- 28 **Schwartz GG**, Oliver MF, Ezekowitz MD, et al. Rationale and design of the Myocardial Ischemia Reduction with Aggressive Cholesterol Lowering (MIRACL) study that evaluates atorvastatin in unstable angina pectoris and in non-Q-wave acute myocardial infarction. *Am J Cardiol* 1998;**81**:578–81.
- 29 **Qanadli SD**, Mesurole B, Aegerter P, et al. Volumetric quantification of coronary artery calcifications using dual-slice spiral CT scanner: improved reproducibility of measurements with 180 degrees linear interpolation algorithm. *J Comput Assist Tomogr* 2001;**25**:278–86.
- 30 **Callister TQ**, Coöl B, Raya SP, et al. Coronary artery disease: improved reproducibility of calcium scoring with an electron-beam CT volumetric method. *Radiology* 1998;**208**:807–14.
- 31 **Hong C**, Becker CR, Schoepf UJ, et al. Coronary artery calcium: absolute quantification in nonenhanced and contrast-enhanced multi-detector row CT studies. *Radiology* 2002;**223**:474–80.
- 32 **Rumberger JA**, Kaufman L. A Rosetta stone for coronary calcium risk stratification: Agatston, volume, and mass scores in 11,490 individuals. *AJR Am J Roentgenol* 2003;**181**:743–8.

IMAGES IN CARDIOLOGY

doi: 10.1136/hrt.2005.078733

Anomalous origin of right coronary artery from the mid left anterior descending coronary artery

A 59-year-old woman underwent diagnostic coronary angiography with a history of atypical chest pain and an inconclusive treadmill exercise tolerance test. Cine-angiogram revealed an unusual origin of the right coronary artery (RCA) arising from the mid left anterior descending coronary (LAD) artery and coursing to the right, anterior to the right ventricular outflow tract. Such an anomaly is unusual and has not been listed in the classification of such anomalies.

Coronary anomalies are seen in about 1% of cineangiograms. While some anomalies have been associated with adverse clinical outcomes, most are benign. The RCA has been documented to have an anomalous origin from the left anterior coronary sinus and

pulmonary trunk, but the origin of the RCA from the LAD has not been reported before.

P Saravanan, P Mennim, J E Hancock
saravananpl@aol.com

doi: 10.1136/hrt.2005.078394

Huge left atrial thrombus in a patient with mitral bioprosthesis

A 77-year-old woman had suffered from atrial fibrillation and rheumatic mitral stenosis for more than 20 years. She underwent mitral valve replacement with bioprosthesis six months before her admission. Inadequate anticoagulation treatment was noted during the follow-up period. She presented with unsteady gait and dizziness to our emergency room. Brain magnetic resonance images confirmed cerebellar infarction. Echocardiography was arranged to search for the possible embolus source, and revealed a huge left atrial thrombus. Because of the thrombus burden and recent stroke, redo cardiac surgery was proposed three weeks after the cerebrovascular event. The preoperative computed tomography (CT) for redo surgery found a large left atrial mass (left panel). During the less invasive cardiac surgery via right small thoracotomy, transoesophageal echocardiography

Computed tomography demonstrating a huge mass in an enlarged left atrium. LA, left atrium; LV, left ventricle; T, thrombus.

revealed the significant thrombus burden again (right panel). The bioprosthesis was found to be functioning well and thrombus-free. Additional left atrial appendage closure and endocardial

Transoesophageal echocardiography revealing a heavy thrombus burden in the posterior wall of left atrium with the bioprosthesis in the mitral position (M).

ablation were performed to reduce the risk of future thromboembolism.

K-M Chiu, T-Y Lin, S-H Chu
kmchiu@yahoo.com.tw