A 60 years female was evaluated for heart failure. She had inferior myocardial infarction six years back. Echocardiography revealed an aneurysm in basal inferior part of left ventricle. Aneurysm clearly extended beyond the border of LV epicardium. Mouth of the aneurysm was smaller than the maximum diameter of the aneurysm with a distinct shelf like opening into the LV. A large thrombus almost filled the cavity of the aneurysm (Figures 1, 2, 3).

An aneurysm is defined as a discrete segment of the left ventricle that protrudes during systole as well as diastole.\(^1\)

True aneurysm results from progressive stretching of the thinned out infarcted myocardium by the systolic intraventricular pressure.\(^2\) Neck of the aneurysm (communication with the left ventricle) is as wide as or wider than the maximal diameter of the aneurysm resulting in gradual opening in LV. True aneurysms are mostly present in the anterolateral segment near the apex. Wall is formed by dense fibrous tissue with excellent tensile strength that prevents rupture. Such aneurysms may or may not contain a thrombus. In contrast, false aneurysm (pseudoaneurysm) occurs due to localized myocardial rupture.\(^3\) Blood escaping into the pericardial cavity remains localized around the site of rupture and is walled by the pericardium that becomes adherent around the rupture site. Neck of the aneurysm is smaller than the maximal diameter of the aneurysm with a distinct shelf like opening into the LV. Such aneurysms mostly follow inferior infarction and are seen in the inferoposterior segment. Pseudoaneurysm at the base of the heart may have a wider mouth. Such aneurysms almost always contain a thrombus and are more likely to rupture due to progressive stretching of pericardium.

**References**