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P79
Left sided phrenic nerve injury during cryoballoon ablation of atrial fibrillation
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Introduction: Phrenic nerve injury (PNI) during cryoballoon ablation (CBA) of the right pulmonary veins is a known complication; however, left PNI during CBA of the left pulmonary veins is rare and reported only in sporadic cases. We report here a case of left phrenic nerve palsy during CBA of atrial fibrillation (AF) without full recovery after 6 months.

Case presentation and Intervention: A 57-year-old male patient with paroxysmal AF was referred for interventional pulmonary vein isolation by CBA. On admission, the patient was asymptomatic with unremarkable physical examination. Preprocedural cardiac computed tomography demonstrated normal atrial anatomy with 2 left and 2 right pulmonary veins and absence of a clot in the left atrium (LA). The left atrium was accessed as usual with a single, successful transseptal puncture and the transseptal sheath was exchanged for the steerable FlexCath sheath (Medtronic, Minneapolis, MN, USA). A 20-mm diameter circular electrode catheter (Achieve, Medtronic) was sequentially positioned in each PV ostium to guide the 28-mm CB (Arctic Front Advance, Medtronic) into each PV. An optimal PV occlusion was confirmed with selective contrast dye injection with a total contrast retention and no backflow to the LA. As usual, only right pulmonary veins isolation was performed under diaphragmatic stimulation. Nonetheless, the second week after discharge, he started to complain about progressively increasing exertional dyspnea. He presented to his general practitioner, who performed a chest X-ray which demonstrated left sided pulmonary veins pathology. The patient was regularly followed-up in our clinic 3 and 6 months after the procedure. Clinically, his symptoms declined over time while phrenic nerve palsy was not completely recovered after 6 months of follow-up.

Discussion: With the widespread use of CBA of AF, phrenic nerve injury (PNI) has emerged as a clinical problem. PNI is more common during CBA of the right pulmonary veins, preferentially the right upper PV, while PNI has been only reported sporadically. Various factors might predispose to left PNI including the anatomic course of the left phrenic nerve, the temperature drop during freezing as well as the depth of cryoballon placement within the PV ostia for the ablation procedure. Even though this is only a single experience of left sided PNI, the question arises, whether stimulating the left PN during ablation of the left-sided PVs is necessary as well.

P80
How to get more time: eosinophilic myocarditis complicated by cardiogenic shock
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Introduction. Eosinophilic myocarditis is a life-threatening condition which often requires endomyocardial biopsy to achieve the diagnosis. Its treatment varies widely depending on the underlying cause.

Case report. An 83-years-old man presented to the emergency department with chest pain and dyspnoea. He had been suffering exertional chest pain and dyspnoea, weight loss and diarrhoea for six months. His medical history was significant for allergic rhinitis, asthma and a newly diagnosed eosinophilic esophagitis. His blood pressure, heart rate and cardiac examination were normal, whereas his lungs revealed decreased breath sound and rales on auscultation, consistent with the pulmonary congestion and pleural effusions shown on chest X-ray. Due to ECG, echocardiogram and blood test, which showed anterior ST-segment elevation and biphasic/negative T-waves in V3-V6, left ventricular systolic impairment (LVEF 25%), elevated high-sensitive troponin-T (267 ng/l, URL < 14 ng/l) and NT-proBNP (3641 ng/l) levels, we initially suspected a subacute myocardial infarction and, therefore, we performed a coronary angiography, which revealed no significant stenosis. Subsequent analysis showed an elevated eosinophil count of 6.74x10^9 cells/l (URL 0,7x10^9 cells/l) and increased C-reactive protein level (18 mg/l). Suspecting an acute myocarditis, the patient underwent to a cardiac MRI which showed oedema and patchy subepicardial/midwall fibrosis in the apical segments and confirmed the diagnosis. 3 days after his admission, mechanical circulatory support (MCS) with a percutaneous axial flow pump
(Impella) and endomyocardial biopsy were necessary due to hemodynamic instability refractory to inotrope and vasopressors administration. Because of the patient's history and the histological results showing extensive eosinophilic infiltrate involving the myocardium, high dosage corticosteroids were initiated. Haemodynamic parameters rapidly improved and the MCS weaning was completed 3 days after, allowing corticosteroids gradual reduction and heart failure treatments up-titration. LVEF slightly recovered (LVEF 32%) whereas eosinophil count normalized. After further investigations, an idiopathic eosinophilic syndrome was diagnosed.

Conclusions. In conclusion, we report a rare disease that led to rapidly worsening heart failure requiring MCS with Impella, and that was successfully treated with high dosage corticosteroids, which allowed a slight recovery of left ventricular function.

P81

Bilateral single pulmonary vein slings: first-ever case description

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Introduction: In the absence of shunting in case of abnormal pulmonary venous connection, most congenital anomalies in pulmonary vein (PV) number, size and/or course are coincidental findings. Embryologic PV development is still debated on.

Method: first-ever description of bilateral single pulmonary veins with a meandering course (“PV sling”) around the pulmonary arteries.

Results: Our patient was born in 1974 with multiple congenital heart defects: a bicuspid aortic valve, a hypoplastic left aortic arch with an arteria lusoria dextra that arised directly after a significant coarctation. The latter required resection and end-to-end anastomosis 15 days after birth and a reoperation with end-to-side anastomosis 2 years later because of re-coarctation. For many years he enjoyed a good physical condition with normal biventricular and aortic valve function at echocardiography and without suspicion of significant re-coarctation. At the age of 43y, he consulted a private cardiologist because of mild exercise intolerance with early leg fatigue. Physical examination (a.o. differential blood pressures) did not suggest a relevant re-coarctation but because of incomplete visualisation of the aortic arch and mild flow acceleration at echocardiography, a cardiovascular MRI (CMR) was ordered.

CMR revealed a mildly hypoplastic aortic arch with 3 microaneurysmata at the site of previous repair but neither relevant recoarctation nor arteria lusoria stenosis. The function of the aortic valve and both ventricles was normal. As an incidental finding, a single left and a single right pulmonary vein were visualized, each with a pronounced meandering course wrapping around the pulmonary arteries.
(PA). Whereas the left PV initially ran inferiorly before rotating posteriorly over ±180° and crossing to right superior side of the left atrium, the right PV initially ran superiorly before encircling the right PA rightwards and anteriorly over ±180° (figures P81-1 and P81-2).

Very few cases have been described of unilateral single meandering PV, none however of bilateral single PV configured as directionally opposite slings. Awaiting more knowledge on PV development to elucidate the exact cause, the aortic arch and PV anomalies in this case hint towards disturbances in mechanisms regulating vessel involution and/or rotation.

**Conclusion:** A case of bilateral single PV slings with opposing rotational direction is presented. Cases like this may shed new light in the debate on embryologic PV development.

**Figure:** P81-1. Focus on LPV sling.

**Figure:** P81-2. Focus on RPV sling.

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**P82**

**Carcinoid heart disease: unusual cause of right-sided valvular heart disease**

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**Introduction:** Carcinoid syndrome is a rare entity characteristic of neuroendocrine tumours secreting different vasoactive peptides. Most common symptoms include flushing and diarrhea. The syndrome is commonly complicated by right-sided valve involvement displaying pathognomonic pathologic and echocardiographic features. The findings are characterized by plaque-like endocardial deposits of fibrous tissue with thickening, fusion and shortening of the valvular apparatus. The fixed cusps and retracted leaflets cause coaptation defects with often severe regurgitation and occasional stenosis. Left-sided valve disease is uncommon in the absence of right-to-left shunt or pulmonic metastases due to inactivation of most vasoactive peptides in the lung. Therapeutic approaches aim at reducing circulating mediator levels (somatostatin analogues, surgical or interventional cytoreductive therapy) for symptom control although not reversing valvular disease. Diuretics are the primary treatment option for carcinoid heart disease while valve surgery is an option in controlled metastatic disease.

**Case presentation:** A 55-year-old male presented with mild shortness of breath, pitting oedema and an elevated NT-proBNP of 800pg/ml. Echocardiography showed dilated right-sided chambers with mildly reduced right ventricular function. Further examination demonstrated thickened, retracted tricuspid leaflets and immobile pulmonary cusps each with severe regurgitation. No left-sided valvular lesions were noted. Detailed history was significant for facial flushing and mild diarrhea. Further oncologic evaluation showed markedly elevated 24h urinary excretion of 5-HIAA. CT revealed a calcified 4cm mesenterial mass and bilateral hepatic metastases, 68-Ga DOTATATE PET-CT proved high levels of somatostatin receptors in these lesions. Liver biopsy confirmed the presence of a neuroendocrine tumour. Intramuscular depot octreotide besides diuretics was started with only mild control of symptoms and oncologic biomarkers. Surgical debulking with hemihepatectomy and resection of the mesenteric mass was discussed. The patient ultimately declined surgery as well as peptide receptor radionuclide therapy.

**Conclusion:** Carcinoid syndrome and is a rare cause of acquired right-sided valvular heart disease with distinct echocardiographic features. Valve surgery is an option only in controlled carcinoid disease and can be discussed within the heart team if medical therapy fails.

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**P83**

**Dysfunctional Björk-Shiley single tilting disc mitral valve prosthesis: cinefluoroscopy - simple and helpful**

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Abstracts

Background: Echocardiography plays a key role in evaluating dysfunctional prosthetic valves. However cinefluoroscopy remains a simple and feasible modality to assess mechanical prostheses and remains the gold standard to visualize mechanical disc motion.

Case report: We report the case of a 45-year old female patient with prior mechanical mitral valve replacement (MVR) with a 29mm Björk-Shiley single tilting disc (Figure P83-1A) for rheumatic mitral valve disease at the age of 16 years in 1988.

In 2018 the patient presented with heart failure. Echocardiography data revealed a significant increase in transvalvular mean diastolic mitral valve gradient of 11mmHg (heart rate of 80/min) despite therapeutic anticoagulation with Marcoumar (INR 3-3.5). According to the literature (Rosenhek et al, J Am Soc Echocardiogr 2003;16: 1116-27) the reference mean gradient for this valve model is 4.26 ±1.26 mmHg. Neither transhoracic (TTE) nor transesophageal echocardiography (TEE) could identify a clear cause of the increased gradient. There was no obvious evidence of thrombus or pannus formation (Figure P83-2A).

We performed cinefluoroscopy and identified an abnormal single dis P83-c opening angle of only 32 degrees (refer-ence opening angle 70 degrees; (Figure P83-1B and 1C). There was high suspicion of valve dysfunction by pannus.

The patient underwent repeat MVR with a bileaflet mechanical prosthesis (SJM Masters 29mm).

Intraoperative findings confirmed large subannular pannus formation with subsequent impairment of disc motion/opening. (Figure P83-2B)

Further postoperative course was complicated due to spontaneous subarachnoidal bleeding requiring surgical evacuation. Fortunately, the patient recovered well without residual signs of heart failure and was discharged after a prolonged hospital stay.

Conclusion: This case highlights the value and feasibility of cinefluoroscopy in evaluating dysfunctional mechanical valve prostheses by providing the most reliable assessment of mechanical disc motion. In older e.g. single tilting disc mechanical valves it is crucial to have information on de-tailed model type and reference values for disc opening an-gles. Furthermore strict orthogonal projection planes are required for correct assessment of disc motion. Pannus and thrombus formation can be missed in the echocardiographic examination especially in mechanical valves due to acoustic shadowing of the mechanical leaflets.

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Case presentation: A 46 years old man with end-stage hypertrophic cardiomyopathy and electrical storm underwent urgent orthotopic heart transplantation. The donor was a 54 years old woman in cerebral death due to brain hemorrhage. Pre-transplant workup showed an angiographically significant stenosis in the middle right coronary artery (RCA) (Fig. P84-1) with normal LVEF and no wall-motion abnormalities or valvopathy, which necessitated an additional venous CABG.

Immediate postoperative course was complicated with severe primary graft failure requiring mechanical support with ECMO and IABP. Cardiac tamponade on post-op erative day 1 led to surgical revision, where an occlusion of the venous CABG on the RCA was noticed. An urgent coronary angiogram with OCT showed a non-significant plaque at the same location in the mid RCA (Fig. P84-1), which led to conclude that the previously diagnosed high-grade stenosis was in fact related to a superimposed vasospasm. No further intervention was performed and the ECMO could later be weaned on day 9 after full recovery of the LV function.

At postoperative week 4, the patient developed asymptomatic and stable sustained ventricular tachycardia at rest. Cardioversion was achieved with 2 mg magnesium sulfate IV but followed by ST-segment elevation in the inferior leads (Fig. P84-2), with inferior and inferolateral hypokinesia. An urgent coronaryography confirmed a severe localized vasospasm in the proximal RCA (Fig. P84-1), rapidly reversed after intracoronary injection of 1 mg isosorbide dinitrate. Endomyocardial biopsy excluded an acute cellular or humoral rejection. The patient was then treated with calcium channel blockers without relapse until his discharge home.

Conclusion: Our case illustrates that a transplanted heart predisposed with coronary spasm may suffer from early relapse in the recipient despite of complete post-surgical autonomic denervation. Endothelial dysfunction, possibly induced by immunological, neurohormonal and metabolic...
factors, is now seen as the main trigger, and may be exacerbated by ischemia-reperfusion injury in the near post-operative course.

Our case identifies pre-existent atherosclerosis and vasospasm in the donor heart as a clear risk factor for early post-transplant vasospasm.

**P85**

**Isolated endomyocardial fibrosis of the right ventricle**

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**Case:** In a 38-year-old African woman who lived in Cameroon until age 32, cardiomegaly was incidentally diagnosed on an abdominal CT-scan. On echocardiography (TTE), the left ventricle (LV) was normal but the right cardiac chambers were dilated with obliteration of the RV cavity. After exclusion of carcinoid and hypereosinophilic syndrome, and after an endomyocardial biopsy only revealing fibrotic tissue, a tropical form of endomyocardial fibrosis (EMF) was diagnosed.

Evolution over 10 years was characterized by slowly progressing exertional dyspnea and fatigue despite remarkably little peripheral oedema, moderate hepatomegaly and no signs of left heart failure. Progressive transition from sinus rhythm to permanent atrial fibrillation further increased exercise limitation. At the last visit, NT-proBNP was only moderately increased (1322 ng/l), but a maximal cardiopulmonary exercise test confirmed a severely reduced aerobic capacity (peak VO₂ of 10.3 ml/kg/min). Liver function tests were almost normal, and liver ultrasound showed congestive hepatomegaly but no image of cirrhosis.

Repeat cardiac imaging with TTE and CMR (Figure P85-1) showed a non-dilated LV with an EF of 70%. Inflow part of the RV was dilated but its muscular part was almost completely obliterated. Restrictive RV physiology was illustrated by a restrictive RV inflow pattern (E-wave velocity 1.7 m/s DT 70 ms), a triangular shape of the tricuspid regurgitation profile and severe right atrium dilatation complicated by a 3cm-large thrombus. Tissue characterization by CMR revealed diffuse sub-endocardial late gadolinium enhancement and by T1-mapping, myocardial extracellular volume was 51% in the RV free wall, 36% in the septum and 31% in the LV free wall (N< 28%) indicating bi-ventricular myocardial fibrosis with clear RV predominance.

**Discussion:** EMF represents the chronic stage of an active endocardial inflammation leading to progressive fibrosis of the apical endocardium and restrictive cardiomyopathy. While it classically involves both ventricles, isolated RV involvement may occur. EMF is one of the most frequent cause of heart failure in equatorial Africa, which may be related to chronic infection, environmental and dietary factors. Supportive treatment with diuretics and anticoagulation is associated with a poor long-term outcome. Surgical endomyocardial resection is reported to have a high immediate post-operative mortality (15-30%), which led us to discuss cardiac transplantation.

**Figure:** P85-1. Localized obliteration of the RV apex (red arrows) with associated fibrosis of the subendocardium (yellow arrows). Thrombus in the right atrium (*).
second son was diagnosed of an aortic root dilation of 39 mm.

Conclusions: We identified a very rare, missense variant in the MYH11 gene predicted to be damaging and affecting a conserved amino-acid in the myosin tail of the protein. This variant appears to be responsible for our familial case of TAA, as the clinical expression reunited all features of genetic aneurysms. Of note, the presence of a giant coronary artery aneurysm (CAA) suggests that alteration of the contractile function of coronary smooth muscle cells might at least contribute to the development of CAA.

P87
Impella CP as a bridge-to-surgery for anterior post-ischemic septal rupture
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A 76-year-old female was evaluated for worsening dyspnea and a previously absent oslosystolic murmur. ECG and laboratory markers were consistent with a subacute anterior MI and echocardiography confirmed an anteroseptal akinesia with a mid-anterior 15 mm VSD, a systolic pulmonary pressure of 45 mmHg, a significant left-to-right shunt and right ventricular overload, with a TAPSE of 8 mm. Coronary angiography showed an occlusion of the mid-LAD. The patient was addressed for surgical correction of the VSD, requiring further deferral for scar stabilization. According to the width of the defect and RV overload we implanted an Impella CP to warrant a safer bridge to surgery. Positioning was guided by TTE in order to prevent scar tissue damage and embolization. Serial TTE controls showed a reduced shunt and improved parameters of right ventricular function. After 7 days the patient underwent surgical closure of the VSD and left ventriculoplasty, and is now following a rehab program in good clinical conditions.

Post-AMI ventricular septal defects (VSD) still hit 1-2% of all AMI patients and are related to a bad prognosis. Despite surgical repair, peri-operative mortality is still no lower than 60%. An early intervention seems to be related to a worse post-procedural outcome, due to unstable sutures on a soft tissue scar. Bridge therapies are thus pivotal to stabilize patients’ hemodynamics and defer surgical correction to semi-elective conditions. Several cases of bridge therapy using IMPELLA have been reported. Some concerns have been aroused by the possibility of blood aspiration in proximity of the septal defect, able to provoke shunt inversion, systemic hypoxia and paradoxical embolisms of tissue debris, which is more likely in case of anterior VSD. Impella has accordingly been reserved to posterior defects, usually related to a worse prognosis due to a remarkable impairment of right ventricular performances. Case series have shown its benefits in terms of organ perfusion and pulmonary and wedge pressures lower-
ing, thanks to a left-to-right shunt reduction. Our choice to implant an Impella in an anterior VSD was supported by its width and pathophysiological impact, though, preluding to a likely hemodynamic deterioration. Impella technology warranted a safe bridge-to-surgery without complications, and should probably be considered as a support possibility even for anterior shunts, although some further positioning and monitoring cautions are required.

**P88**

How to deal with pericardial effusion after combined procedure of Mitraclip and left atrial appendage closure

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We present the case of 76 years old male who was referred for combined severe degenerative mitral regurgitation causing effort-limiting dyspnoea (panel A). Coronary angiography showed mid left anterior descending significant stenosis. Due to comorbidities the patient was judged to be high risk for surgery by local Heart Team and a staged approach with percutaneous coronary intervention (PCI) followed by percutaneous mitral valve repair with Mitra-clip system was decided. First, patient underwent PCI with drug-eluting stent implantation and after three days, Mitraclip procedure with two clips deploying was successfully performed (panel B-D). After last clip positioning, some left atrial (LA) sludge was observed. Considering the need for triple therapy (permanent atrial fibrillation with CHADS2-VASc= 4), it was decided to proceed with left atrial appendage closure (LAA) with Amplatzer device. The procedure was successful without any acute complica-

tion (panel E). Two hours later, significant pericardial effusion causing initial hemodynamic compromise occurred so patient underwent urgent pericardiocentesis. Intrapro-
cedural transoesophageal echocardiogram showed interesting and specific findings (panel F and G): i) posterior interatrial septum (IAS) haematoma; ii) right atrial (RA) posterior wall damage (panel G); iii) IAS defect draining blood flow directly from left to right side, increasing shunt after pericardiocentesis. This was attributed to posterior trans-septal puncture (panel H). IAS defect was immediately closed with Amplatzer device, so closing “the breach” that had caused septal hematoma and initial rupture of RA wall (panel I-L). Hemodynamic recovery soon occurred and any further complications occurred during the stay in the intensive care unit.

**P89**

A mouth-watering case of mycoplasma salivarium endocarditis

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**Introduction:** Mycoplasma endocarditis is rare. Not even a single case of mycoplasma salivarium endocarditis has been reported in the scientific literature.

**Case presentation:** We report the case of a 69-year-old Caucasian male who presented to our emergency department with a history of 2 weeks of painful oligoarthritis involving knees and 1st metatarsophalangeal joints bilaterally.
Past medical history was significant for psoriasis and lymphoma, both cured after autologous peripheral blood cell transplantation performed several years ago.

On admission, physical examination was relevant for an oligoarthritis with a large intraarticular effusion of the right knee, which prompted an arthroscopic paracentesis and initiation of empirical antibiotic therapy with amoxicillin and clavulanic acid. Articular fluid revealed a neutrophilic effusion (53’000 leukocytes of which 64% were neutrophils), with no crystals or germs on direct examination, while culture did not grow bacteria.

Over the next week the patient developed high grade fever and a new 3/6 ejection murmur on cardiac auscultation. Transoesophageal echocardiography showed a large tear-shaped mobile and echodense mass (16x9mm) located in the posterior mitral valve annulus with no impact on valvular function. At that time, the molecular biology in the articular effusion was positive for M. salivarium (ebacterial PCR).

Fundoscopy, cerebral MRI, and a thoraco-abdominopelvic CT did not show evidence in favour of arterial embolism. A presumptive diagnosis of M. salivarium endocarditis with intraarticular embolization was made.

The antibiotic regimen was changed for moxifloxacin 400 mg o.d. with rapid resolution of fever and progressive clinical improvement. The TEE performed 2 weeks later showed partial regression of the mobile mass on the mitral annulus.

A (18)F-FDG PET/CT performed 3 weeks after the change in antibiotic regimen showed an abnormal uptake restricted to the mitral valve. A glucocorticoid therapy was added for persistent inflammatory rheumatic complaints and was tapered over the course of 4 months without relapse of symptoms.

Conclusion: To our knowledge, this is the first probable case of mycoplasma salivarium infectious endocarditis. The microbiological culprit was identified by performing ebacterial PCR on the intraarticular effusion. Conservative treatment with quinolone monotherapy was successful in treating both the endocarditis and the rheumatic condition in this patient.

P90

Congenital atresia of the left main coronary artery: a rare cause of severe heart failure in a 5 year old child

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Introduction: Coronary artery anomalies (CAAs) are a diverse group of congenital cardiac malformations with varying clinical significance. Atresia of the left main coronary artery is one of its least frequently observed variations. We present the case of a 5 year old infant presenting with severe acute heart failure and mitral regurgitation.

Method and Results: A 5-year-old male infant was admitted to our emergency department because of cardiac murmur, recurrent ventricular tachycardia and heart failure symptoms. Transthoracic echocardiographic examination showed a dilated left atrium and a severe mitral regurgitation. The left ventricular ejection fraction was preserved. Due to refractory cardiac arrhythmias causing low cardiac output, the child was put on veno-arterial extracorporeal membrane oxygenation. Under extracorporeal membrane oxygenation support a heart catheter examination was performed, revealing atresia of the left main coronary artery. The main stem of the left coronary artery was 1.4mm and the right coronary artery 2.8mm. There were multiple collateral branches from the right coronary artery supporting the territory of the left ventricle. Surgical reconstruction was performed on cardiopulmonary bypass (CPB), using a patch plastic of the aortic part with reinsertion into the left sinus of Valsalva. As patch material served a small part of the right saphenous vein which was harvested from the upper leg. Postoperative course was uneventful. The patient could be weaned from extracorporeal mechanical support five days after the operation. He was discharged home 3 weeks later.

Conclusion: Congenital atresia of the left main coronary artery is an extremely rare variant in which the left coronary ostium is absent or has a blind end. Treating physicians should be aware of this malformation and it should be considered as differential diagnosis in unexplained mitral regurgitation and heart failure. Due to the unfavorable prognosis, surgical revascularization is the therapy of choice, as the anomaly is inaccessible to catheter wires.

P91

Impressive left atrial masses with lobulated morphologies: differential diagnosis from frequent to very rare

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Background: Primary cardiac tumors (CT) are a very rare finding (incidence after autopsies 0.3-0.7%) and mainly of benign character. Atrial myxomas are the most frequent CT. However, 25% are malignant and present predominantly in the form of sarcomas. We present two cases of patients with left atrial (LA) masses with similar appearance but completely different dignity.

Case 1: A 81 year old woman was referred because of dizziness, nausea and unsteady gait. Cerebral magnetic resonance imaging (MRI) showed subacute ischemic lesions in different cerebral territories. During the diagnostic workup a huge LA mass prolapsing into the left ventricle (LV) was detected by transthoracic echocardiography (TTE). Transeosophageal echocardiography (TOE) (Fig. P91-1) confirmed a 6x3cm lobulated LA mass with diastolic prolaps into the LV. We suspected a left atrial myxoma which could be confirmed by postoperative histological findings. The postoperative course was uneventful.

Case 2: A 52 year old man with sudden onset of pain in both legs was diagnosed with embolization of multiple arteries in the lower extremity on both sides. During the workup of a suspected cardiac source of embolization on TTE a mass in the LA was detected. TOE showed a mostly hypoechogenic and rather heterogeneous lobulated mass
with a diameter of 3.9 cm attached to the atrial septum (Fig. P91-2). Positron Emission- (PET), computed tomography and cerebral MRI ruled out additional emboli and showed an isolated manifestation of the LA. The LA mass was surgically removed. Histopathology showed a fibrin-associated Ebstein Barr virus (EBV)-positive large B-cell lymphoma, a very rare form of an already rare primary CT. The postoperative course was uneventful, and actually chemotherapy is not considered to be necessary.

**Conclusion:** Despite an initial very similar morphological presentation, the underlying disease, of the LA tumors of these two case reports, is of clearly varying dignity. Fibrin-associated EBV positive large B-cell lymphoma is a very rare entity and manifest at unusual anatomic sites. Thus, there are only few published case reports involving only the heart. Due to the rarity of this type of lymphoma, no defined subsequent treatment concept after surgical intervention is available. Due to absence of emboli and inconspicuous PET scan, a watch and wait concept has been chosen for our patient. However, myxomas on the other hand are the most common primary CT and surgical resection is generally curative.