enoxaparin, 2.4% for UFH, $p = 0.106$). Transfusions were similar (17.0 vs. 16.0%, $p = 0.155$), and intracranial hemorrhage was very low and similar. There were no differences in rates of unsuccessful PCI, threatened or actual abrupt closure, or emergency CABG.

Among patients randomized without prior antithrombin treatment, death/MI was significantly lower for enoxaparin (12.6 vs. 14.8%) with increased bleeding (significant for GUSTO severe, nonsignificant for TIMI major).

Conclusions: In a high-risk population treated with an early invasive management strategy, enoxaparin was not superior but was at least as effective as UFH. Bleeding was more frequent with enoxaparin. Enoxaparin is an effective and safe alternative to UFH for the early invasive management of high-risk patients with ACS.

Comment (James Ferguson, M.D.): Among the 50% of patients receiving GP IIb/IIIa inhibitors, outcomes and safety were similar.

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Images in Cardiology: Primary Extramedullary Plasmacytoma of the Heart

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FIG. 1 Intracardiac mass (arrowheads) in both atria through patent foramen ovale (arrow), with extension to the superior vena cava.

A 74-year-old man presented with a one-week history of orthopnea and dyspnea on exertion. Initial evaluation revealed cardiac tamponade requiring pericardiocentesis. Transesophageal echocardiography demonstrated a 7.0×4.0 cm cauliflower mass in the right atrium crossing the patent foramen ovale to the left atrium with partial obstruction of the distal superior vena cava (Fig. 1). A biopsy of the mass was consistent with plasmacytoma (Fig. 2). Computed tomography scan showed metastasis to the anterior mediastinum, diaphragm, peritoneum, and right kidney.

This is a rare case of extramedullary plasmacytoma originating in the right atrium.¹

FIG. 2 Biopsy of intracardiac mass showing plasma cells (H & E, $\times 500$ oil).

Reference

1. Wan X, Tarantolo S, Orton DF, Greiner TC: Primary extramedullary plasmacytoma in the atria of the heart. *Cardiovasc Pathol* 2001;10:137–139