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# EACVI recommendations on cardiovascular imaging for the detection of embolic sources: endorsed by the Canadian Society of Echocardiography

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ESC European Society of Cardiology

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**EACVI DOCUMENT**

# EACVI recommendations on cardiovascular imaging for the detection of embolic sources: endorsed by the Canadian Society of Echocardiography

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Cardioaortic embolism to the brain accounts for approximately 15–30% of ischaemic strokes and is often referred to as 'cardioembolic stroke'. One-quarter of patients have more than one cardiac source of embolism and 15% have significant cerebrovascular atherosclerosis. After a careful work-up, up to 30% of ischaemic strokes remain 'cryptogenic', recently redefined as 'embolic strokes of undetermined source'. The diagnosis of cardioembolic stroke remains difficult because a potential cardiac source of embolism does not establish the stroke mechanism. The role of cardiac imaging—transthoracic echocardiography (TTE), transoesophageal echocardiography (TOE), cardiac computed tomography (CT), and magnetic resonance imaging (MRI)—in the diagnosis of potential cardiac sources of embolism, and for therapeutic guidance, is reviewed in these recommendations. Contrast TTE/TOE is highly accurate for detecting left atrial appendage thrombosis in patients with atrial fibrillation, valvular and prosthesis vegetations and thrombosis, aortic arch atheroma, patent foramen ovale, atrial septal defect, and intracardiac tumours. Both CT and MRI are highly accurate for detecting cavity thrombosis, intracardiac tumours, and valvular prosthesis thrombosis. Thus, CT and cardiac magnetic resonance should be considered in addition to TTE and TOE in the detection of a cardiac source of embolism. We propose a diagnostic algorithm where vascular imaging and contrast TTE/TOE are

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considered the first-line tool in the search for a cardiac source of embolism. CT and MRI are considered as alternative and complementary tools, and their indications are described on a case-by-case approach.

**Keywords** stroke • ischaemic stroke • embolic stroke • cryptogenic stroke • cardiovascular imaging • echocardiography • magnetic resonance imaging • computed tomography • guidelines

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## Recommendations



## Abbreviations and acronyms

2D, two-dimensional
3D, three-dimensional
AF, atrial fibrillation
ASA, atrial septal aneurysm
CEA, carotid endarterectomy
$CHA_2DS_2$-VASc, Congestive heart failure, Hypertension, Age ≥75 years, Diabetes mellitus, prior Stroke, TIA, or thromboembolism, Vascular disease, Age 65–74 years, Sex category (female)
$CHADS_2$ , Congestive heart failure, Hypertension, Age ≥75 years, Diabetes mellitus, prior Stroke, TIA, or thromboembolism
CI, confidence interval
CMR, cardiac magnetic resonance
CT, computed tomography
CTA, computed tomography angiography
DCM, dilated cardiomyopathy
EACVI, European Association of Cardiovascular Imaging
EAE, European Association of Echocardiography
ECST, European Carotid Surgery Trialists
EDV, end-diastolic velocity
ESUS, embolic strokes of undetermined source
HCM, hypertrophic cardiomyopathy
HR, hazard ratio
ICA, internal carotid artery
LA, left atrial or left atrium
LAA, left atrial appendage; LAAT
left atrial appendage thrombus/thrombi
LASP, left atrial septal pouch
LAT, left atrial thrombus
LV, left ventricular or left ventricle
LVEF, left ventricular ejection fraction
LVSD, left ventricular systolic dysfunction
LVT, left ventricular thrombus
MESA, Multi-Ethnic Study of Atherosclerosis
MI, myocardial infarction
MR, magnetic resonance
MRI, magnetic resonance imaging
NASCET, North American Symptomatic Carotid Endarterectomy Trial
NBTE, non-bacterial thrombotic endocarditis
PET, positron-emission tomography
PFO, patent foramen ovale
PSV, peak systolic velocity
RA, right atrial or right atrium
RR, risk ratio
SEC, spontaneous echocardiographic contrast
SSFP, steady-state free precession
TIA, transient ischaemic attack
TOAST, Trial of ORG 10172 in Acute Stroke Treatment
TOE, transoesophageal echocardiography
TTE, transthoracic echocardiography

## Introduction

Ischaemic stroke is a major cause of disability and mortality worldwide.[1–4] Cardioaortic embolism to the brain accounts for approximately 15–30% of ischaemic strokes and is often referred to as 'cardioembolic stroke'.[5,6] Cardioembolic stroke is generally severe and prone to early and long-term recurrences.[7] Identifying potential cardiac sources of embolism is a key objective, because treatment may vary according to the cardiac condition diagnosed.[8] Unfortunately, and often despite comprehensive evaluation of the underlying cause, up to 30% of ischaemic strokes remain 'cryptogenic' (i.e. without an established cause).[5,9] Consequently, a new entity has recently been defined: embolic strokes of undetermined source (ESUS).[10]

The diagnosis of cardioembolic stroke is often difficult because the presence of a potential cardiac source of embolism alone does not establish the stroke mechanism. The clinical significance of minor or uncertain sources of cardiac risk remains controversial,[11] as reported in the Canadian guidelines.[12] Furthermore, approximately 25% of patients have more than one cardiac source of embolism and 15% have significant cerebrovascular atherosclerosis.[13] Combined, these clinical factors emphasize the role of cardiac imaging—transthoracic echocardiography (TTE) and transoesophageal echocardiography (TOE) as the first-line, and cardiac computed tomography (CT) and magnetic resonance imaging (MRI) in addition—in the evaluation of

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patients with stroke, in the diagnosis of potential cardiac sources of embolism, and for therapeutic guidance.[14,15]

Recommendations for classifying cardiac conditions that predispose to cerebral embolism have been made previously,[16] but we strongly believe that the subject should be revisited based on new imaging capabilities and evidence.

## The need to update the recommendations

Recommendations for the use of echocardiography in the diagnosis and management of cardiac sources of embolism were published in 2010 by the European Association of Echocardiography (EAE).[16] The EAE recommends the use of TTE and TOE when neurological symptoms potentially due to a suspected cardiac cause are present.[16] We believe that an update is needed for the following reasons:

(1) The probability of detecting potentially emboligenic cardiac disease depends on the diagnostic method used. Taking into account the advances in ultrasound investigation techniques [real-time three-dimensional (3D) echocardiography—both TTE and TOE] and the improved value of the other imaging modalities (CT and MRI), we think it worthwhile to introduce herein these non-echocardiographic techniques.
(2) 'New' potentially cardiac sources can be discussed [e.g. lef atrail septal pouch (LASP), atrial cardiomyopathy].[17]
(3) In the absence of evidence, clinical expertise recommends the use of a synthetic algorithmic approach to cardiac work-up of a patient with ischaemic stroke or transient ischaemic attack (TIA).
(4) Based on these recommendations, research projects could be conducted to confirm and improve the level of evidence for performing a diagnostic test or another investigation in the clinical context.
(5) The present recommendations do not deal with specific imaging aspects related to exploration of the vessels. We focus instead on cardiac and aortic arch sources of systemic emboli, most of which are cerebral.

# Definitions

## Cerebral infarction

Cerebral infarction is defined as brain, spinal cord, or retinal cell death attributable to ischaemia, based on neuroimaging, neuropathological evidence, and/or clinical evidence of permanent injury.[15]

## Transient ischaemic attack

TIA is a transient episode of neurological dysfunction caused by focal brain, spinal cord, or retinal ischaemia, without acute infarction.[15]

## Cryptogenic stroke

Cryptogenic ischaemic strokes are symptomatic cerebral infarcts for which no probable cause is identified after adequate diagnostic evaluation. More expansive definitions include strokes in patients who are incompletely evaluated and in those with more than one probable identified cause, defined according to the Trial of ORG 10172 in Acute Stroke Treatment (TOAST) criteria.[5,8] However, if the TOAST criteria clearly specify that cryptogenic stroke is one that is not attributable to known aetiologies, they do not indicate specific diagnostic modalities that must be negative to declare a cryptogenic stroke.

More recently, the notion of cryptogenic embolism was introduced in the Causative Classification of Stroke System.[18] In this classification, cryptogenic embolism refers to a stroke for which there is angiographic evidence of abrupt cut-off consistent with a blood clot within otherwise angiographically normal-looking intracranial arteries, or imaging evidence of complete recanalization of a previously occluded artery, or the presence of multiple acute infarctions that have occurred closely related in time without detectable abnormalities in relevant vessels.

## Embolic strokes of undetermined source

ESUS are defined as non-lacunar brain infarcts without substantial proximal arterial stenosis or major cardioembolic sources, and account for 80–90% of cryptogenic ischaemic strokes.[10] ESUS are thought to be a therapeutically relevant entity, as antiplatelet therapy and stroke risk-factor reduction are not highly effective in preventing recurrent strokes. Criteria for the diagnosis of ESUS are described in Supplementary data online, *Table S1*.

ESUS account for approximately one in six ischaemic strokes. Patients with ischaemic stroke meeting the criteria for ESUS are relatively young compared to patients with other ischaemic stroke subtypes, and tend to have minor strokes consistent with small emboli. The retrospective methods used in the published studies limit confidence in predicting stroke recurrence rates, but indicate a substantial (>4% per year) rate of stroke recurrence during (mostly) antiplatelet therapy.[19,20]

Several clinical and imaging findings suggest an embolic stroke:

a. abrupt onset of stroke symptoms;
b. previous infarctions in various arterial distributions;
c. multiplicity in space (infarct in both the anterior and posterior circulation, or bilateral);
d. multiplicity in time (infarcts of different ages);
e. other signs of systemic thromboembolism (e.g. edge-shaped infarctions of kidney or spleen; Osler splits; blue toe syndrome); and
f. territorial distribution of the infarcts involving the cortex, or subcortical 'large lenticulostriate infarct'.

Illustrations of patterns of brain infarctions signalling different mechanisms of stroke are shown in *Figure 1*.[16]

# Cardiovascular imaging tools

## Transthoracic and transoesophageal echocardiography for work-up of cryptogenic stroke and stroke with a suspected cardioembolic cause

TOE is a semi-invasive examination with possible associated complications but is widely performed in patients with ischaemic stroke. TOE is consistently superior to TTE, particularly when the patient presents without clinical signs suggestive of heart disease, but its superiority appears dependent on the patient's age. Therefore, patient age and history, and the risks of recurrence and consequences of treatment must be considered when making a diagnosis of a cerebral or peripheral embolic event. When a cardioembolic cause is suspected, it is recommended to consider both TTE and TOE. TOE should be performed according to the clinical context, but emergent indications are limited (e.g. fever, prosthesis).[8]

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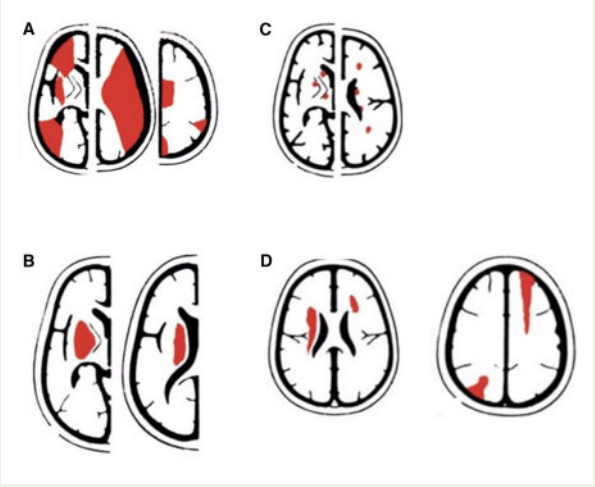


**Figure 1** Schematic drawings of patterns of brain infarctions signalling different stroke mechanisms.[16] (*A*) Cardioembolic stroke is probable in cortical infarcts with territorial distribution; (*B*) the same holds true for large striatocapsular infarcts; (*C*) but not for lacunar infarctions, by definition located subcortically; and (*D*) low-flow infarct can be located subcortical (left panel) or cortical (right panel), but their distribution is interterritorial not territorial.

A 2006 study reported that more than one in eight patients of any age with normal TTE findings had a major cardiac risk factor revealed on TOE that warranted anticoagulation.[21] More than 30 cross-sectional studies have evaluated the yield of TTE or TOE, or both, in detecting cardiac sources of embolus in patients with stroke. In consecutive patients, the yield of echocardiography for the detection of intracardiac masses ranged from 0% to 21%.[12] Pooled data from these studies suggest an overall yield of 4% for TTE and 11% for TOE.

A systematic review and meta-analysis of 27 studies that aimed to assess TOE for cryptogenic stroke revealed that TOE-detected findings prompted the introduction of anticoagulant therapy in up to one-third of patients.[22] In a retrospective study that included 1458 patients hospitalized for stroke with a suspected cardioembolic cause, TOE changed the management in approximately 16% of patients, leading to the introduction of anticoagulation and antibiotics, closure and surgical closure of patent foramen ovale (PFO), and coil embolization.[14] In a meta-analysis of 12 studies, the pooled rate of reported anticoagulation therapy attributed to abnormal TOE findings among 3562 patients with acute ischaemic stroke was 8.7% [95% confidence interval (CI) 7.3–10.4]. The rates of initiation of anticoagulation therapy on the basis of TOE investigation did not differ ($P = 0.315$) among patients with cryptogenic stroke (6.9%, 95% CI 4.9–9.6), ESUS (8.1%, 95% CI 3.4–18.1), or ischaemic stroke (9.4%, 95% CI 7.5–11.8).[11]

## Computed tomography and magnetic resonance imaging for work-up of cryptogenic stroke and stroke with a suspected cardioembolic cause

Both CT and MRI show potential for the detection of causes of cardioembolic stroke.[23] Indeed, both tests are highly accurate for detecting left atrial appendage (LAA) thrombosis (LAAT) in patients with atrial fibrillation (AF), with almost 100% sensitivity and specificity relative to TOE.[24–27] CT also allows the identification of valvular prosthesis thrombosis, aortic atheroma, PFO,[28,29] atrial septal defect,[30] and intracardiac tumours.[31] Cardiac magnetic resonance (CMR) is more sensitive and accurate than TTE for the detection of intraventricular thrombi after acute or chronic myocardial infarction (MI),[32] and allows the detection of left ventricular (LV) thrombi in patients with ESUS and a history of MI that may have been missed on TTE.[33]

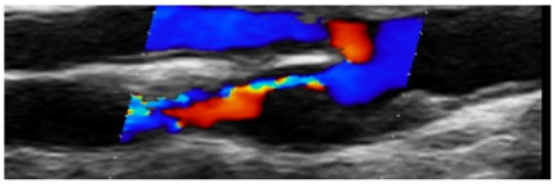

**Figure 2** Carotid bifurcation with an echolucent ICA stenosis. The aliasing shown by colour Doppler is a direct sign of severe ICA stenosis. ICA, internal carotid artery.

Few studies have evaluated the sensitivity and accuracy of these techniques in stroke, and the published literature is conflicting (Supplementary data online, *Table S2*). In one study that included patients with cryptogenic stroke undergoing TTE or TOE, CMR reduced the percentage of patients classified as having cryptogenic stroke after echocardiography, from 27% to 20%.[34] However, in other research, CMR had limited additional value over TOE[35] and failed to identify all potential cardioembolic sources identified by TOE.[36] CT has 89% sensitivity and 100% specificity for identifying causes of cardioembolic strokes identified by TOE,[37] and has a similar predictive value as TOE for recurrence of ischaemic stroke.[38] Combined use of CT and TTE/TOE was more sensitive than TTE/TOE alone for detecting patients with at least one cardiac or aortic high-risk finding after acute stroke,[39] and in particular was able to identify more cerebral infarcts. In contrast, CT alone was less suitable for diagnosing small left atrial thrombi (LAT) or PFO than was TOE.

The main advantage of CT and MRI is that these tests are less invasive than TOE. The main limitation of cardiac CT is radiation exposure. However, when CT is already being performed in patients with acute stroke for evaluation of the aortic arch and carotid arteries, extension of the CT scan to the heart may be possible, allowing detection of high-risk cardiac and aortic sources of embolism with no increased incidence of contrast-induced nephropathy and only a minimal increase in radiation exposure.[40] Thus, CT and CMR should also be considered in addition of TTE and TOE in the detection of a cardiac source of embolism.

## Vascular imaging for work-up of cryptogenic stroke and stroke with a suspected cardioembolic cause

Approximately 25% of ischaemic carotid territory strokes are caused by embolization from a ruptured plaque, or by an acute occlusion of the internal carotid artery (ICA) or middle cerebral artery. The main cause is atherosclerosis. Atherosclerotic stenoses are mostly located at carotid bifurcations. There are other less frequent locations: brachiocephalic trunk, common carotid arteries, intracranial arteries,

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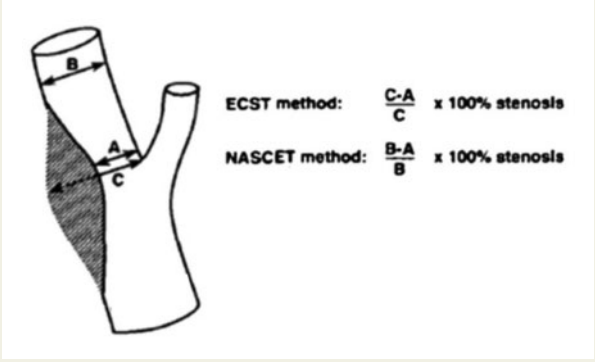


**Figure 3** NASCET and ECST methods: A, B, are measured with colour Doppler, B-flow, or eFlow; C is the normal lumen diameter before development of the stenosis.[42] ECST, European Carotid Surgery Trialists; NASCET, North American Symptomatic Carotid Endarterectomy Trial NASCET.

vertebral arteries, and middle cerebral artery. Approximately 10–15% of all ischaemic strokes are related to a previously asymptomatic ICA stenosis >50%,[41] but ischaemic strokes can also be preceded by TIA or fugax amaurosis.

Duplex ultrasound is considered as the first-line imaging modality for carotid atherosclerosis. Unless they are too calcified, stenoses can be evaluated by direct two-dimensional (2D) echo measurements, colour Doppler (*Figure 2*), and optionally by Power Doppler, eFlow, or B-flow.

Several methods can be used for 2D measurements of ICA stenoses.[42] The standard method is the North American Symptomatic Carotid Endarterectomy Trial (NASCET) method, which is better related to haemodynamics and CT or magnetic resonance (MR) angiography. The European Carotid Surgery Trialists (ECST) method gives a better assessment of plaque burden (*Figure 3*).

The NASCET and ECST methods measure diameter reduction. Alone they are not sufficient to evaluate the degree of stenosis, especially for irregular or eccentric stenoses, and must be correlated with Doppler velocities (see below). The area-reduction method can also be used to measure ICA stenoses (*Figure 4*).

Of note, the ECST and area-reduction methods overestimate the severity of the stenosis compared with the standard method (NASCET) (*Table 1*). Their use must therefore be recorded in the patient's files.[42]

CT and MR angiography may also be required. Their advantage is the ability to give simultaneous imaging of the aortic arch, supra-aortic vessels, carotid bifurcation, distal ICA, intracranial arteries, and brain. Conversely, the main asset of duplex ultrasound is the haemodynamic data provided by Doppler. Stenosis assessment is based primarily on direct signs: ICA peak systolic velocity, ICA end-diastolic velocity, and carotid ratio (*Table 2*).

In the case of severe stenosis (>80%) or ICA occlusion, indirect signs can give additional information: altered intracranial blood flow (transcranial Doppler) and/or reduced or reverse flow in the ophthalmic artery.[42]

Catheter angiography is no longer needed apart from during endovascular procedures.

Carotid stenoses require the best medical treatment whether they are symptomatic or asymptomatic. In symptomatic patients, studies

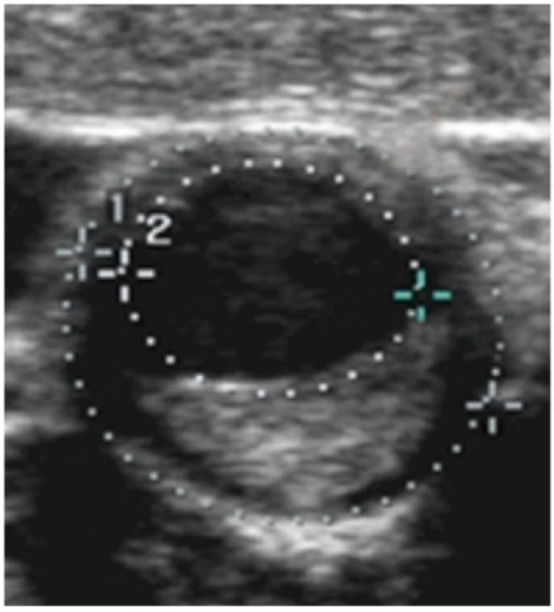


**Figure 4** Area-reduction method for measuring internal carotid artery stenoses.

**Table 1 Grading of internal carotid artery stenoses with NASCET and ECST[42]**

| NASCET | ECST |
|---|---|
| 50% | 75% |
| 70% | 85% |
| 80% | 90% |

ECST, European Carotid Surgery Trialists; NASCET, North American Symptomatic Carotid Endarterectomy Trial.

show the maximum benefit of carotid endarterectomy (CEA) is in patients with NASCET 70–99% stenoses (number needed to treat = 6). The benefit was lower in patients with 50–69% NASCET stenoses (number needed to treat = 13), and no benefit was found in patients with NASCET 0–49% stenoses. Revascularization should preferably be done within 14 days of symptom onset.[44]

Optimal medical treatment has considerably reduced the risk of ischaemic stroke in patients with asymptomatic ICA stenoses, and currently, there is sufficient evidence for a more conservative approach in these individuals.[4] Nevertheless, predicting how dangerous an asymptomatic ICA stenosis is remains difficult. Some clinical and imaging features are associated with an increased risk of ischaemic stroke (*Table 3*). According to the European Society of Cardiology guidelines,[4] CEA should be considered in patients with asymptomatic 60–99% ICA stenoses, life expectancy >5 years, favourable anatomy, and ≥1 feature suggesting higher stroke risk on best medical treatment.

Ischaemic strokes can be caused, less frequently, by non-atherosclerotic lesions: arteritis (giant cell or Takayasu arteritis),

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**Table 2 Combined criteria for grading ICA stenosis (according to von Reutern et al.[43])**

| % stenosis | 50% | 60% | 70% | 80% | 90% |
|---|---|---|---|---|---|
| PSV threshold | 125 cm/s | | 230 cm/s | | |
| PSV average | 210 cm/s | 240 cm/s | 330 cm/s | 370 cm/s | Variable |
| PSV post-stenotic | | | ≥50 cm/s | <50 cm/s | <30 cm/s |
| EDV in the stenosis | | <100 cm/s | >100 cm/s | | |
| Carotid ratio[a] | ≥2 | ≥2 | >4 | >4 | |

EDV, end-diastolic velocity; ICA, internal carotid artery; PSV, peak systolic velocity.
[a]ICA PSV divided by common carotid artery PSV.

**Table 3 Clinical and imaging features associated with increased risk of ischaemic stroke in patients with asymptomatic ICA stenosis[4]**

| Clinical features | Contralateral TIA/stroke |
|---|---|
| Cerebral imaging | Ipsilateral silent infarction |
| Ultrasound | Stenosis progression (>20%) |
| | Stenosis characteristics: large plaque, echolucent plaque, juxta-luminal hypoechogenic area |
| | Vascularization of the plaque (contrast-enhanced echo) |
| | Impaired cerebral vascular reserve (transcranial Doppler) |
| | Spontaneous embolization in the ipsilateral middle cerebral artery on transcranial Doppler monitoring (high-intensity transient signals) |
| MRI | Intra-plaque haemorrhage |
| | Lipid-rich necrotizing core |

ICA, internal carotid artery; MRI, magnetic resonance imaging; TIA, transient ischaemic attack.

**Recommendations for cardiovascular imaging tools[45]**

**TTE, TOE, CMR**

TTE should be performed systematically before TOE for evaluation of the cardiovascular source of embolus.

Contrast TTE, using intravenous injection of agitated saline, should be performed systematically at baseline and after provocative manoeuvres (Valsalva manoeuvre, coughing, both).

**General indications in search of cardiac or aortic sources of embolism**

Contrast TTE is the initial imaging modality of choice for evaluation of the cardiac and aortic sources of embolus.

Contrast TOE should be done in selected patients for evaluation of the cardiovascular sources of embolus if no identified source is found on TTE.

Contrast TOE should be performed according to the clinical context, but emergent indications are limited (e.g. fever, prosthesis).

Contrast TOE should be performed rapidly (ideally within 48 h) in case of ischaemic stroke, peripheral embolism, or previous heart valve replacement (percutaneous or surgical).

Contrast TOE is not indicated in ischaemic stroke patients with a previously identified source.

A comprehensive stroke CT protocol, including the intracranial and cervical arteries, aortic arch, cardiac chambers and walls, and coronary arteries, can be proposed in trained centres as an alternative initial imaging modality for evaluation of the cardiac and aortic sources of embolus.

CMR could be proposed in unselected patients with cryptogenic stroke who have a non-diagnostic cardiac evaluation including contrast TOE.

**Vascular imaging**

Doppler ultrasound (first-line), CTA, and/or MR angiography are recommended for evaluating carotid stenoses.

When carotid stenting is being considered, it is recommended that any Doppler ultrasound study be followed by either MR or CTA to evaluate the aortic arch, as well as the extra- and intracranial circulation.

When CEA is considered, it is recommended that Doppler ultrasound be corroborated by MR or CTA or repeat Doppler ultrasound performed by an expert.

CEA, carotid endarterectomy; CMR, cardiac magnetic resonance; CT, computed tomography; CTA, computed tomography angiography; MR, magnetic resonance; TOE, transoesophageal echocardiography; TTE, transthoracic echocardiography.

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dissection (e.g. trauma, idiopathic, Marfan syndrome, fibromuscular dysplasia, Ehlers-Danlos syndrome, carotid bulb diaphragm).

# Cardiac sources of cerebral embolism

## Major cardiac sources of cerebral embolism

Major (as well as minor and unclear) sources of cerebral embolism are detailed in *Table 4*.

### Left atrial thrombus and risk factors

*Left atrial thrombi*

LAT and particularly LAAT are the primary sources of cerebral embolism and are the most common sites for intracardiac thrombi. They are primarily, but not exclusively, seen in patients with AF and mitral stenosis.[46] AF is the most frequent dysrhythmia and is closely associated with advancing age. The stratification risk of thromboembolic events in AF is currently based on clinical risk scores, mainly $CHADS_2$[47] (Congestive heart failure, Hypertension, Age ≥75 years, Diabetes mellitus, prior Stroke, TIA, or thromboembolism) and $CHA_2DS_2$-VASc[48] [Congestive heart failure, Hypertension, Age ≥75 years, Diabetes mellitus, prior Stroke, TIA, or thromboembolism, Vascular disease, Age 65–74 years, Sex category (female)]. The risk of stroke for individuals in sinus rhythm increases along with left atrial (LA) dimensions.[49] LA/LAA thrombus is very infrequently detected in the presence of sinus rhythm.[46] LAT and LAAT are often associated with spontaneous echocardiographic contrast (SEC), defined as dynamic 'smoke-like' and slowly swirling echodensities in the left atrium (LA) and/or LAA. TOE is the gold standard for the diagnosis and exclusion of LAT and LAAT, and is a useful tool for embolic risk stratification in AF. TOE allows the identification of risk factors for thromboembolism such as LV ejection fraction (LVEF) <35%,[50] complex aortic plaques, SEC in the LA/LA appendage (LAA), and LAT/LAAT, LAA dysfunction as measured by emptying/filling velocities ≤20 cm/s on pulsed Doppler,[50] and dynamic evaluation of LA function by evaluation of LA global longitudinal strain.

Whereas TTE is recommended in all patients with AF to identify the underlying causes of AF, TOE as a semi-invasive tool is not systematically needed. In a meta-analysis by Romero *et al.*,[24] the mean sensitivity and specificity of cardiac CT was, respectively, 96% and 92% compared with TOE. In a further subanalysis of seven mostly prospective, single-centre studies in which delayed imaging CT was performed, sensitivity and specificity further increased to 100% and 99%, respectively.

In addition to its non-invasive character, CT also offers a superior visualization of the anatomy of the LAA.[51]

In a retrospective registry analysis of patients undergoing pulmonary vein isolation, all thrombi detected by TOE were also found with the use of delayed enhancement cardiac MRI.[27]

*Rheumatic valve disease (mitral stenosis)*

Rheumatic valve disease and mitral stenosis are still common in developing countries. Patients with rheumatic mitral stenosis are at increased risk for embolic events. Systemic embolization occurs in 10–20% of patients with mitral stenosis, with 75% of cases manifesting as cerebral embolism.[52–54] Various factors are related to an increased risk for embolization, including age, AF, and LA enlargement.[54–56] Embolic events can be the first clinical manifestation of the disease and do not appear to be related to the severity of mitral stenosis.[52]

Although AF appears to be a determining factor in the formation of left intra-atrial thrombosis and is a major potential source of peripheral arterial embolism in mitral stenosis, 8–20% of patients presenting with mitral stenosis and systemic embolism are in sinus rhythm.[57,58] In these patients, not only the size and shape of the LA but also the presence of SEC is significantly associated with a higher risk of clot formation.[58]

Oral anticoagulant therapy is mandatory when AF complicates mitral stenosis, regardless of its severity and $CHA_2DS_2$-VASc score. In patients with mitral stenosis and sinus rhythm, those with larger LA volume and the presence of SEC might also benefit from prophylactic anticoagulation. Non-vitamin K antagonist oral anticoagulants are not recommended in moderate-to-severe mitral stenosis due to the lack of data.[59]

*Atrial fibrillation*

The most common cardioembolic sources of ischaemic stroke are LAAT during AF; however, a thrombus can also rapidly appear just after reduction of the arrhythmia, during the stunning period, despite the absence of thrombus when the patient was in AF.[60]

AF affects 0.3–0.4% of adults,[61] and the prevalence rises with age to 10% in those >75 years.[62] Specific recommendations about the use of multimodality imaging in that field have been published by the European Association of Cardiovascular Imaging (EACVI).[60] The

**Table 4 Major and minor/unclear sources of ischaemic stroke**

| Major sources of stroke risk | Minor or unclear sources of stroke risk |
|---|---|
| Atrial fibrillation | Mitral valve prolapse |
| Recent myocardial infarction | Mitral annulus calcification |
| Previous myocardial infarction (LV aneurysm) | Spontaneous echo contrast |
| All cardiomyopathies including non-compaction and takotsubo cardiomyopathies | Calcified aortic stenosis |
| Cardiac masses (except calcifications) | Valvular strands |
| Intracardiac thrombus | Atrial septal aneurysm without PFO |
| Intracardiac tumours | |
| Fibroelastoma | |
| Marantic vegetations | PFO |
| Rheumatic valve disease (mitral stenosis) | |
| Aortic arch atheromatous plaques | Atrial septal pouch |
| Endocarditis | Giant Lambl's excrescences |
| Prosthetic valve (mechanical especially) | |

LV, left ventricular; PFO, patent foramen ovale.

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incidence of ischaemic stroke in patients with AF reportedly ranged from 1% in low-risk patients to 15% in high-risk patients, and silent AF was detected in 26% of patients who had recently had a cryptogenic stroke.[61] The loss or reduction of LA and LAA contractility during AF causes a reduction of LAA emptying and an increase in blood stasis, which is favoured by the chicken-wing (cul-de-sac) shape and multilobate anatomical structure of the LAA.[60,63] The risk of thrombus formation can be conveniently estimated using the $CHA_2DS_2$-VASc score,[48] which accurately predicts the risk of ischaemic stroke but only takes clinical variables into consideration.[64,65] LA and LAA anatomical and functional factors can, however, significantly influence the risk of thrombosis. Recent studies that investigated LA reservoir function have demonstrated the value of this echocardiographic parameter for predicting the risk of ischaemic stroke.[66–70] Accordingly, echocardiography has been proposed as a tool in the management of patients with AF.[60] TOE can accurately identify LAT and LAAT, and provides fundamental information for the timing of cardioversion in patients who have been in AF for >48 h, allowing immediate cardioversion without the need for 3 weeks of anticoagulation once the presence of LAT/LAAT has been excluded.[60,71] In addition, TOE can detect dense SEC, LAA contractility, and LAA anatomy.[51,72] CT angiography (CTA) is a reasonable alternative to TOE when the primary aim is to exclude LAT and LAAT, and in patients in whom the risks associated with TOE outweigh the benefits (consider the delayed scan post-contrast).[51,60]

The recent literature strongly encourages the use of strain measurement of LA reservoir function.[66,73] Deformation of LA walls during LV systole is associated with thromboembolic risk.[70,74] The value is independent of LA volume and may be a target for further treatment strategies. The results from an ongoing large EACVI registry will probably provide input for future guidelines.[75]

Imaging techniques are not currently used to estimate the risk of AF, which can be silent and could be detected in patients who are assessed by devices.[76–78] Van Gelder *et al.*[79] demonstrated that subclinical AF lasting for >24 h is associated with an increased risk of ischaemic stroke or systemic embolism. In a study involving 1251 patients, 217 had SEC, 127 had LAT/LAAT, 241 had complex aortic plaque, and 746 had none of these.[80] The rates of ischaemic stroke/systemic embolism were not significantly different among patients with and without these echocardiographic findings when they are properly treated with a non-vitamin K antagonist oral anticoagulant.[80]

### *Atrial flutter*

Atrial flutter is often associated with, or preceded by, AF; the annual thromboembolic risk for patients with atrial flutter ranges from 1% to 5%.[81] The primary and secondary prevention methods are the same as for AF.[82–85]

In a meta-analysis of 52 studies that assessed the relationship between atrial flutter and ischaemic stroke, Vadmann *et al.*[86] showed that observational studies reported an overall elevated stroke risk (risk ratio 1.40, 95% CI 1.35–1.46) and mortality risk [hazard ratio (HR) 1.9, 95% CI 1.2–3.1] over long-time follow-up compared with a control group. Moreover, this study confirmed that clinical thromboembolic events, LAT, and SEC are highly prevalent in patients with atrial flutter.[86]

### *Left atrial/left atrial appendage spontaneous echocardiographic contrast*

SEC refers to smoke-like echoes that can be visualized on echocardiography when ultrasound is backscattered by red blood cell aggregates.[87] The severity of SEC is graded from 0 to 4 according to the Fatkin classification,[88] with the following criteria:

(1) Mild (minimal echogenicity located in the LAA or sparsely distributed in the main cavity of the LA; may be detectable only transiently during the cardiac cycle; imperceptible at operating gain settings for 2D echocardiography analysis);
(2) Mild to moderate (more dense swirling pattern than grade 1, but with similar distribution; detectable without increased gain settings);
(3) Moderate (dense swirling pattern in the LAA, generally associated with somewhat lesser intensity in the main cavity, may fluctuate in intensity but detectable constantly throughout the cardiac cycle); and
(4) Severe (intense echodensity and very slow swirling patterns in the LAA, usually with similar density in the main cavity).[89]

More recently, sludge (an early thrombotic stage) has been defined in echocardiography as a dynamic, viscid, layered echodensity without a discrete mass, visualized throughout the cardiac cycle.[90]

SEC has been associated with a higher rate of ischaemic stroke in patients with AF (Supplementary data online, *Table S3*). Furthermore, clinical outcomes in patients with ischaemic stroke and AF are poor in the presence of coexisting SEC.[91,92] TOE plays an important role in detecting and defining the degree of SEC in the LA cavity.[89,93,94] Sludge has been reported to be abolished with appropriate anticoagulation, in contrast to SEC. Sludge is an independent predictor of embolic events and all-cause death.[63,90,93]

Among patients with AF of different causes, greater than mild mitral regurgitation was much less associated with LA SEC than mild or lesser mitral regurgitation.[95]

### *Left atrial appendage dysfunction*

**Multimodality imaging of left atrial appendage and association with ischaemic stroke.** The development of LA ablation procedures and LAA occlusion devices for the treatment of AF has increased the interest in LAA anatomy and function.[96–98] The LAA is an embryonic remnant of the primordial LA and is an important site of thrombus formation in AF. Anatomically, the LAA is divided into three regions: the ostium, the neck, and the lobar region. The LAA ostium is usually oval, but can be round, triangular, or water-droplet shaped.[99] A post-mortem study[100] reported that most people had two lobes (54%), followed by three lobes (23%), one lobe (20%), and four lobes (3%). In most cases, the tip of the LAA is directed antero-superiorly and the LAA extends between the anterior and lateral walls of the LA.[99] The LAA contains pectinate muscles, which have to be differentiated from thrombi. With its complex morphology and function, the LAA can be studied using TTE, 2D/3D TOE, CT, and MRI to improve understanding of its association with ischaemic stroke. A 3D modality is recommended to best assess the complex shape of this structure.

**Two-dimensional transthoracic echocardiography.** TTE imaging provides partial evaluation of the LAA. Unusually LAAT can be visualized using TTE. Some authors have reported a relationship between LAA dysfunction—measured by LAA wall velocity using TTE—and

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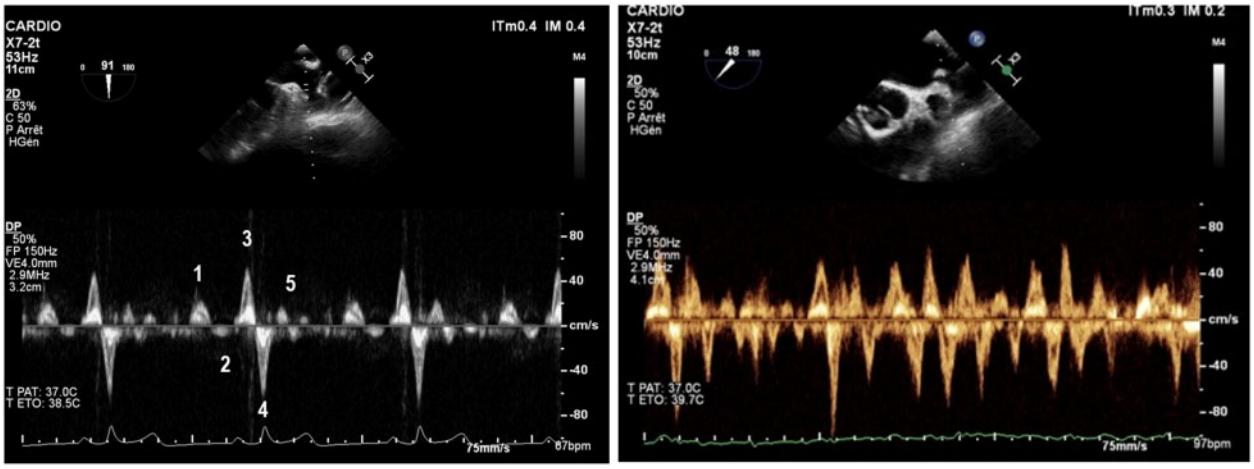


**Figure 5** 2D TOE: pulsed Doppler in the LAA during (left) sinus rhythm and (right) AF. (1) Early positive diastolic LAA emptying; (2) early negative diastolic LAA filling; (3) late positive diastolic LAA emptying (just after the P-wave on the electrocardiogram); (4) early negative systolic LAA filling; (5) systolic reflection waves. 2D, two-dimensional; AF, atrial fibrillation; LAA, left atrial appendage; TOE, transoesophageal echocardiography.

cerebrovascular events.[101] In addition to LAA evaluation, TTE imaging is essential for the evaluation of LAA risk of thrombus formation and cardioembolic events. LV dysfunction is an echocardiographic risk factor for LAAT, probably mediated by ventricular diastolic dysfunction and its effect on LA dynamics and pressure. Evaluation of diastolic function may improve stroke prediction in patients with non-valvular AF. *E*/*e*′ ratio and *e*′ velocity are associated with LAAT, independent of $CHA_2DS_2$-VASc score.[102] LA volume and mechanical dysfunction are closely associated with high risks of LAT and LAAT formation, and increased LA volume increases the risk of first ischaemic stroke.[103] LA global longitudinal strain—assessed using speckle-tracking TTE—discriminates the presence of LAT or LAAT on TOE in patients with acute ischaemic stroke.[74]

**Transoesophageal echocardiography (2D initially and now, mainly 3D with all capabilities related to the 3D acquisition).** TOE is a mandatory complement to TTE for the optimal evaluation of LAA anatomy and function. The LAA can be visualized using 2D TOE in the mid-oesophageal view by rotating the imaging sector from 0° to 180°. For LAAT detection—in comparison with surgical data—TOE has excellent sensitivity (92%) and specificity (98%).[104,105] Some years ago, before the dissemination of 3D TOE probes, some authors demonstrated that contrast injection could enhance visualization of the LAA and facilitate the exclusion of LAAT on TOE.[72,106]

One of the strengths of 2D TOE is the ability to perform Doppler evaluation of the emptying and filling velocities of the LAA (*Figure 5*). LAA blood-flow velocities are obtained using pulsed Doppler by positioning the sample volume at the proximal third of the LAA cavity after necessary gain and filter adjustments. LAA flow during sinus rhythm is divided into several phases.[107,108] After mitral valve opening, the following can be successively measured: early positive diastolic LAA emptying (the consequence of LV filling); early negative diastolic LAA filling (the consequence of LA filling); late positive diastolic LAA emptying (LAA contraction); early negative systolic LAA filling (LAA elastic recoil); and systolic reflection waves. In AF, no identifiable waves are individualized in the LAA, with a 'saw tooth' flow profile.

LAA dysfunction with alterations in LAA emptying and filling velocities <20 cm/s have been associated with an increased risk of thrombus formation within the LAA and a higher incidence of thromboembolic events in patients in normal sinus rhythm.[109,110]

3D TOE is superior to 2D TOE for anatomical evaluation of the LAA. 3D TOE has become 'a must'. 3D TOE allows visualization of the entire LAA and LAA orifice, their relation to the surrounding structures (mitral valve and left upper pulmonary vein), and evaluation of LAA volume, LAA ejection fraction, and LAA orifice area.[111–113] 3D TOE has to be considered to differentiate thrombi from artefacts or pectinate muscles within the LAA.[112,113]

In acute ischaemic stroke, LAA volume (analysed by real-time 3D TOE) is larger in patients with versus those without paroxysmal AF.[114] Multivariable analysis revealed $CHADS_2$ ($P = 0.002$), LVEF ($P = 0.01$), degree of LA SEC ($P = 0.02$), LA volume ($P = 0.02$), and number of LAA lobes ($P < 0.001$) to be independently associated with thrombus formation. Most patients with LAA thrombus (32/34, 94.4%) had ≥3 LAA lobes.[115]

**Cardiac computed tomography and cardiac magnetic resonance imaging.** In cardiac CT, differentiation between thrombi and blood stasis is possible with the analysis using delayed imaging.[116–119] In a meta-analysis of 753 patients with delayed imaging of the LAA, the mean weighted sensitivity and specificity for the detection of LAAT was 100% and 99%, respectively, and the positive predictive value and negative predictive were 92% and 100%, respectively.[24]

Using CT, a larger LAA orifice area is a significant risk factor for ischaemic stroke (adjusted odds ratio 6.16, 95% CI 2.67–14.18; $P < 0.001$).[120] Using MRI, ischaemic stroke risk has been reported to be highest in patients with an LAA volume >34 $cm^3$.[121] A retrospective study reported an association between LAA

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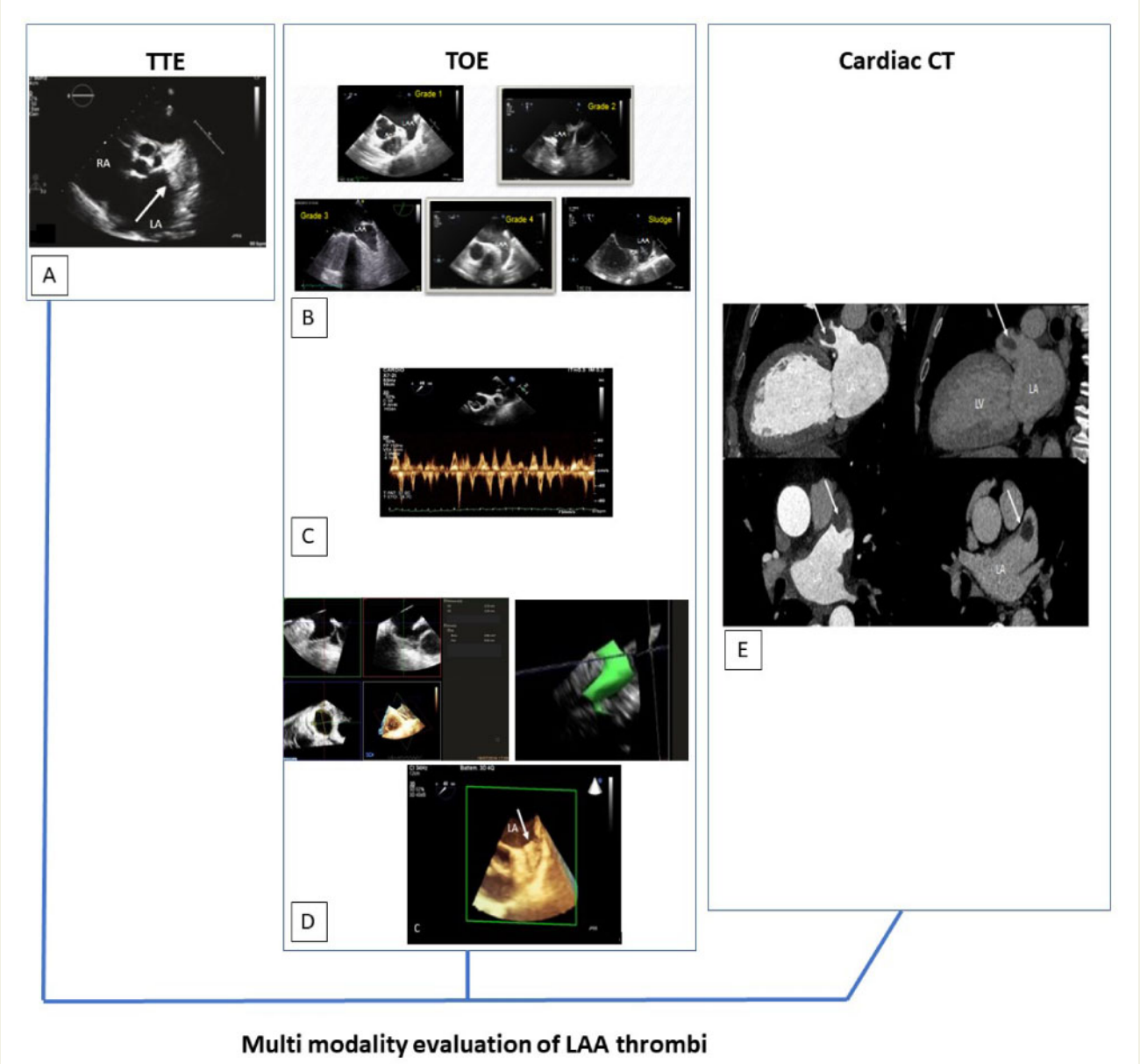


**Figure 6** Multimodality imaging of LAA thrombi: (*A*) 2D TTE parasternal short-axis view depicting LAA thrombus in a patient with mitral stenosis; (*B*) TOE illustration of the different grades of LA SEC (see Supplementary data online, *Video S1A–D*); (*C*) 2D TOE: pulsed Doppler in the LAA during AF; (*D*) 3D TOE: analysis of the ostium of the LAA (upper left) and volume evaluation (upper right); example of LAA thrombus in a patient with mitral stenosis (bottom) (see Supplementary data online, *Video S2*); (*E*) Cardiac CT, arterial phase on the left and delayed phase on the right (90 s after iodine injection), two-chamber view on the top and axial view on the bottom, showing LAAT (courtesy of Gilles Soulat, MD, PhD). 2D, two-dimensional; 3D, three-dimensional; AF, atrial fibrillation; AO, aorta; CT, computed tomography; LA, left atrium; LAA, left atrial appendage; LAAT, left atrial appendage thrombus; LASEC, left atrial spontaneous echocardiographic contrast; RA; right atrium; SEC, spontaneous echocardiographic contrast; TOE, transoesophageal echocardiography; TTE, transthoracic echocardiography.

morphology and previous thromboembolic events, using CT and MRI.[122]

LAA morphology has been classified into four types: chicken wing, cauliflower, windsock, and cactus, based on cardiac CT. In a meta-analysis of eight studies, patients with chicken wing morphology were less likely to have an embolic event compared with the other LAA morphologies.[123] LAA morphology by CT is an independent determinant of LAA flow velocity by TOE, suggesting an association between LAA morphology (and number of lobes) and embolic events.[124] Delayed contrast CT has been shown to be almost as sensitive as TOE for detection of LAAT.[24–27]

Using MRI, extensive fibrosis of the LA is a significant predictor of TOE abnormalities (LAAT or SEC).[125]

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*Summary*

*Figure 6* summarizes the multimodality imaging of LAA thrombi and *Figure S1* the echocardiographic predictors of LAAT formation and ischaemic stroke. Supplementary data online, *Tables S4* and *S5* summarize studies that assessed the associations between: LAA anatomy/function and LAAT; diastolic function and LAAT; and LAA anatomy/function and LAA flow velocity (Supplementary data online, *Table S4*)[102,115,124]; and LAA anatomy/function and ischaemic stroke (Supplementary data online, *Table S5*).[101,109,120,122,123]

**Recommendations on imaging techniques to evaluate LA/LAA anatomy, geometry, and function in AF**

LA/LAA SEC and sludge should be reported when a TOE is performed. The degree of LA/LAA SEC is associated with the prognosis.

Repeated TOE is indicated to monitor resolution of LAT/LAAT after anticoagulation in the case of AF/atrial flutter cardioversion and/or ablation.

3D TOE (better than 2D) is recommended for the anatomical and functional evaluation of the LAA and evaluation of LAAT.

CT and MRI are recommended for a more complete assessment of LAA anatomy before/during procedures of ablation of atrial arrhythmias and percutaneous LAA closure. LAA geometry is better defined with CT scans.

CT may detect LAAT with similar sensitivity and specificity than TOE when a delayed imaging is used.

2D, two-dimensional; 3D, three-dimensional; AF, atrial fibrillation; CT, computed tomography; LA, left atrial; LAA, left atrial appendage; LAAT, left atrial appendage thrombi; LV, left ventricular; MRI, magnetic resonance imaging; SEC, spontaneous echocardiographic contrast; TOE, transoesophageal echocardiography; TTE, transthoracic echocardiography.

*Atrial cardiomyopathy*

Atrial cardiomyopathy is defined in the EACVI/European Heart Rhythm Association expert consensus document[60] as 'any complex of structural, architectural, contractile, or electrophysiological changes affecting the atria with the potential to produce clinically relevant manifestations'.[126] This term implies adverse consequences that can be independent of atrial arrhythmias.

The presence and type of cardiomyopathy are independent predictors of ischaemic stroke in patients with AF; however, atrial cardiomyopathy may be an independent determinant of stroke risk. In fact, frequent temporal discordance between AF episodes and stroke leads to the concept that an underlying atrial cardiomyopathy may cause thromboembolism even in the absence of AF.[127]

Atrial remodelling is caused by cardiovascular diseases or risk factors, including ageing-induced atrial remodelling, through fibrosis, leading to LA/LAA mechanical and endothelial dysfunction (LA strain), substrate for increased LA thrombogenicity though Virchow's triad, and thus increased risk of ischaemic stroke.[128] Recently, Habibi *et al.*[129] reported an inverse association between LA reservoir function [measured as total LA ejection fraction, using MRI in the Multi-Ethnic Study of Atherosclerosis (MESA) study] and the risk of cerebrovascular events. This association was independent of known cerebrovascular risk factors and AF.

The concept of a thrombogenic atrial cardiomyopathy remains speculative, but the assessment of atrial structure (LA volume), function (LA ejection fraction, LA strain), and fibrosis (cardiovascular MR) may help improve stroke risk stratification independently from the presence of AF.

## Left ventricular thrombus and risk factors

*Recent myocardial infarction*

Ischaemic heart disease, notably acute anterior MI, is a major source of LV thrombus (LVT) formation. Here, the combination of blood stasis and an inflamed necrotic myocardium predispose to thrombus formation. Several other cardiac conditions are also associated with LVT formation, including dilated cardiomyopathy (DCM), stress-induced cardiomyopathy, and severe LV systolic dysfunction (LVSD) complicating valvular heart disease. The overall prevalence of LVT in the general population is low. In a retrospective review of >80 000 medical records, the incidence of LVT was 7 per 10 000 patients.[130] Of these cases, 80% were related to infarction while the rest were due to DCM and stress-induced cardiomyopathy.[130] LVTs have been reported in 4–39% of patients with anterior wall MIs.[131] The prevalence of LVT following an MI was 9.1% in recent study in which CMR was systematically used.[132]

LVTs appear as echo-dense masses within the LV cavity, adjacent to an abnormally contracting LV segment (akinetic and less frequently hypokinetic) or an aneurysmal myocardium. The LVT appears to have distinct margins between the LV wall and the LV cavity, a structural texture that is different from the LV myocardium, and a clear thrombus–blood interface. The LVT is visible throughout the entire cardiac cycle and in at least two modified views or transducer positions. The LVT shape is called 'protuberant' (intracavitary) when the borders mainly protrude into the LV cavity. It may be pedunculated or sessile. The LVT shape is termed 'mural' when the mass is flat and parallel to the contiguous endocardial surface (concave borders). The LVT is considered mobile when a segment of it moves independently of the adjacent endocardial motion.

Weinsaft *et al.*[133] reported a specificity for TTE as high as 100% for LVT detection. However, TTE has a lower sensitivity for detecting LVT (21–33%) compared with late gadolinium enhancement CMR. Sensitivity of TTE increases to 61% when contrast agents are used. TTE performance for LVT detection may vary according to the clinical indication of the echocardiograph.[133] When echocardiograms were performed for the well-defined clinical indication of LVT, TTE sensitivity increased from 26% to 60% and TTE positive predictive value increased from 21% to 75%.[134]

The diagnosis of LVT is facilitated by using a contrast echocardiogram, as the contrast fills the LV cavity and thus enhances the visibility of endocardial border delineation. LVT appears on contrast images as a dark linear or protruding structure, adjacent to akinetic (or hypokinetic) myocardium, and is surrounded by opacified blood (which appears bright) in the LV cavity. LVT identification is based on anatomical appearance.

Rates of sensitivity and specificity of 88% and 96%, respectively, for conventional echocardiography have been reported using contrast

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echocardiography for the detection of LVT in a series of 392 patients with anterior MI.[135]

MRI has a higher sensitivity and specificity for the detection of LV thrombi compared with TTE and is considered the gold standard in this setting.[33] Delayed-enhancement cardiac MRI has been validated as a more sensitive method for detecting LVT compared with cine MRI. Indeed, in this sequence, the thrombus is characterized by the absence of contrast agent enhancement.[136] Nevertheless, TTE is most frequently used for the detection of LVT and may serve as an initial screening test. In a large study of 361 patients who had surgical or pathological validation, the sensitivity of cardiac MR was 88% and the specificity was 99%.[137]

On cardiac CT, LVT has a significantly lower attenuation in comparison with a normally perfused myocardial wall.[138] Currently, there are few validated data on the role of cardiac CT in the detection of LVT in comparison with TOE or MRI. *Figure 7* illustrates examples of LVT diagnosed using TTE and MRI.

Pathological evaluation may distinguish fresh thrombi (no organization), organizing thrombi, and laminated chronic organized thrombi. CMR characteristics enable distinction between acute and older thrombi. An acute thrombus shows high signal intensity on T1- and T2-weighted images, whereas an older thrombus has low signal intensity in both T1 and T2 sequences and occasionally shows evidence of calcification.[139] Embolic risk increases with more mobile thrombi and a greater number of thrombi. In a retrospective study, the overall rate of post-treatment thromboembolism in patients on anticoagulant treatment was about 17%.[130] However, this rate can vary from 0% to 33%.[140–147] Clinical or pathological endpoints at 6-month follow-up (TIA, cerebrovascular accident, or pathology-verified thrombus) seem to occur more frequently in patients with LVT detected by delayed-enhancement CMR than with TTE (16.7% vs. 7.7%).[134]

Certain LVT characteristics are known predictors of embolism, including LVT morphological variations over time in serial examinations, protruding shape, and mobility.[148]

**Acute phase of myocardial infarction.** Subsequent to the Olmsted County study,[149] a meta-analysis[150] reported a prevalence rate of 11.1 for ischaemic stroke per 1000 MIs in patients hospitalized for MI. At 1 month, the rate rose to 12.2 per 1000 and was 21.4 after 1 year.[150] Predictors of ischaemic stroke after MI include older age, diabetes, arterial hypertension, previous ischaemic stroke, anterior MI, previous MI, AF, heart failure, and race.

LVT is reported in 20% of cases when the coronary artery is not reperfused, and can reach 40% in anterior MI and 60% in the event of extensive MI involving the LV apex.[151] MI location and severity of LV dysfunction determine the embolic risk.[152] Thus, the rate of embolic events can reach 20% in patients with extensive anterior MI and LVT.[153]

Within 4 weeks of an acute MI, 1–2.5% of patients will present with ischaemic stroke, most often (in 50% of cases) within the first week.[154–156] The risk is particularly high (4–12%) when the Q-wave MI affects the anterior wall and apex of the LV.[157,158] These locations promote the formation of a left intraventricular thrombus, which generally arises in the 10 days following an MI. The risk of ischaemic stroke in patients presenting with an anterior MI and a left intraventricular thrombus is 12% in the month following the MI.[158] This risk seems to be higher if the thrombus is pedunculated and mobile. The risk of systemic embolism decreases markedly in the subsequent months in the absence of AF and heart failure, irrespective of the natural history of the LVT.[158] The incidence of embolism is high when the thrombus is forming (first 3 months), but then decreases.[159]

The presence of preclinical coronary artery disease in patients with stroke seems to be highly prevalent[160] and is a major cause of death during follow-up.[161]

Investigation of stroke patients for asymptomatic coronary artery disease (using coronary artery calcium score, CT coronary angiography, iodine coronary angiography), remains debatable.[162]

### *Cardiomyopathy*

Cardiac thrombi are major sources of risk for embolism.[16] Blood stasis, myocardial wall damage, and hypercoagulability are the three main determinants of intracardiac thrombus formation.

**Dilated cardiomyopathy.** Dedicated recommendations have been published by the EACVI.[163] Irrespective of their cause, all DCM cases can be complicated by an LVT whose formation is promoted by the decrease in ventricular contractility,[164] dilatation of cardiac chambers,[165,166] and, in certain cases, the presence of endocardial lesions.[167] The incidence of LVT in DCM ranges from 11% to 44%.[167] AF increases this embolic risk.[168] In patients with non-ischaemic DCM, the risk of embolic events and ischaemic stroke is similar to that in patients with ischaemic cardiomyopathy.[164] The incidence of ischaemic stroke seems to be related to the degree of LVSD.[169]

Chagas disease is caused by the parasite *Trypanosoma cruzi*, and it is the most common cause of DCM in South America. Chagas cardiomyopathy has a particular high risk of thromboemboli. A risk score has been developed from a prospective study of 1043 patients with Chagas cardiomyopathy. The following risk factors are summed: age >48 years (1 point), ST-T changes on electrocardiogram (1 point), LV apical aneurysm (2 points), and any degree of LVSD (2 points). Patients with 4–5 points have an annual incidence of ischaemic stroke of 4.4% and no patient with a score of 0 had stroke.[6]

**Hypertrophic and restrictive cardiomyopathies.** Hypertrophic cardiomyopathy (HCM) is a genetically inherited condition with a large clinical spectrum and a wide variety of consequences, particularly the risk of sudden death, heart failure, and, to a lesser degree, ischaemic stroke.[170,171] The level of evidence in regard to the risk of cardiac emboli is weak. Maron *et al.*[172] compiled 900 patients in a registry, 51 of whom (prevalence rate 6%) presented with an ischaemic stroke or other vascular event during a mean follow-up of 7 ± 7 years. The registry also included 44 cases of cerebral infarction. The overall annual incidence was 0.8%, increasing to 1.9% for patients aged >60 years. Most events (72%) arose in patients aged >50 years, although 28% of the patients were <50 years. The onset of an ischaemic stroke or peripheral embolic event was independently associated with signs of congestive heart failure, increasing age, and AF (present in 88% of patients) at the time of the initial evaluation. The cumulative incidence of peripheral and cerebrovascular events in patients with AF was higher among those who were not receiving anticoagulant treatment vs. those taking vitamin K antagonists (31% vs. 18%; $P < 0.05$).[172] In addition, specific disease complications were more

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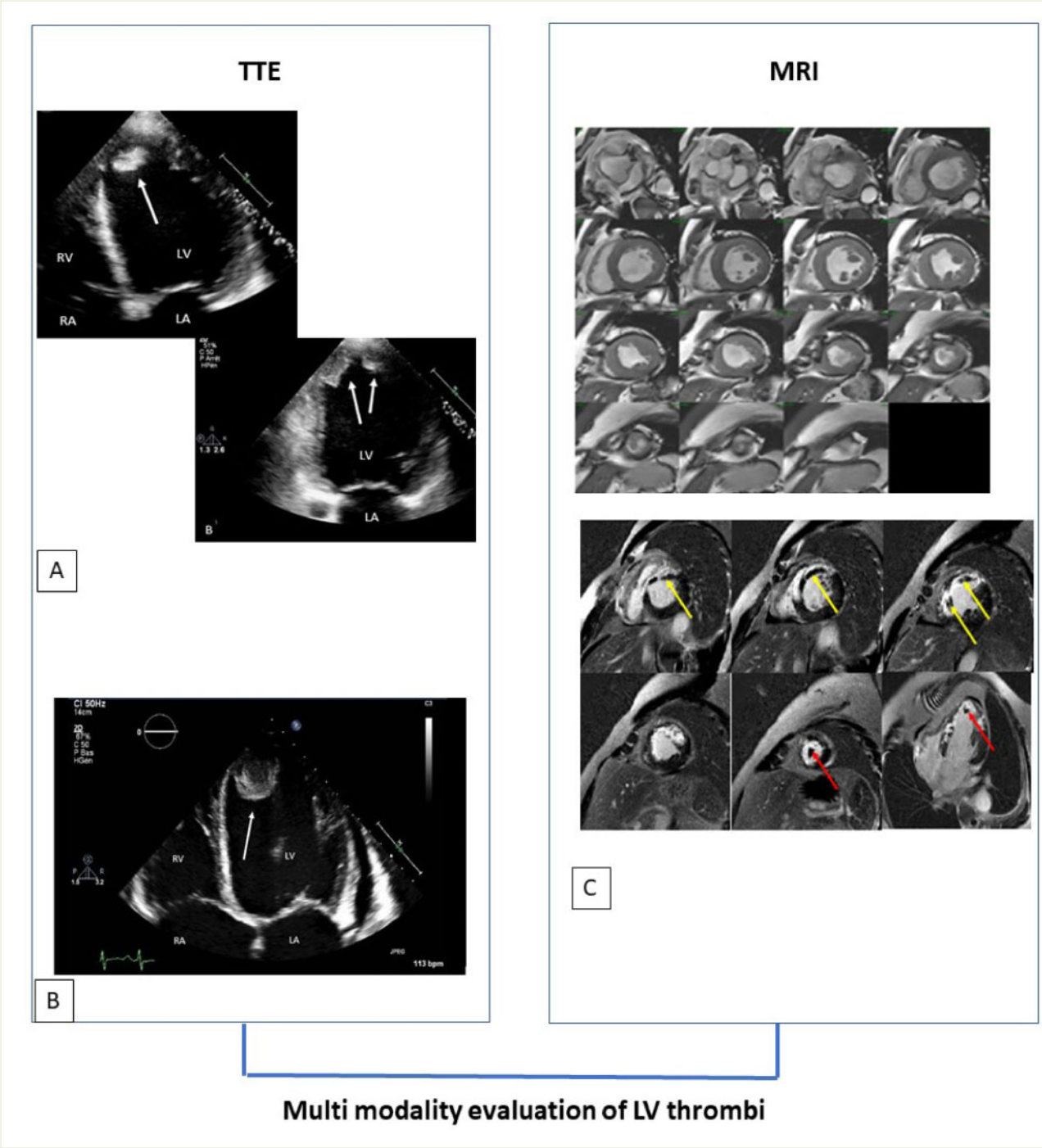


**Figure 7** Multimodality evaluation of LVT. (*A*) 2D TTE four-chamber and two-chamber (*B*) of an apical LVT (arrow) in a patient with recent MI (see Supplementary data online, *Videos S3A and B*). (*B*) 2D TTE four-chamber. LVT (white arrow) in a patient with non-ischaemic cardiomyopathy. (*C*) Cardiac MRI: short-axis view with cine MRI on the left [SSFP sequence (balanced steady state free precession)] and late gadolinium enhancement on the right in a patient 48 h after ST-segment elevation MI involving the left anterior descending artery. Both no-reflow (yellow arrows) and LVT (red arrow) are present in the late gadolinium enhancement images (courtesy of Gilles Soulat, MD, PhD). 2D, two-dimensional; LA, left atrium; LVT, left ventricular thrombus; MI, myocardial infarction; MRI, magnetic resonance imaging; RA, right atrium; RV, right ventricle; SSFP, steady-state free precession; TTE, transthoracic echocardiography.

common in association with large or medium compared with small aneurysms, such as ischaemic stroke/LV apical thrombus (4 vs. 0).[173]

In a study that enrolled 593 patients with clinically diagnosed HCM (mean age at diagnosis 51.0 ± 15.6 years; mean follow-up 10.7 ± 7.5 years), 68 (11.5%) experienced ischaemic stroke and

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embolic events.[174] Among the 431 patients without previously documented AF (39 with events and 392 without events), older age at diagnosis and LA dimension ≥48 mm were identified as independent determinants of an embolic event. The incidence of ischaemic stroke and embolic events was about 1.0% per year.[174] Rowin *et al.*[175] showed that there is evidence of apical aneurysm in 4.8% of all patients with HCM. Of these 4.8%, 14% had apical LVT, which was associated with thromboembolic events in non-anticoagulated patients. These findings emphasize the importance of CMR in HCM. Moreover, in HCM patients with cardioembolic events, a dedicated assessment for LV apical aneurysm is needed to guide management (including contrast TTE, and possibly adding CT/MRI). Multimodality imaging techniques are essential for the diagnosis, prognostic evaluation, and management of patients with restrictive cardiomyopathy.[176] In restrictive cardiomyopathy, patients with cardiac amyloidosis, and particularly those with AL (amyloid light-chain) type and AF, have a very high risk for thromboemboli. Amyloid infiltration of the atria and atrial mechanical dysfunction predispose to atrial thrombi. Intracardiac thrombi were present in 33% of explanted or autopsied hearts of patients with amyloid cardiomyopathy in a case series of 116 patients from the Mayo Clinic.[177] Of the 63 thrombi found in this autopsy study, only one was an LVT.[177] Embolic risk in restrictive cardiomyopathy is mediated by atrial dysfunction, and LVT is uncommon.

Other cardiomyopathies. Isolated LV non-compaction is characterized by trabeculations with deep intertrabecular recesses in which thrombi may form. A retrospective study of 144 patients with LV non-compaction found a prevalence of cardioembolic stroke of 10%. The majority of patients had either AF or LVSD.[178]

Takotsubo or stress cardiomyopathy is a transient form of regional LVSD, most commonly involving the mid and apical left ventricle. Ventricular thrombus was present in 1.3% patients with takotsubo cardiomyopathy in a registry of 1750 patients.[179]

Heart failure. Olsson *et al.*[180] reported on a study in 7599 patients divided on the basis of their baseline LVEF (≤40% or >40%) and monitored for a mean of 37.7 months. Patients with AF and low LVEF had the highest absolute risk of cardiovascular events. Patients with AF and low ejection fraction had the highest absolute risk of adverse cardiovascular outcomes (e.g. 45% with cardiovascular death or congestive heart failure hospitalization) relative to those with low ejection fraction and sinus rhythm (37% with an event), preserved ejection fraction, and AF (34% with an event), or preserved ejection fraction and sinus rhythm (21% with an event).[180] AF at baseline remained an independent predictor of all-cause death regardless of baseline ejection fraction: preserved ejection fraction HR 1.37 (95% CI 1.06–1.79) and low ejection fraction HR 1.22 (95% CI 1.04–1.43).

In a retrospective study, Doukky *et al.*[181] showed that diastolic function indices *E*/*e*′ and *e*′ were independently associated with LAAT in non-valvular AF.

Heart failure is associated with increased risks of ischaemic stroke and intracerebral haemorrhage at short- and long-term follow-up.[182] The associations persist in patients without AF or flutter, across age groups and sexes.[182] Di Tullio *et al.*[183] showed that among patients with systolic heart failure and sinus rhythm, LVEF of <15% more than doubled the risk of ischaemic stroke. In randomized clinical trials, the overall rate of ischaemic stroke in patients with heart failure with preserved ejection fraction and patients without AF (1.0% per year[184]) was similar to the rate reported in patients with heart failure with reduced ejection fraction without AF (CORONA study, 1.2% per year).[185] The CORONA study did not show that LVEF was an independent predictor of stroke risk; however, only patients with an LVEF ≤45% were included.[185]

**Recommendations for identification and evaluation of LVT**

TTE is recommended for the evaluation of patients with cardiac conditions who are at risk of LVT formation (e.g. MI, cardiomyopathy, severe LV systolic dysfunction, non-compaction and takotsubo cardiomyopathies).

TOE is not indicated when looking for LVT.

Contrast echocardiography and 3D echocardiography have to be considered to better characterize LVT. According to local facilities, CMR could be preferred for its sensitivity.

CMR has higher sensitivity for identification of LV thrombi and should be used when TTE is of suboptimal quality or when the TTE is negative in the setting of suspected apical thrombus.

Repeated TTE is indicated to monitor resolution of LVT after 4–6 weeks of anticoagulation.

3D, three-dimensional; CMR, cardiac magnetic resonance; LV, left ventricular; LVT, left ventricular thrombus; MI, myocardial infarction; MR, magnetic resonance; TOE, transoesophageal echocardiography; TTE, transthoracic echocardiography.

## Cardiac masses

*Intracardiac tumours*

Primary benign cardiac tumours, a rare condition with a post-mortem incidence of 0.1–0.3%,[186] may affect the endocardium, myocardium, or epicardium. Three-quarters of primary cardiac tumours are benign. Atrial myxomas are the most prevalent type among benign tumours, whereas cardiac sarcomas are the most frequent type among malignant ones.[187]

The clinical presentation of cardiac tumours depends on the histological type, morphology, and intra-cardiac location. Four different clinical manifestations can be produced by a cardiac tumour: systemic (e.g. fever, fatigue, weight loss), embolic, cardiac, and metastatic. The evidence to build a strong recommendation is limited.

Myxoma. Cardiac myxomas are generally sporadic tumours of endocardial origin and are typically located in the LA opposite the fossa ovalis region. They can also be located atypically in other areas of the LA, in the right atrium (RA), or in the ventricles. Mean age at diagnosis is 50 years, with 90% of patients aged 30–60 years.[188] 'Carney syndrome' is present in 10% of cases and is characterized by multiple and recurrent familial myxomas affecting young patients, people with endocrine disorders or with a spotty skin pigmentation.[189]

The macroscopic appearance of a myxoma may be polypoid, often pedunculated or papillary, with villous extensions.[190] Microscopically, myxomas are formed by a myxoid substance. Intratumoural haemorrhage or calcifications are often present.

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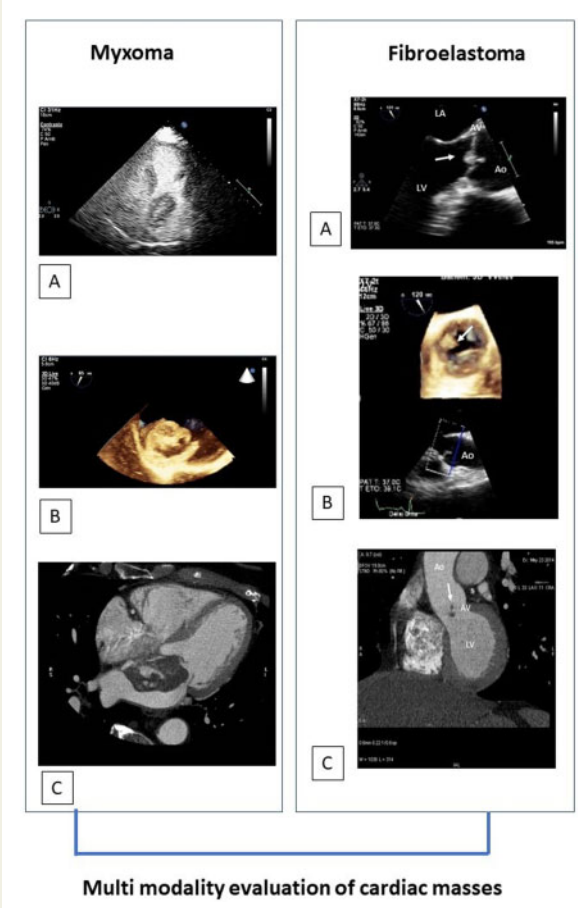


**Figure 8** Multimodality evaluation of cardiac masses. Myxoma (left): same patient with LA myxoma: 2D TTE after (*A*) Sonovue perfusion; (*B*) 3D TOE; and (*C*) cardiac CT (see Supplementary data online, *Video S4A* and *B*, *Videos S5–S7*). Fibroelastoma (right): (*A*) 2D TOE 120°; (*B*) 3D TOE live 3D; and (*C*) cardiac CT: aortic fibroelastoma on the non-coronary cusp (white arrow) (see Supplementary data online, *Video S8A*and *B*) 3D. 2D, two-dimensional; 3D, three-dimensional; Ao, thoracic aorta; AV, aortic valve; CT, computed tomography; LA, left atrium; LAA, left atrial appendage; LV, left ventricle; MV, mitral valve.

The clinical manifestations of a cardiac myxoma are represented by systemic symptoms, secondary embolization, or intracardiac obstruction.[191] Myxoma embolization occurs in up to 75% of patients[192] and is associated with high morbidity and mortality. Owing to the tumour localization, systemic embolization (including cerebral arteries with ischaemic stroke and retinal arteries with secondary visual loss) is frequent. The risk factors for embolic events are irregular surface, atypical localization, and large tumour size.[193] Imaging can provide important information for diagnosis and management: localization, insertion, size, appearance, mobility, and features of embolic risk.

The main imaging modality for myxoma diagnosis is TTE, whereas TOE is often necessary for morphological details (e.g. localization of the attachment point). On cardiac CT, myxomas appear as isodense or slightly hypodense masses with weak enhancement after iodine contrast injection. Therefore, the differential diagnosis with a thrombus may be difficult.[194] On MRI, myxomas have a homogeneous hyperintense signal intensity on T2-weighted images, an isointense aspect on T1-weighted images, low signal on early gadolinium enhancement, and intense signal enhancement on late gadolinium enhancement, often with a hypointense core due to haemorrhage.[194] Gadolinium enhancement imaging is an important method for differentiating myxomas and thrombi.[195]

Fibroelastomas. Papillary fibroelastomas are papillary lesions of the endocardium, generally located on the surface of cardiac valves (80–90%), making them the most common valve tumour.[196,197] The aortic valve is most frequently affected.[198] Cardiac papillary fibroelastomas are benign tumours with an incidence of 0.002–0.33% in autopsy series, with incidence increasing with age.[199] Fibroelastomas represent almost 10% of intracardiac tumours.[200] The typical macroscopic description for a papillary fibroelastoma is a 'sea anemone' due to its round shape with digitations.[201] Microscopically, the tumour consists of connective tissue lined by endothelium.

The clinical manifestation of these tumours is very variable, from asymptomatic incidental discoveries during echocardiography to ischaemic stroke or even sudden cardiac death due to tumour embolization.[200] Tumour localization (aortic valve), mobility, and dimensions are predictors of arterial embolization.

Echocardiography is the first-line imaging modality. The echocardiographic appearance of a papillary fibroelastoma is a pedunculated free-moving mass with high-frequency oscillations during the cardiac cycle, with variable dimensions from a few millimetres to a few centimetres (rarely >3 cm), attached to the middle portion of the cardiac valves but without any valvular destruction (enclosure is exceptional and, although possible, regurgitation is minimal).[198,202] On cardiac MRI, the tumour might be not easily visualized due to its small size

**Recommendations for evaluation of cardiac masses**

The presence of a tumour may lead to a rapid surgical decision and this decision should not be delayed by performing a useless diagnostic examination. However, when making the decision on whether or not to operate, a multimodality approach is often requested. Cardiac CT and CMR are often considered in addition to echocardiographic exams. A PET scan may also be valuable when a metastasis or primary cardiac tumour is sought.

TOE (with 3D capabilities if possible) is recommended in addition to TTE in evaluating cardiac tumours (e.g. myxoma, papillary fibroelastoma).

Contrast echocardiography or 3D echocardiography is recommended to better characterize cardiac masses (atria > ventricles).

CT can be a helpful complementary tool to differentiate a myxoma from a thrombus in cases in which TTE/TOE is inconclusive.

CMR imaging is considered as the modality of choice for evaluating cardiac tumours.

3D, three-dimensional; CMR, cardiac magnetic resonance; CT, computed tomography; PET, positron emission tomography; TOE, transoesophageal echocardiography; TTE, transthoracic echocardiography.

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and high mobility, but may be described as a hypointense mobile mass on cine images.[195]

The differential diagnosis of the tumour includes valvular calcifications, thrombi, vegetations (generally associated with valvular destructions), strands, and Lambl's excrescences (generally arising from the coaptation line). *Figure 8* illustrates the use of multimodality imaging in the diagnosis of cardiac masses.

*Valvular vegetations*

**Infective endocarditis**. Cerebral emboli are a frequent complication of infective endocarditis and are related to the migration of infected valvular vegetations in the cerebral arteries.[203] These emboli occur in 15–30% of patients with infective endocarditis, can arise at any time during the disease (before and during treatment), and are associated with a worse prognosis.[204–207]

Echocardiography plays a major role in the assessment of embolic risk in patients with infective endocarditis.[203,208] The 2015 European Society of Cardiology guidelines for the management of infective endocarditis recommend that both TTE and TOE are performed in patients with suspected or definite infective endocarditis.[204] In a meta-analysis of 16 observational studies, the diagnostic properties of TTE for detecting infective endocarditis findings was compared with those of TOE. For detecting vegetations, TTE had a sensitivity of 61% and a specificity of 94%, and thus had the potential to miss many vegetations detected on TOE.[209]

Several factors have been associated with an increased risk of cerebral embolism.[204,210,211] Among them, the size and mobility of the vegetations are the most potent independent predictors of a new embolic event[211,212] (Supplementary data online, *Table S6*). Patients with vegetations >10 mm are at higher risk of embolism and this risk is even greater in patients with very large (>15 mm) and mobile vegetations, especially in staphylococcal infective endocarditis.[208] An observational study[213] found that the risk of neurological complications was even higher in patients with very large (>30 mm) vegetations. In a study of 847 patients with infective endocarditis, the 6-month incidence of new embolism was 8.5%. Six factors (age, diabetes, AF, previous embolism, vegetation length, and *Staphylococcus aureus* infection) were associated with an increased embolic risk and were used to create an 'embolic risk calculator'.[211]

The risk of embolism is particularly high during the first days after the initiation of antibiotic therapy and decreases after 2 weeks,[207] although some risk persists indefinitely while vegetations remain present, particularly for very large vegetations.[213] For this reason, the benefit of surgery to prevent embolization will be greatest during the first week of antibiotic therapy, when the embolic rate is highest.[204]

In addition to echocardiography, other imaging techniques should be used for the assessment of patients with neurological complications of infective endocarditis (Figure 9). These include $^{18}$F-fluorodeoxyglucose positron emission tomography (PET) CT, which is particularly useful for the diagnosis of prosthetic valve infective endocarditis,[204,214,215] and cerebral imaging, which is mandatory in patients with suspected or definite neurological complications of infective endocarditis. This may include CT scanning, with or without contrast, and/or MRI, depending on the neurological status of the patient.[204]

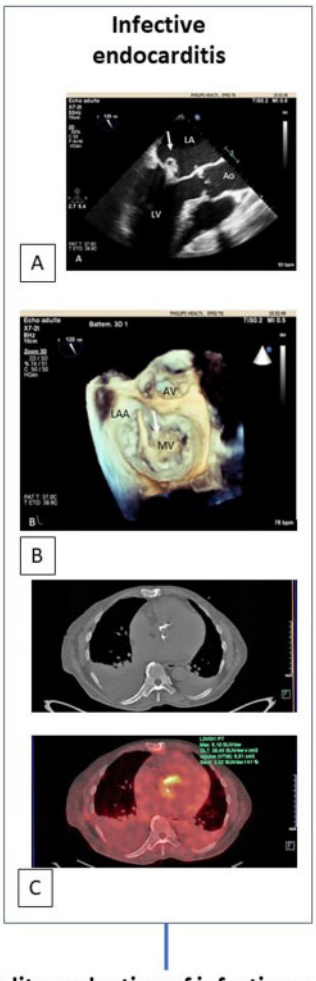


**Figure 9** Multimodality evaluation of infective endocarditis. (*A*) 2D TOE 120° and (*B*) 3D TOE zoom 3D: mitral posterior valve vegetation in an active endocarditis (white arrow) complicated with ruptured chordae tendineae; (*C*) $^{18}$F-FDG PET/CT images show infected prosthetic aortic valve (see Supplementary data online, *Video S9*). Ao, thoracic aorta; AV, aortic valve; CT, computed tomography; FDG, fluorodeoxyglucose; LA, left atrium; LAA, left atrial appendage; LV, left ventricle; MV, mitral valve; PET, positron emission tomography.

In a meta-analysis of 20 studies (including 496 patients) with prosthetic valve infective endocarditis, TTE, TOE, and multidetector CT plus TOE had a pooled sensitivity/specificity for vegetations of 29/100%, 82/95%, and 88/94%, respectively. Although multidetector CT data are limited, this review showed that multidetector CT in addition to TOE may improve sensitivity in detecting life-threatening periannular complications.[216]

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### Marantic vegetations. Non-bacterial thrombotic endocarditis

Non-bacterial thrombotic endocarditis (NBTE) is a form of non-infectious endocarditis that most commonly affects patients with advanced cancer (known as marantic endocarditis) and systemic lupus erythematosus (known as Libman–Sacks endocarditis), but also other chronic diseases.[217–219] In these conditions, endothelial damage and a hypercoagulable state concur to form sterile vegetations composed of bland fibrin–platelet thrombi. These lesions can affect both undamaged and damaged cardiac valves, as well as the chordae tendineae or the endocardium. They are classically found in mitral and aortic valves along valvular coaptation lines and are usually small, broad based, and irregularly shaped.[220] In comparison to the lesions in infective endocarditis, the weak inflammatory reaction at the site of attachment renders NBTE vegetations more friable and prone to systemic embolization, although they are less destructive and rarely cause a significant degree of valvular dysfunction.[221]

The typical clinical presentation of NBTE is systemic embolization. The incidence of cerebral ischaemia is higher in NBTE than in infective endocarditis (33% vs. 19%).[222,223] Patients with NBTE tend to have evidence of multiple, widely distributed brain infarcts on diffusion-weighted MRI, whereas single lesions or focal infarcts are more characteristic of infective endocarditis.[224]

The diagnosis of NBTE can be challenging and relies on strong clinical suspicion. Laboratory studies and imaging techniques play a decisive role in confirming a predisposing disease, establishing the presence of valvular vegetations using echocardiography, and ruling out infective endocarditis. TOE should be ordered when there is a high suspicion of NBTE. TOE has a higher sensitivity and specificity than TTE for the detection of NBTE; it should be considered either as a complement to a non-diagnostic TTE or as the initial test in patients with suspected cardioembolism, moderate or worse valve dysfunction, or superimposed infective endocarditis.[225,226]

**Recommendations for evaluation of valvular vegetations**

TTE is recommended as the first-line imaging modality in suspected infective endocarditis.

TOE is recommended in patients with a high clinical suspicion of infective endocarditis and a normal TTE, and when a prosthetic heart valve or an intracardiac device is present.

TOE should be considered in the majority patients with suspected infective endocarditis, even in cases with positive TTE findings.

Repeat TTE/TOE within 5–7 days is recommended in case of initially negative examination when clinical suspicion of infective endocarditis remains high.

Additional imaging techniques (cardiac CT, PET/CT) that allow the diagnosis of embolic events and cardiac involvement should be performed when TTE/TOE findings are negative or doubtful.

$^{18}$F-fluorodeoxyglucose PET/CT is predictive of major cardiac events in prosthetic valve endocarditis and new embolic events within the first year following infective endocarditis.

TOE is recommended in case of systemic lupus erythematosus with or without primary antiphospholipid antibody syndrome and ischaemic stroke/TIA or neurological manifestations plus focal lesions on cerebral MRI.

*Continued*

***Continued***

**Recommendations for evaluation of valvular vegetations**

TTE is indicated in patients with cancer (e.g. lymphoma, carcinoma of the gastrointestinal tract, and carcinoma of the lung) who have an ischaemic stroke or arterial embolism to document marantic vegetations.

TOE should be used in the characterization of valvular masses (differential diagnosis based on clinical and biological arguments).

CT, computed tomography; PET, positron emission tomography; MRI, magnetic resonance imaging; TIA, transient ischaemic attack; TOE, transoesophageal echocardiography TTE, transthoracic echocardiography.

When an early TOE examination is performed, the prognosis of NBTE is improved.[227] A prospective study that compared paired 3D TOE with 2D TOE in 29 patients with systemic lupus erythematosus and manifestations of cerebrovascular disease demonstrated that although 2D TOE has high diagnostic value for the detection of Libman–Sacks vegetations, 3D TOE provides clinically relevant additional information that complements 2D TOE for the detection, characterization, and clinical correlations of Libman–Sacks endocarditis.[228] Following embolization, small remnants (≤3 mm) on affected valves may result in false negative echocardiography results.[204]

## Aortic arch atheromatous plaques

Imaging of the aorta is essential in the evaluation of ischaemic stroke and peripheral embolization. Atherosclerotic plaque is the most common source of embolism originating from the aorta (Supplementary data online, *Tables S7 and S8*).[229–234] In rare instances, embolism can arise from mobile thrombi[235,236] or aortic tumours.[237] Atherosclerotic plaques are a manifestation of general atherosclerosis and are associated with known atherosclerosis risk factors such as hypertension, diabetes mellitus, advanced age, hypercholesterolaemia, inflammation, and tobacco smoking.[238,239] Atherosclerotic plaques in the aorta may cause either thrombotic (thromboembolic) or atherosclerotic (cholesterol crystal) emboli.[240] Thromboemboli are usually large and commonly occlude medium-to-large arteries, causing ischaemic stroke, TIA, renal infarct, and peripheral thromboembolism. By contrast, cholesterol crystal emboli tend to occlude small arteries and arterioles and may cause 'blue-toe' syndrome, renal insufficiency, or mesenteric ischaemia. This atheroembolic syndrome can arise spontaneously,[241] after the aorta is instrumented during angiography or arterial catheterization,[242,243] or after heart surgery involving clamping of the aorta.[244] Finally, mobile thrombi of the aorta without diffuse atherosclerosis mostly located at the aortic arch have been reported since the introduction of TOE imaging for patients with cerebral or peripheral emboli. Clots floating in the aorta frequently become embedded in atherosclerotic plaque and carry a high embolic risk.[236]

The detection, characterization, and quantification of aortic plaques can be accomplished by TOE, CT, or MRI. Several classifications have been proposed to quantify severity of aortic atherosclerosis.

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However, based on the results of most studies, atherosclerosis severity is considered mild when intimal thickening (focal or diffuse) is 2–3 mm (grade I), moderate when the atheroma is <4 mm (grade II), severe when the atheroma is ≥4 mm (grade III), and complex when any grade has associated mobile or ulcerated components (grade IV).[245,246]

TOE provides higher resolution images than TTE for diagnosing aortic atheroma. TOE characterizes the plaque by measuring plaque thickness, ulceration, calcification, and superimposed mobile thrombi, thereby determining the embolic potential of each plaque. Compared with 2D TOE, 3D TOE provides superior visualization of the number, morphology, volume, and spatial extent of aortic atheromas.[247] Assuming the intrinsic limitation of suprasternal TTE, this approach may be helpful for the preliminary screening of atherosclerotic plaques in the aortic arch. In one study, adequate transcutaneous image quality could be achieved in 84% of cases.[248] This approach may help to identify subjects at higher risk of subclinical cerebrovascular disease.[249] However, the low negative predictive value of TTE does not allow aortic plaques to be ruled out or a complex lesion to be correctly established.

The prevalence of aortic atheromas on TOE varies depending on the population studied. In a community study,[250] aortic atheromas were present in 51% of randomly selected residents aged ≥45 years, with a greater prevalence in the descending aorta. Complex atheromas were present in 7.6%. In patients with known significant carotid artery disease, the prevalence of aortic atheromas was 38%, and 92% in those with significant coronary artery disease.

Aortic plaques with a complex lesion are a risk factor for recurrent ischaemic stroke, silent brain infarction, and peripheral thromboembolic events in patients with ischaemic stroke[229,230] or TIA.[231] This association has been described for proximal aortic plaques, particularly in the aortic arch[232–234]; however, no clear association exists between the presence of descending aortic plaques and thromboembolic events. Complex and severe atheromas of the ascending aorta and aortic arch are associated with cerebral and peripheral embolic complications.[229,239] A meta-analysis[251] has identified an increased risk of cerebral infarction in patients with a plaque ≥4 mm in thickness, regardless of whether the two principal risk factors for cerebral infarction in older adults (i.e. carotid stenosis and AF) were also present. In addition to the presence of a plaque ≥4 mm, the risk of recurrent cerebral infarction is also higher in patients with ulcerated, uncalcified plaques, and plaques with mobile elements.[234,246] Attention has been drawn to some of the factors involved in aortic thrombosis,[252] such as hypercoagulability[253] and high homocysteine[238] or ultra-sensitive C-reactive protein levels, independently of other atherosclerotic risk factors.[254]

Few studies have focused specifically on the relationship between atheroma and peripheral artery embolism outside the cerebrovascular region.[255] However, TOE is indicated for the diagnosis of complex atheroma or the presence of a large mobile thrombus of the aorta, an infrequent cause of systemic emboli, which appears to be a complication of atherosclerosis, but is not always extensive or severe.

Multidetector CTA of the aorta can also be used to detect aortic atheromas. Its sensitivity, specificity, and overall accuracy for identifying a severe aortic atheroma are similar to those of TOE, the reference method.[256–258] Calcified plaque appears as a light, high-attenuation signal, whereas lipid-rich or fibrous plaque appears as hypo-attenuated dark signals within the vessel wall. In a retrospective study, CTA had a high negative predictive value for aortic arch disease atheromas; however, sensitivity for detecting grade 1–4 atheromas was 53%.[259] Benyounes *et al.*[260] observed that agreement between CTA and TOE is poor (61%) and that CTA lacks sensitivity but had high specificity (93%) for detecting aortic arch atheromas. Nevertheless, CTA has improved and can be reasonably considered in routine clinical practice.

MRI provides information on plaque characteristics.[261,262] However, MRI has limited utility for assessing mobile thrombi that are often superimposed on plaques. Moreover, its spatial resolution is inferior to that of CT. Compared with TOE, MRI overestimates plaque thickness and consequently classifies more patients as at high risk (≥4 mm plaque thickness).[263] 3D multicontrast MRI vessel wall imaging is capable of characterizing at-risk atherosclerotic plaques in the thoracic aorta.[264] A recent study[265] using a 3D multicontrast protocol was tailored to characterize aortic plaque. The CMR sequences showed high intra- and interobserver agreement regarding image quality grading of the 3D sequences and assessment of four-dimensional flow path lines. A high intra- and inter-rater agreement of plaque classification evaluation according to American Heart Association definitions.[266]

*Figure 10* illustrates the use of multimodality imaging in the diagnosis of aortic arch atheromatous plaques.

### Prosthetic cardiac valves (e.g. mechanical, biological, clips)

Intracardiac devices and prosthetic valves represent a major source of embolism. The presence of an intracardiac material in the setting of an embolic event raises a high level of suspicion of a cardioembolic source. A TOE is, in most cases, indicated within 48 h.

Two complications of prosthetic valve replacement must be suspected when an embolic event occurs in a patient with a valve: prosthetic valve infective endocarditis (see section Infective endocarditis) and prosthetic thrombosis. Prosthetic thrombosis is one of the most severe complications of mechanical heart valves, although it has been less frequently observed in other types of valve substitute. Particular attention should be taken to the bioprosthesis, and especially to transcatheter aortic valves.[267] Situations at risk include the early postoperative period, interruption of anticoagulant therapy, and pregnancy.[267–269] Both TTE and TOE must be performed in suspected prosthetic valve thrombosis as soon as possible:

- In severely obstructive thrombosis, TTE is the first-line examination and may provide evidence of an abnormal transprosthetic colour flow jet, an elevated Doppler transprosthetic gradient, and a reduced effective orifice area.
- A high transvalvular gradient is of great value for the diagnosis of prosthetic thrombosis, especially when comparison with a reference value is available.
- Although direct evidence of valve thrombus may be obtained by TTE, TOE is the method of choice to diagnose the main signs of prosthetic thrombosis (restricted leaflet or disc motion, abnormal central regurgitation, loss of physiological regurgitant jets in mechanical valves, and direct visualization of thrombus or pannus formation).
- Cinefluoroscopy may also be useful assess leaflet motion of mechanical prostheses.

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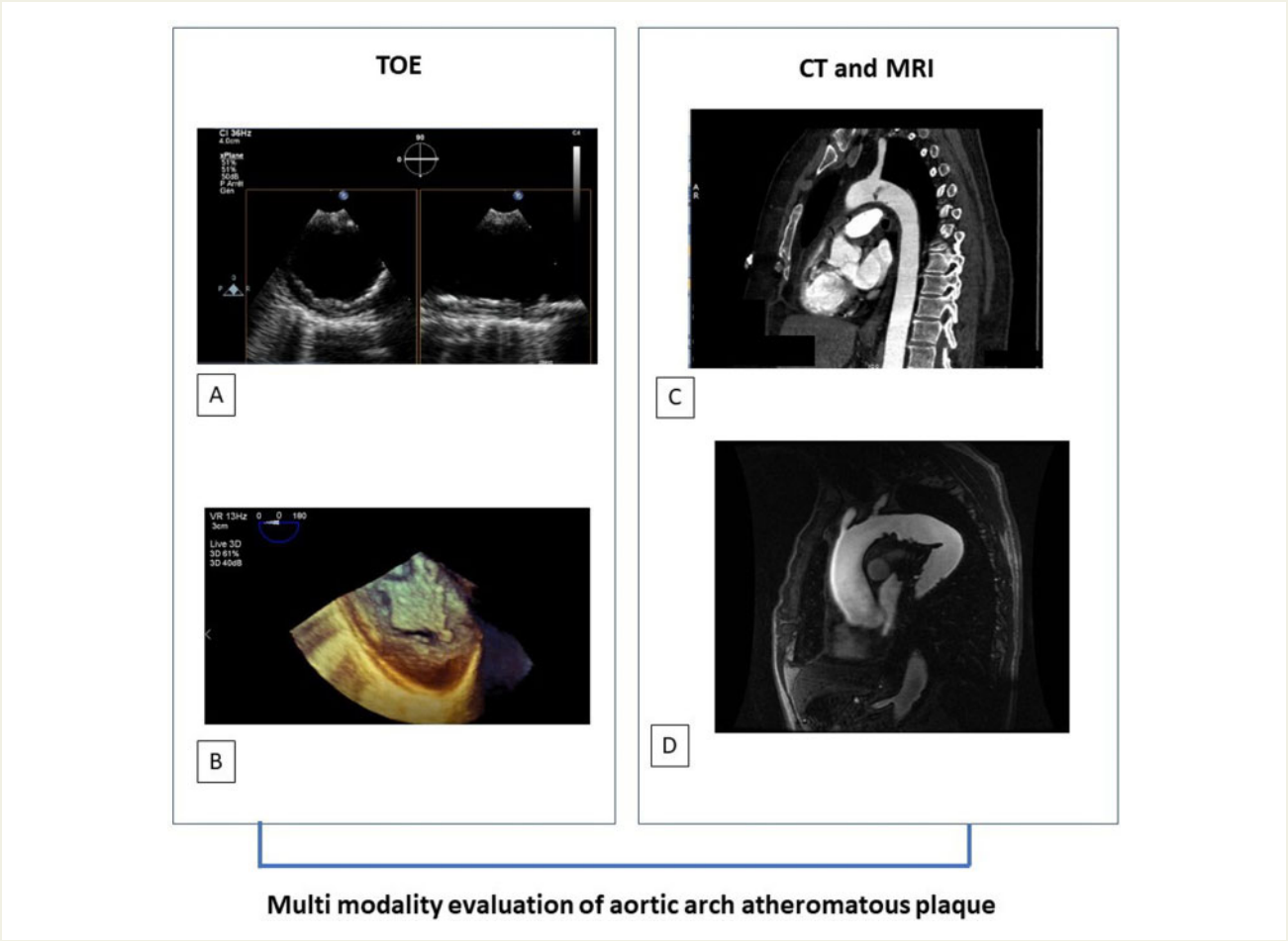


**Figure 10** Multimodality evaluation of aortic arch atheromatous plaque: TOE (left) and CTA and angio MRI (right). (*A*) 3D TOE Xplane showing complex atheroma (≥4 mm in thickness and/or mobile components) of the ascending thoracic aorta with mobile components; (*B*) 3D live reconstruction of complex atheroma of the ascending thoracic aorta; (*C*) CTA and (*D*) angio MRI showing atherosclerotic arch plaques >4 mm (courtesy of Gilles Soulat, MD, PhD) (see Supplementary date online, *Videos S10* and *S11*).

**Recommendations for evaluation of aortic arch atheromatous plaques**

| |
|---|
| TOE is the reference echocardiographic method for the evaluation of thoracic aortic atherosclerosis location (descending, arch, ascending aorta) and severity (complex thoracic aortic plaques).[234] |
| TOE is the reference echocardiographic method for the description of complex thoracic aortic plaques (plaque thickness, ulceration, mobile elements suggesting thrombus). |
| TOE can characterize aortic plaques as a surrogate marker of ischaemic stroke risk, irrespective of AF or carotid stenosis. |
| TTE (suprasternal window when available) can be used to identify aortic arch atheromas. |
| CT is competitive with TOE in aortic plaque (ascending and arch thoracic aorta) characterization. |
| MRI can be proposed in aortic wall and atherosclerotic plaque characterization. |

AF, atrial fibrillation; CT, computed tomography; MRI, magnetic resonance imaging; TOE, transoesophageal echocardiography; TTE, transthoracic echocardiography.

TOE is very helpful for assessing the extent of thrombus formation. Cardiac CT could be also considered. Recent evidence from expert teams demonstrates the great value of cardiac CT for identifying thrombi that are not easily seen on echocardiography.[270,271]

The risk of embolism and complications in prosthetic thrombosis is related to the size of the thrombus, with a large thrombus (≥0.8 $cm^2$) being a major risk factor for complications of thrombolytic treatment.[272] Thus, TOE may help in the choice between surgery and anticoagulant or thrombolytic therapy. TTE and TOE must also

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be used for the follow-up of patients with prosthetic thrombosis after initiation of specific therapy.[273]

Diagnosis of partial prosthetic thrombosis is difficult, especially when obstruction is mild or absent. TTE is of limited value in this setting and TOE is the method of choice for the diagnosis of small prosthetic thrombosis. However, the diagnosis of prosthetic thrombosis, even with TOE, suffers from some limitations. First, small abnormal echoes around the prosthesis may also be observed in prosthetic endocarditis, and it may be difficult to differentiate thrombus formation from vegetation. Moreover, examination of aortic prostheses is often difficult when a mitral prosthesis is also present, owing to attenuation of the ultrasound beam. Cardiac CT should be considered after clear agreement about the setting required to get valuable results from the CT acquisitions.[270]

**Recommendations for prosthetic heart valves**

| | |
|---|---|
| TTE must be performed within the 48 first hours in patients with a prosthetic valve and an embolic event. | |
| TOE must be performed in patients with a prosthetic valve and an embolic event, even if the results of TTE are negative. | |
| TOE plays an important role in guiding the therapeutic strategy in prosthetic thrombosis, the presence of a large thrombus favouring surgery. Cinefluoroscopy should not be forgotten in case of a mechanical prosthesis, and cardiac CT should be considered. | |
| Repeated TTE/TOE is recommended for follow-up after thrombolytic therapy or anticoagulant therapy of a prosthetic valve thrombosis. | |

CT, computed tomography; TOE, transoesophageal echocardiography; TTE, transthoracic echocardiography.

## Minor or undetermined cardiac sources of cerebral embolism

### Atrial septal abnormalities

*Atrial septal aneurysm*

Atrial septal aneurysm (ASA) is defined as excursion of septal tissue (typically the fossa ovalis) >10 mm from the plane of the atrial septum into the RA or LA, or a combined total excursion right and left of 15 mm.[274] Excursion of the atrial septum can be documented by 2D imaging as well as by M-mode when the cursor can be aligned perpendicular to the plane of the interatrial septum. This can be done in the subcostal four-chamber views by TTE or in the bicaval views by TOE. The incidence of ASA in the general population, as estimated by TTE, is considered to be only 0.23%,[275] rising to 4.6% in TOE studies.[22] The link between ASA and PFO is well established, with approximately 60% of patients presenting with ASA plus PFO.[275] ASA has also been associated with multiple septal fenestrations, and this should be evaluated carefully by colour Doppler.[276–278] TOE is a more sensitive method than TTE for evaluating ASA. The presence and extent of an ASA is a factor in device selection for PFO closure. A relatively large device can be chosen to encompass and stabilize the atrial septum or a smaller and softer device for better conformation with the ASA.

The link between ASA and systemic embolism was initially described from isolated cases.[279] In one series,[280] the incidence of ASA was estimated to be 2.2% in the general population, significantly lower than the 7.2% incidence in patients undergoing TOE after an ischaemic stroke ($P = 0.002$). The embolic mechanisms proposed included a thrombus in the ASA, a paradoxical embolism from a venous thrombus through a PFO or coexisting paroxysmal AF.[281]

*Patent foramen ovale*

PFO is a flap-like opening between the septum primum and septum secundum at the fossa ovalis. During foetal life, the foramen ovale plays a physiological role, with the purpose of directing most oxygenated placental blood from the RA to the LA, avoiding the pulmonary bed. A PFO is the result of the failure of the septum primum and septum secundum to fuse postpartum. The reported prevalence of PFO in the general population is 25%, increasing to over 50% in patients with cryptogenic stroke.[275,282] Paradoxical embolism occurs when there is embolic transit from the systemic venous circulation to the systemic arterial circulation through a right-to-left shunt, such as a PFO or atrial septal defect. PFO refers to when right-to-left shunting of blood has been demonstrated by saline contrast injection without a true deficiency of the interatrial septum. Typically, the PFO is closed due to the gradient between the LA and RA, and no left-to-right shunting is seen. Under certain haemodynamic conditions, such as elevated right atrial (RA) pressure due to acute or chronic pulmonary hypertension, cough, or with a Valsalva manoeuvre, a right-to-left shunt can be seen.

The presence of PFO is presumed when agitated saline contrast is observed in the LA within three cardiac cycles after complete opacification of the RA.[283,284] Injections should be given at rest and with certain provocative manoeuvres such as cough and the Valsalva manoeuvre to increase RA pressure. Deviation of the interatrial septum to the LA side confirms elevated RA pressure. If agitated saline contrast is noted after five cardiac cycles, pulmonary arteriovenous malformations must be considered.[285,286] Elevated LA pressure from LV failure or mitral valvular disease can prevent right-to-left shunting, because higher RA pressure is required to overcome the elevated LA pressure. In a study comparing patients with or without left heart disease, the detection of PFO was 5% in patients with left heart disease and 29% in those without left heart disease.[287]

TTE, TOE, and transcranial Doppler are useful for the diagnosis of PFO[16,284] (Supplementary data online, *Table S9*). Transcranial Doppler records high-intensity transient signals, representing microbubbles passing through the middle cerebral artery. TTE is the primary method reported to characterize the presence of right-to-left shunting through a PFO and remains the most commonly used screening test due to its non-invasiveness and wide availability. The accuracy of TTE vs. TOE as the reference has been evaluated in a meta-analysis, which included 13 studies with 1436 patients.[288,289] The weighted mean sensitivity and specificity for TTE were 46% and 99%, respectively. Using different contrast agents, different

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microbubble cut-offs for a positive TTE/TOE, and different cardiac cycle cut-offs for a positive TTE/TOE, did not affect the accuracy of TTE. In a population of patients with cryptogenic stroke, TOE had a sensitivity of 89% and a specificity of 91% for the diagnosis of PFO. The low negative likelihood ratio of TOE suggests that it is a proficient test of exclusion for PFO.[290]

In a systematic review of all prospective studies that assessed the accuracy of TOE for the detection of PFO using confirmation by autopsy, cardiac surgery, and/or catheterization as the reference, only four studies met the inclusion criteria.[290] Among 164 patients, TOE had a weighted sensitivity of 89% and a specificity of 91% to detect PFO.[290]

TTE is recommended first and should be performed as its sensitivity is important and it is easier to perform the Valsalva manoeuvres during a TTE. TOE is recommended in addition, but could be less sensitive according the condition of the examination.[290–293] Transcranial Doppler is a viable alternative to contrast TTE for screening, with higher sensitivity than TTE, but with the disadvantage of being unable to identify associated lesions, such as ASA, and failure to distinguish pulmonary from cardiac sources of shunting.[294]

A meta-analysis compared transcranial Doppler with TOE as the reference; both tests were performed with a contrast agent and a manoeuvre to provoke right-to-left shunt.[288] A total of 27 studies (29 comparisons) with 1968 patients (mean age 47.8 ± 5.7 years; 51% men) fulfilled the inclusion criteria. The weighted mean sensitivity and specificity for transcranial Doppler were 97% and 93%, respectively.[288]

A simultaneous study of TTE, TOE, and transcranial Doppler showed TTE to be more sensitive than TOE for the diagnosis of PFO.[295] TOE returned a false negative result in 10% of patients, and tended to underestimate the severity of right-to-left shunt. Transcranial Doppler performed simultaneously with TTE and with TOE showed that these false negatives were not due to the imaging technique used itself, because transcranial Doppler performed during TOE also yielded a similar number of false negatives, perhaps related to sedation and lower quality of the Valsalva manoeuvre.[295]

Cardiac CT has been evaluated in 152 patients after ischaemic stroke and showed a sensitivity of 73%, specificity of 98%, positive predictive value of 91%, and negative predictive value of 94.7% for the diagnosis of PFO. CT had a lower sensitivity than TOE in detecting PFO, because PFO requires a provocative manoeuvre diagnosis, which is impossible to do during CT.[29] CT may be of limited use for detecting cardioembolic sources in younger patients with stroke, as the incidence of PFO or ASA is higher in younger patients with stroke or those with cryptogenic stroke.[37]

Several studies have evaluated PFO as a predictive factor of recurrent ischaemic stroke in patients with cryptogenic stroke.[285,296–301] A strong association between PFO and ischaemic stroke has been observed in patients of all ages.[282,302] However, not all studies support the association between cryptogenic stroke and PFO.[299,302,303] Despite circumstantial evidence, prospective studies have failed to demonstrate causality between recurrent ischaemic stroke, presence of PFO or ASA, or right-to-left shunt size.[304–307] Similarly, controversy exists in the management of these patients. A meta-analysis has shown that among medically treated patients with ischaemic stroke/TIA, those with PFO did not have a higher risk of recurrent cerebrovascular ischaemia than those without PFO.[308] No relationship between the degree of right-to-left shunt and the risk of future cerebrovascular events was found when shunt size was dichotomized as small or moderate vs. large.[308] However, three recent studies have shown that among adults who had had a cryptogenic stroke, closure of a PFO with an ASA or large interatrial shunt was associated with a lower rate of recurrent ischaemic strokes than medical therapy alone during extended follow-up.[309–311] However, PFO closure was associated with higher rates of device complications and AF.[309–311]

**Recommendations for evaluation of atrial septal anomalies (ASA, PFO)**

| |
|---|
| In patients with cryptogenic stroke or TIA, PFO should be ruled out by contrast TTE and, if contrast TTE is negative, on contrast TOE. |
| ASA is defined as a >10 mm excursion from the plane of the atrial septum or a combined total excursion right and left ≥15 mm. |
| Contrast TOE is the reference method for defining a PFO. Contrast TTE has a lower sensitivity than other techniques, including transcranial Doppler. However, if contrast TOE is negative in the case of cryptogenic stroke, a second method should be performed (i.e. contrast TTE or transcranial Doppler). |
| At-risk PFO should be defined, based on the following: presence of an ASA, PFO size, length of the tunnel, number of bubbles crossing the interatrial septum (≥30 bubbles) (presence of Chiari network or Eustachian valve can be linked to a causal role of PFO). |
| 3D contrast TOE may provide additional information in assessing interatrial septal anatomy and localization of the right-to-left shunt. |
| Contrast TOE should be systematically performed before the indication of a PFO closure and interpreted by the heart–brain team before any decision. |

3D, three dimensional; ASA, atrial septal aneurysm; PFO, patent foramen ovale; TIA, transient ischaemic attack; TOE, transoesophageal echocardiography; TTE, transthoracic echocardiography.

No specific imaging pattern has been associated with a causal role of PFO in patients with ischaemic stroke.[312] ASA, PFO size, shunt severity, presence of Chiari network or Eustachian valve, and an atrial septal hypermobility can be linked to a causal role of PFO.[312–314]

Of note, in patients with endocardial leads (endocardial pacemaker and defibrillator), the presence of a PFO is associated with a greater than threefold increased risk of ischaemic stroke/TIA.[315]

*Mechanisms of paradoxical embolism*

Right atrial thrombi: thrombi 'in transit' (paradoxical embolism). RA thrombi are usually diagnosed in the setting of pulmonary embolism, and have been identified in 7–18% of patients with pulmonary embolism. RA thrombi are related to venous thromboembolic disease, as the RA represents a transit zone on the pathway between the legs and the pulmonary arteries.[316] TOE shows mobile and freely moving masses not attached to an intracardiac structure. When a systemic thromboembolic event occurs, a paradoxical embolism should be suspected.

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**Recommendation on the evaluation of PFO and paradoxical embolism**

| | |
|---|---|
| Contrast TTE should be performed or repeated in case of the occurrence of a TIA, ischaemic stroke, or peripheral embolism in patients with documented venous thrombosis and/or pulmonary embolism. | |

TIA, transient ischaemic attack; TTE, transthoracic echocardiography.

Another condition more linked to systemic thromboembolism is the thrombus straddling the PFO. It is diagnosed by TOE and appears as an oblong echodensity trapped in the foramen ovale, with two distal extensions. It is best visualized on a short-axis view of the heart. The thrombus is often described as long, mobile, and snake-shaped; sometimes it prolapses into the right ventricle and/or LV through the atrioventricular valves. This diagnosis of a thrombus straddling the PFO is rarely made by TTE; however, TTE may document the consequences of pulmonary embolism (dilated right cavities, paradoxical septum, and arterial pulmonary hypertension). TTE may also show serpentine thrombi in the LA and/or RA.[317]

In the setting of systemic embolism, the documentation of a thrombus straddling the PFO confirms a paradoxical embolism. The optimal choice of treatment remains challenged.[317]

Left atrial septal pouch. LASP is defined as incomplete fusion of the cranial segment of the overlap between the septum primum and septum secundum, resulting in a recess opening into the LA in the absence of an interatrial shunt at rest or with Valsalva manoeuvre release.[318] LASP may serve as a nidus for thrombus formation, particularly in the presence of low flow states, and therefore predisposes to thromboembolic events.[318] LASP is best identified using a standard bicaval view by TOE imaging, and 3D TOE may add incremental value for detecting and characterizing LASP morphology.[17] LASP generally cannot be identified using TTE, whereas they can be detected using either cardiac CT or MRI.[319] A previous autopsy study reported a prevalence of 39% among randomly selected patients with cardiovascular disease,[320] although subsequent studies have reported a lower prevalence with a suspected decline with increasing age.[321]

Published case reports have speculated on a causal relationship between LASP and ischaemic stroke,[319,322,323] and a number of retrospective studies have more closely examined this association. However, results to date have been discordant (Supplementary data online, *Table S10*).[318,324–326] A retrospective case–control study of 187 patients aged >50 years undergoing TOE after presenting with ischaemic stroke found no significant association between the presence of LASP and ischaemic stroke after comparison with 157 stroke-free controls.[318] A more recent study of 126 patients presenting with cryptogenic stroke undergoing TOE compared with 137 patients without stroke reported an association with LASP that was significant after adjustment for multiple other stroke risk factors.[321] A systematic review pooling data from 516 ischaemic stroke patients and 779 controls found no significant association.[326]

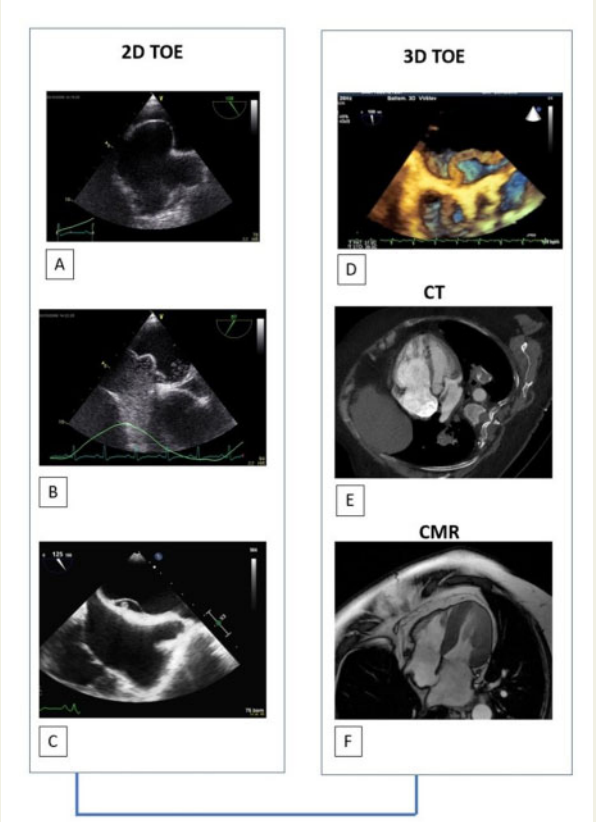


**Figure 11** Multimodality evaluation of atrial septal abnormalities. 2D TOE (left panel): (*A*) ASA and (*B*) PFO in the same patient, diagnosed using contrast TOE (57°) during the Valsalva manoeuvre; (*C*) thrombus within an atrial septal pouch. 3D TOE (right panel): (*D*) entrapped thrombus through an ASA with a PFO; (*E*) entrapped thrombus through a PFO in patient with acute pulmonary embolism; (*F*) CMR: ASA on 2D SSFP imaging (Supplementary data online, *Videos S12–S14*). 2D, two-dimensional; 3D, three-dimensional; ASA, atrial septal aneurysm; CMR, cardiac magnetic resonance; CT, computed tomography; PFO, patent foramen ovale; SSFP: steady-state free precession; TOE, transoesophageal echocardiography; TTE, transthoracic echocardiography.

*Figure 11* illustrates the use of multimodality imaging in the diagnosis of atrial septal abnormalities.

## Valvular abnormalities

*Mitral valve prolapse*

Mitral valve prolapse arises as a result of myxomatous degeneration of the valve tissues and presents on 2D TOE as a hernia or protrusion measuring >2 mm in one or both of the LA mitral valve leaflets in systole, referred to as 'floppy valve syndrome' (morphological abnormality), and coaptation of the two mitral leaflets posterior to the mitral annulus mainly observed in the long-axis, parasternal longitudinal view.[327,328] The sensitivity and specificity of TOE for the detection of mitral valve prolapse are 87% and 97%, respectively.[329] Higher values, approaching 100%, have been obtained using TOE[330] and 3D echocardiography.[331]

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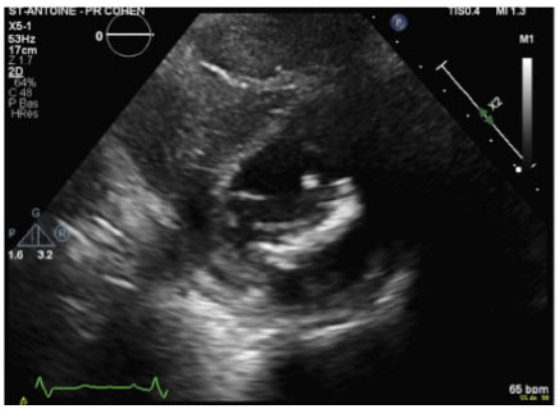

**Figure 12** Mitral annular calcifications on 2D TTE (short-axis view) (see Supplementary data online, *Video S15*). 2D, two-dimensional; TTE, transthoracic echocardiography.

A link between mitral valve prolapse and ischaemic stroke has been described in young subjects, predominantly those aged <45 years[332] or with a diffuse-form prolapse (mitral, aortic, and tricuspid) and valve thickening[333,334] but, as yet, the attributable risk of mitral valve prolapse to ischaemic strokes in young patients is very low (0.14–0.6/100 patient-years).[335]

The mechanism of stroke in mitral valve prolapse is not clearly understood. They may be caused either by platelet emboli forming on splits in the valve endothelium and subendothelium conjunctive tissue, or cruoric thrombi developing in the cul-de-sac formed by the posterior mitral valve and the LA wall. They are most likely related to the presence of other risk factors for embolism, primarily AF, which may be paroxysmal and asymptomatic. High-risk echocardiographic features in mitral valve prolapse are: ≥5 mm valve thickening, valvular dystrophy (redundancy), enlarged LA, ≥mild mitral regurgitation, and the presence of interatrial septal aneurysms.[336]

*Mitral annulus calcification*

Mitral annulus calcification is a very common (incidental finding) degenerative process (detected at echocardiography in approximately 14% of cases).[337] It mainly affects older people (>60 years), women, and patients with hypertension, diabetes, chronic renal dysfunction, or dysregulated mineral metabolism.[338–340] Patients presenting with mitral annulus calcification often have comorbidities such as endocarditis, arrhythmia, systemic emboli, and aortic valve calcification.[340] In advanced cases, it may cause significant obstruction of LV inflow and symptomatic mitral stenosis.

Mitral annulus calcification refers to a chronic inflammatory fibrous calcification of the mitral annulus (endothelial dysfunction, lipids, and calcium deposit in the fibrous ring of the mitral valve). No clear causal relationship between ischaemic stroke and mitral annulus calcification has been established because it is more a marker for generalized atherosclerosis.[338,339] However, occasionally, mobile plaques may be clearly identified at the level of the calcified annulus by echocardiography and, in those cases, the probability of a migration of calcified emboli or thrombotic debris is much higher. Certain ischaemic strokes may be related to an increased incidence of AF.[337]

Multimodality imaging with 2D, 3D, and Doppler echocardiography (*Figure 12*) and CTA can delineate the extent and location of mitral annulus calcification to help guide therapeutic strategies. Three semi-quantitative grades of severity can be identified: mild (focal, limited increase in echodensity of the mitral annulus), moderate (marked echodensity involving one-third to one-half of the ring circumference), or severe (marked echodensity involving more than half of the ring, or with intrusion into the LV inflow tract). Multislice CT can better quantify the severity of calcification. It is usually visualized on echocardiography as an echodense shelf-like structure with an irregular, lumpy appearance involving the mitral valve annulus, with associated acoustic shadowing. Using $^{18}$F-sodium fluoride (calcification activity) and $^{18}$F-fluorodeoxyglucose (inflammation activity) PET, mitral annulus calcification has recently been shown to be characterized by both calcification and inflammatory activity that increases proportionally to the baseline calcification burden (highest baseline CT calcium scores).[341]

Cardiac CT has been proposed in the evaluation of the extent and location of mitral annular calcification.[342]

*Aortic valve calcification and stenosis*

Calcific aortic valve disease with or without stenosis is a very common feature, especially among older adults. The clinical precursors of atherosclerosis are also risk factors for calcific aortic valve disease.[343] Spontaneous embolic complications observed in calcific aortic valve disease are rare and most often clinically silent, particularly owing to the small size of the thrombi, which preferentially migrate to the retinal artery.[344] Rarely, larger emboli have been associated with calcific aortic valve disease, mainly in procedural settings such as cardiac catheterization and percutaneous intervention or heart surgery.[345] TTE or TOE may rarely visualize small debris or mobile plaques at the level of the valve leaflets or annulus, further reinforcing the potential for an embolic event. Cardiac imaging techniques play a key role in the study of calcific aortic valve disease by confirming the diagnosis and estimating its severity. Calcium scoring CT offers the advantage of quantifying the calcium load at the valve level, which is associated with the severity of aortic valve stenosis (≥2000 Agatston units for men and ≥1200 Agatston units for women to distinguish severe from moderate aortic stenosis), and predicts poor prognosis and disease progression.[346,347]

*Giant Lambl's excrescences and strands*

Lambl's excrescences (or fibrous filaments or strands) are thin, elongated, mobile structures that arise opposite the contact surfaces of cardiac valve leaflets. They are more commonly described on the mitral valve (atrial surface), but are also described on the ventricular side of the aortic valve, and can also be found on prosthetic valves and, rarely, on native tricuspid and pulmonary valves.[348] Two case-

**Recommendations for evaluation and treatment of minor and putative sources of ischaemic stroke**

Isolated and uncomplicated mitral valve prolapse should not be considered as a potential cardiac source of embolism.

*Continued*

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***Continued***

**Recommendations for evaluation and treatment of minor and putative sources of ischaemic stroke**

Mitral annulus and aortic valve calcifications should not be considered as potential cardiac sources of embolism because both are incidental and associated with other causes (e.g. aortic atheroma).

The significance of LASP for patients presenting with cryptogenic ischaemic stroke remains uncertain, and no recommendation can be made regarding the management of ischaemic stroke patients with LASP. Larger studies are needed to evaluate whether LASP is a risk factor for ischaemic stroke.

Lambl's excrescences are only weakly correlated with stroke risk. Their discovery during work-up for a cryptogenic stroke should not discourage the search for another possible cause. It has no effect on patient management.

LASP, left atrial septal pouch.

controlled studies[348,349] had discordant findings with respect to the association between valvular strands and ischaemic stroke, although both detected a relatively high prevalence in patients referred for exploration of cryptogenic stroke. Another case–control study[350] involving 284 patients referred for evaluation after an ischaemic stroke and 276 controls aged >60 years found a significantly increased stroke risk in patients presenting with mitral valve strands identified by TOE. These patients were monitored for a mean of 2.3 years and the risk of recurrent ischaemic stroke was not different in those with or without strands (6% vs. 4.2% per patient-year, respectively). The presence of mitral valve strands was not an independent predictor of risk for this outcome. A recent case-control study including 77 systemic lupus erythematosus cases and 26 age- and sex-matched controls found a similar frequency of Lambl's excrescences between the two groups and no association with incident ischaemic stroke.[351]

See Supplementary data online, *Videos S16*.

# Flow chart

Vascular imaging and contrast TTE/TOE are considered the first-line tool in the search for a cardiac source of embolism (*Figure 13*). CT and MRI are considered as alternative tools, and their indications are described on a case-by-case approach:

- In the case of normal contrast TTE, cardiac rhythm (atrial tachyarrhythmia vs. sinus rhythm) should be taken into account.
  - In patients with AF, contrast TTE can detect the presence of thromboembolic risk markers (LA size, LA strain alteration, and LVEF <40%). The indication for contrast TOE cannot be part of a routine indication, except to answer a specific question or for inclusion in a research protocol. Without TTE-derived thromboembolic risk markers, contrast TOE indication is mandatory.
  - In the case of sinus rhythm (i.e. cryptogenic stroke), contrast TOE and a Holter electrocardiogram are mandatory.
- In the case of abnormal contrast TTE, a minor cardiac source of embolism has to be distinguished from a major cardiac source of embolism.
  - If a minor cardiac source of embolism is detected, contrast TOE might be indicated: (i) if another potential cardiac source of embolism (>20% of cases) is suspected; (ii) before percutaneous interatrial septum closure; and (iii) in the event of unequivocal results on contrast TTE.
    - In the case of negative contrast TOE, a transcranial Doppler is indicated. In case of a negative transcranial Doppler, a Holter monitoring should be considered.
  - If a major cardiac source of embolism is detected and is an unequivocal potential source of embolism, the indication of contrast TOE may be debatable. However, its input is indisputable for the detection of potential cardiac sources of small size (below the resolution of contrast TTE), such as atrial or LV thrombosis, atrial or LV tumour, or valvular vegetation.
    - When contrast TTE is equivocal, contrast TOE indication is mandatory.

# Conclusions

Cardiac embolism accounts for an increasing proportion of ischaemic strokes, and the role of cardiac imaging (TTE with contrast, TOE with contrast, MRI, and CT) is increasing (Supplementary data online, *Tables S11* and *S12*). Echocardiography constitutes the primary choice for cardiac imaging after acute ischaemic stroke, with TTE and TOE providing complementary information. Cardiac CT and MRI are valuable alternatives in specific situations. AF remains the main cardiac source of embolism, although the role and imaging characteristics of LA/LAA dysfunction remain debatable (e.g. LAA geometry, LAA dysfunction, LA strain, LA/LAA SEC). Improved imaging of aortic atheromas (TOE > CT), ventricular thrombus (MRI > TTE), atrial thrombus (TOE or CT > MRI), valvular masses (3D TOE > MRI or CT) may lead to better aetiological work-up in patients with ischaemic stroke. Despite such a work-up, one-third of ischaemic strokes have an unclear cause, leading to the concept of ESUS, secondary to the so-called atrial cardiomyopathy. A thrombogenic atrial substrate (LA/LAA anomalies in cellular components, geometry, and/or function) can lead to atrial thromboembolism. LA strain, MRI (LA fibrosis), biomarkers and echo-markers, and rhythm anomalies can be further characterized. Atrial septal anomalies deserve careful examination to describe at-risk PFO and to discuss the indications of PFO closure in patients with cryptogenic stroke, after in-depth discussion and the ruling out of other possible causes, including occult AF (Holter or prolonged rhythm monitoring, insertable cardiac monitors). Patients with cryptogenic stroke constitute a heterogeneous group, leading to therapeutic implications based on the potential mechanism. The concept of ESUS deserves further refinement, because the results of the two studies on non-vitamin K antagonist oral anticoagulants are negative.[352,353]

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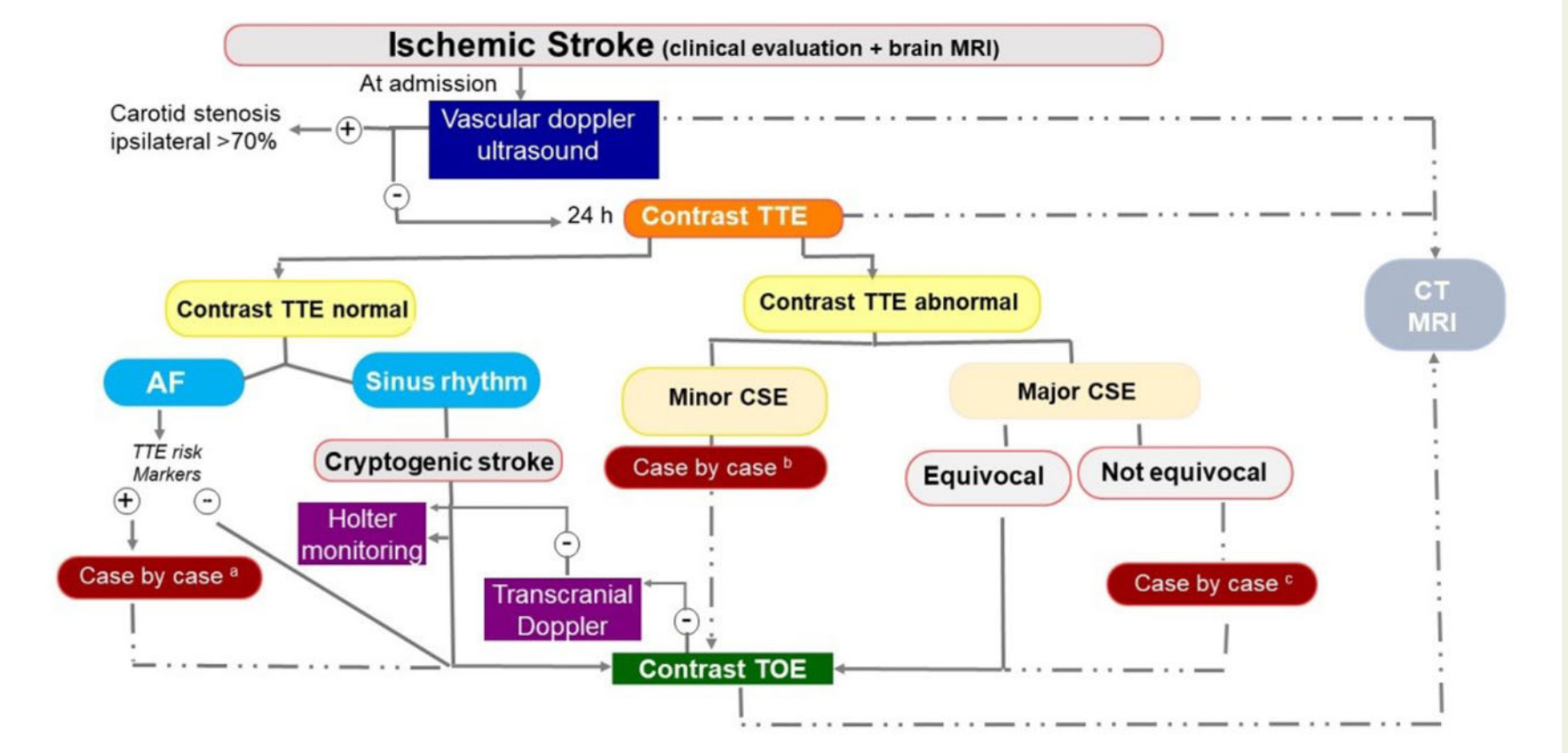


**Figure 13** Diagnostic algorithm: proposal for a diagnostic approach based on the current evidence. [a]Contrast TOE could be useful to identify the presence of a LA/LAA thrombogenic status (LA/LAA thrombus, dense LA/LAA SEC or dysfunction). Biomarkers could be useful (e.g. D-dimers, B-type natriuretic peptide, troponin, von Willebrand factor, C-reactive protein, interleukin 6) to identify a subgroup of patients at higher thromboembolic risk. [b]Contrast TOE is mandatory in the search of other cardiac source of embolism, before percutaneous closure and in case of questionable contrast TOE. [c]Contrast TOE could be useful to identify small size or questionable abnormalities beyond the resolution of TTE, such as LA/LV thrombus, LA/LV tumours, left-sided vegetations. AF, atrial fibrillation (paroxysmal, persistent, permanent); CSE, cardiac source of embolism; CT, computed tomography; LA, left atrial; LAA, left atrial appendage; LV, left ventricular; MRI, magnetic resonance imaging; SEC, spontaneous echocardiographic contrast; TOE, transoesophageal echocardiography; TTE, transthoracic echocardiography.



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# Supplementary data

Supplementary data are available at *European Heart Journal - Cardiovascular Imaging* online.

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