window for protection by PostC is limited and that protective interventions must be applied as soon as possible, in any case before reflow.

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

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**Echinococcosis of the heart**

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A 42-year-old Nepali man with no medical history presented with exertional dyspnoea for 1 week. Cardiac tamponade was diagnosed and emergency pericardiocentesis showed a haemorrhagic pericardial effusion which was negative for microbiology and malignant cells, and symptoms were markedly relieved.

Transthoracic echocardiography (apical four-chamber view) showed the cystic structure with compressing the right cardiac cavities (Panel A). Transoesophageal echocardiography revealed a round, sharply demarcated capsulized cystic mass containing a floating thin curvilinear structure within the right ventricle (RV). (Panel B). Cardiac magnetic resonance imaging (Panel C) showed a complex multi-septated mass. This mass was located between the RV and diaphragm, with infiltration in the pericardium, invading the basal inferolateral segment of the RV wall and it was prolapsed into the RV cavity. Surgery was performed for diagnostic and therapeutic purposes. The cyst was evacuated of the content, followed by cystectomy. The cyst consisted of several minor connective sheaths filled with transparent gelatious contents (Panel D). Histological examination showed classic hooklets of echinococcus with lamellated cyst walls. Genotype analysis identified *Echinococcus ortleppi* (*Echinococcus granulosus* genotype G5) and echinococcosis was definitively diagnosed. Therefore, albendazole therapy was introduced. Five months after surgery, the patient was regularly visiting an outpatient clinic without recurrence or symptoms.

Supplementary material is available at *European Heart Journal* online.