A 78-year-old man was referred to our hospital because of new onset weakness and distended jugular veins; as background, history of valvular rheumatic disease with mitral and tricuspid valve replacement by mechanical prostheses in 2002 (in revisions at outpatient department of cardiology the patient had remained stable and with correct levels of anticoagulation; Figure A). Chest radiography showed mild signs of heart failure and a correct international normalized ratio (INR 3.1). The first suspicion was pulmonary thrombo-embolism. Chest computerized tomography showed a giant heterogeneous mass at the left atrium without signs of pulmonary thrombo-embolism (Figure B, arrow). Transoesophageal echocardiography revealed severe enlargement of the left atrium with a giant mass (Figure C, arrow) attached to the atrial septum, affecting mitral prostheses with reduced mobility anterior disk. Results from a colour-Doppler examination showed peak gradients across mitral prosthesis, assessed by continuous-wave Doppler, and indicated a severe obstruction (transmitral mean pressure gradient of 24 mmHg; Figure D). The patient was submitted to cardiac surgery, it was found a mass of $60 \times 50$ mm (Figure E) with its origin in the atrial septum and roof of the left atrium occluding right lower pulmonary veins and occupied 80% of the atrium, with partial blockage of mitral prosthesis. Tricuspid mechanical prosthesis was not affected. Pathological anatomy showed intra-atrial giant thrombus (Figure F). Thrombophilia screening was negative. We demonstrate such a case of giant thrombus despite a correct INR, without affecting tricuspid mechanical prosthesis (place with low velocity of blood).

LA, left atrium; RA, right atrium; TP, tricuspid prostheses; AV, aortic valve.