reaching the age-dependent work capacity would qualify for a sub-
stantial rebate on their health insurance rates. Exceptions would
have to be made, of course for patients with physical handicaps.
In addition, as recently stated by Joyner in an editorial
comment, deconditioning should become a recognized syndrome
or diagnosis. This would definitively facilitate the education of
the general population as well as the medical community about
the beneficial effects of ET as treatment options for several
diseases.

In conclusion, physical activity is one of the most fundamental
factors necessary for maintaining health and warding-off risk

Conflict of interest: none declared.

References

The list of references is available in the online version of this paper.

CARDIOVASCULAR FLASHLIGHT

doi:10.1093/eurheartj/eht143
Online publish-ahead-of-print 25 April 2013

Unusual complication after infective endocarditis: pseudo-aneurysm
of the left ventricle

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A 37-year-old female, with a history of drug
abuse (including cocaine), was admitted with
fever and malaise. Transoesophageal echocardiog-
raphy demonstrated infective endocarditis of the
native mitral valve, and the patient underwent anti-
biotic treatment for 6 weeks. On 1 year follow-up
trans-thoracic echocardiography, a large cavity
with flow adjacent to the left ventricle was seen
(Panel 1A). Further workup with magnetic reson-
ance imaging confirmed the presence of a
pseudo-aneurysm (83 × 60 × 76 mm, Panel 1B),
with a small neck at the latero-apical aspect of the
left ventricle, with no wall motion abnormalities.
Coronary angiography ruled out any atherosclerot-
ic lesion with normal anatomy (Panel 1C). After this
episode, the patient was temporarily lost to follow-
up due to a relapse into drug abuse, but presented
again two years later with chest pain and dyspnoea.
The patient finally consented to surgery for aneur-
ysm resection. Intra-operatively, the pseudo-aneurysm was opened revealing an oval defect (20 × 40 mm, Panel 2) in scarred myocar-
dium. This defect was closed using a double Dacron patch and prolene sutures. The post-operative echocardiogram demonstrated
good left ventricular dimensions with reasonable function and no signs of local dyskinesia. Diagnosis of a pseudo-aneurysm was confirmed
on pathology. Recovery was uneventful and the patient was discharged on the 10th post-operative day. We suspect that the
pseudo-aneurysm was caused by a local septic embolism or abscess from the infective endocarditis or due to coronary artery spasm oc-
curring with cocaine usage, rather then by ischaemic vessel disease. This case emphasizes the usefulness of echocardiography in the
follow-up after infective endocarditis (Supplementary Material online, Video S1).

Supplementary material is available at European Heart Journal online.