Ventricular thrombi with pulmonary and systemic embolization

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Figure 1) Transesophageal echocardiography revealing a dilated cardiomyopathy with poor biventricular function and multiple large apical thrombi (arrows)

Figure 2) Infarction of the lower lobe of the right lung (arrow)

A 43-year-old woman presented with dyspnea, shock and abdominal pain. Hemorrhagic bulbitis had been diagnosed one week earlier in another hospital, for which proton pump inhibitors were prescribed. She had no other medical history. Urgent transesophageal echocardiography revealed a dilated cardiomyopathy with poor biventricular function, pulmonary hypertension and multiple, large apical thrombi (Figure 1 and [video](#)). The patient went into cardiac arrest and died despite extensive resuscitation efforts. At autopsy, infarction of the lower lobe of the right lung (Figure 2) as well as multiple bilateral segmental pulmonary emboli were identified. Duodenal infarction and multiple smaller jejunal infarctions were also seen (not shown). The left ventricular apex was filled with several large and small thrombi (Figure 3), whereas the right ventricular apex contained only a small thrombus. The origin of the cardiomyopathy could not be established.

Left ventricular apical thrombi are not uncommon (1,2). Biventricular thrombus formation with both pulmonary and systemic embolization is exceptional. To the best of our knowledge, only two cases of documented embolization into the pulmonary and systemic circulation have been reported in patients with dilated cardiomyopathy (3,4).

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Figure 3) Longitudinal section of the left ventricle revealing several large and small thrombi (arrows)

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Received for publication February 20, 2008. Accepted March 21, 2008