A 63-year-old man was hospitalized with 2 days of increasing dyspnoea and presyncope. He had developed confusion, dysarthria, and a left-sided facial droop that morning. Three weeks previously the patient had suffered a urinary tract infection and had taken prolonged bed rest. His only background was hypertension. Clinical assessment revealed tachypnoea, sinus tachycardia, and a mild ground was hypertension. Laboratory testing revealed elevated high-sensitivity troponin (5122 ng/L), led elevated positive D dimer and elevated urea (20 mmol/L), creatinine (420 \text{mol/L}). Transoesophageal echocardiography (TOE) illustrated a mobile mass crossing the interatrial septum and present in both atria and ventricles. Doppler ultrasound revealed a right lower limb deep vein thrombosis (DVT). Brain magnetic resonance imaging demonstrated multiple small strokes. Thrombophilia screening was negative.

He was diagnosed with a thrombus straddling a patent foramen ovale (PFO) causing coronary, pulmonary, renal, and cerebral embolism. The patient was heparinized and surgical thrombectomy was arranged for the subsequent day. However, preoperative TOE showed the thrombus was no longer present. The patient was transitioned to warfarin therapy. His dyspnoea, neurological signs, and renal function gradually improved. He remains well 1 month after discharge and is due for percutaneous PFO closure as soon as possible.

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