurysm with a heavily calcified wall, causing residual compression of the proximal portion of LAD (Panels D–F). Considering the patient remained asymptomatic, myocardial perfusion scintigraphy was normal and the technical difficulty of aneurysm excision, only closure of the aneurysms and mitral valve repair were programmed. Intra-operative transesophageal echocardiography confirmed the P1 prolapse and showed two regurgitant jets, one occurring through the body of the posterior leaflet and the other one at the coaptation zone at the level of P1 scallop. Real-time three-dimensional transesophageal echocardiography delineated the P1 prolapse and the two aneurysms (Panels G and H). The perforated P1 scallop was resected (Panel I), mitral anuloplasty was performed and the aneurysms were excluded with pericardial patches. At 6-month follow-up the patient remained asymptomatic and maximum treadmill stress test was negative for ischaemia.

