The Forgotten Blow

Sandip Ghosh¹, Biswajit Majumder², Pranabananda Goswami³, Sougat Chakraborty⁴, Viral Tandel¹, KN Sudeep¹

A sixty-year-old male patient presented to the cardiology department with non-specific pain chest for last four months. His vitals were stable and JVP normal. Cardiovascular system examination revealed double apical impulse with lateral retraction without any murmur. ECG showed non-specific ST-T changes [A]. A large opacity with well-defined outer margins and a broad medial margin silhouetting the left heart border was seen in the chest X-ray [B]. Echocardiographic examination revealed a large pseudoaneurysm arising from lateral wall of left ventricle with a narrow neck with the ratio of orifice to the maximum diameter of the aneurysm to be <0.5 [C]. Color Doppler showed turbulent bidirectional flow across the neck of the aneurysm [D]. Coronary angiography was normal. On further enquiry the patient gave a history of a blunt trauma to chest 30 years back while working in his shop. CT scan of thorax showed a large [67 mm X 102 mm X 70 mm] thin walled well defined lesion with calcified margins seen close to the left lateral wall of left ventricle with vascular type of enhancement [E, F]. Subtracted black blood and white blood axial MRI images of mediastinum showed a pseudoaneurysm with turbulence [G, H]. Left ventricular pseudoaneurysm form subsequent to cardiac rupture and is contained by the overlying pericardium and scar tissue. True aneurysms are dyskinetic areas of thinned full thickness myocardium. The ratio of the maximum internal diameter of the orifice to the maximum internal diameter of the cavity is usually less than 0.5 in the cases of a pseudoaneurysm, and between 0.9 and 1.0 in the cases of a true aneurysm. Most cases are a sequel of myocardial infarction, prior cardiac surgery and bacterial endocarditis but may rarely occur subsequent to trauma. Congestive heart failure, dyspnea and chest pain are the most frequently reported symptoms. Though a few cases of delayed presentation of LV pseudoaneurysm after blunt trauma have been reported, but presentation thirty years after a blunt trauma chest is very rare. Management consists of surgical repair of the pseudoaneurysm with patch as mortality rate is very high in untreated cases. However, our patient refused any surgical intervention.

References

¹Sr. Resident, ²Assoc. Prof., ³RMO cum Clinical Tutor, Dept. of Cardiology, ⁴Sr. Consultant, MRI Centre, RG Kar Medical College, Kolkata, West Bengal
Received: 24.08.2016; Accepted: 02.02.2017