A 25-year-old woman presented with sudden severe left-sided chest pain. Her co-morbidities include systemic lupus erythematous, antiphospholipid antibody syndrome, four prior strokes, patent foramen ovale (closed percutaneously), and an abdominal aortic aneurysm repair. Upon admission, her INR was 3 (on coumadin). A chest CT scan (Panel A) showed a large mediastinal haematoma (asterisk) and active extravasation (arrow) secondary to rupture of left internal mammary artery aneurysm (Panel B, Supplementary material online, Video S2). She underwent coil embolization (Panel C, Supplementary material online, Video S2). Six days later, the patient went into shock preceded by abdominal pain. Abdominal CT (Panel D) revealed intrahepatic hematomas secondary to ruptured aneurysms seen on angiography (Panel E, Supplementary material online, Video S3). This was treated successfully with selective coil embolization of right and left hepatic arteries (Panel F, Supplementary material online, Video S4). A week later, while anticoagulation was being withheld, the patient had vague chest pain. Electrocardiogram and cardiac biomarkers confirmed myocardial infarction. An echocardiogram showed new wall motion abnormalities (Supplementary material online, Video S5) and left main (LM) coronary artery aneurysm (Panel G), also seen on a CT scan (Panel H). Emergent coronary angiography (Supplementary material online, Video S6) confirmed a giant aneurysm involving LM, left anterior descending (LAD) and left circumflex arteries with a large thrombus in the LAD (Panel I). Despite thrombectomy, revascularization was incomplete (Supplementary material online, Video S7). Aneurysms of the coronary, hepatic, and internal mammary arteries with or without thrombotic or bleeding complications are rare in lupus patients. No case has been reported in the literature in which all these findings were seen simultaneously in the same patient.

Supplementary material is available at European Heart Journal online.