The pill does increase MI risk The pill does increase MI risk


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Heart failure

Valsartan: not an agent for universal use Valsartan: not an agent for universal use


Heart failure

Valsartan: not an agent for universal use


Male cells in a female heart Male cells in a female heart


Male cells in a female heart


In vivo detection of apoptosis In vivo detection of apoptosis


General cardiology

PFO and the risk of stroke

A patent foramen ovale (PFO) on its own may have a risk of stroke, but how large is the risk? Of 581 patients (aged 18–55 years) who had had an ischaemic stroke of unknown origin within the preceding three months, after four years the risk of recurrent stroke was 2.3% (95% CI 0.3% to 4.3%) among the patients with PFO alone, 15.2% (95% CI 1.8% to 28.6%) among the patients with both PFO and atrial septal aneurysm, and 4.2% (95% CI 1.8% to 6.6%) among the patients with neither of these cardiac abnormalities. There were no recurrences among the patients with an atrial septal aneurysm alone. All were on aspirin 300 mg/day. The presence of both cardiac abnormalities was a significant predictor of an increased risk of recurrent stroke (hazard ratio for the comparison with the absence of these abnormalities 4.17, 95% CI 1.47 to 11.84), whereas isolated PFO, whether small or large, was not.


Journals scanned


IMAGES IN CARDIOLOGY

Myocardial viability by contrast enhanced MRI in a patient with left bundle branch block showing a severe defect on FDG-PET

A 53 year old male hypertensive patient with no history of previous myocardial infarction presented with exertional dyspnoea and fatigue. The ECG revealed complete left bundle branch block (LBBB), and echocardiography demonstrated moderately reduced left ventricular function (ejection fraction 36%) with anteroseptal and anteroapical located severe hypokinesia and akinesia. Assessment of myocardial viability using 18F-fluoro-deoxyglucose (FDG) positron emission tomography (PET) (left panels showing a midventricular short axis view (top) as well as a horizontal (middle) and a vertical (bottom) long axis view) revealed a severe defect of the septum from base to apex extending to the anterior and inferior wall (white arrowheads) suggesting scar tissue. Contrast enhanced cardiac magnetic resonance imaging (MRI) 15 minutes after gadolinium–DTPA administration using a T1 weighted gradient echo sequence optimised for the detection of scar tissue (which presents as bright myocardial enhancement as opposed to normal black myocardium) revealed complete absence of scar (right panels showing corresponding short axis and long axis views). Atherosclerotic coronary artery disease was excluded at coronary angiography.

The finding of a reduced tracer uptake on FDG-PET images in the septal region of patients with LBBB is not uncommon, leaving uncertainty about the viability status. In this patient with LBBB and severely abnormal FDG-PET scan, absence of scar tissue in the septal region and hence myocardial viability could be confirmed using contrast enhanced MRI. Thus, contrast enhanced MRI may be a valuable adjunct for the assessment of myocardial viability in patients with regional severe wall motion abnormalities and LBBB.

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