suffered an intracranial haemorrhage as a result of septic embolism to the brain. After approximately 4 weeks of recovery from endocarditis and haemiparesis, follow-up echocardiography revealed a newly formed pseudoaneurysm. Although coronary angiogram was normal at this point, early septic embolism to a coronary artery and subsequent myocardial infarction [2] was the most probable mechanism for pseudoaneurysm formation in this patient. Late gadolinium enhancement MRI [2] of the heart to visualize infarction was not performed due to reduced renal function. He underwent uneventful left ventricular repair and was discharged in good condition.

**SUPPLEMENTARY MATERIAL**

Supplementary material is available at ICVTS online.

Conflict of interest: none declared.

**REFERENCES**


**eComment. Pseudoaneurysm secondary to native valve endocarditis**

Authors: Jamil Haji-Chahine, Christophe Jayle, Paul Menu and Pierre Corbi
Department of Cardio-Thoracic Surgery, University Hospital of Poitiers, Poitiers, France
doi: 10.1093/icvts/ivt042
© The Author 2013. Published by Oxford University Press on behalf of the European Association for Cardio-Thoracic Surgery. All rights reserved.

We read with great interest the paper by Sartipy et al. regarding the successful surgical management of a left ventricle pseudoaneurysm in a 76-year old patient with mitral valve endocarditis [1]. In this paper, we think that there may be a few matters to be clarified. To date, a handful of reports, mostly isolated case reports and small clinical series, have described successful management of left ventricle pseudoaneurysms [2–4]. What is remarkable in their report is that Sartipy et al. made no allusion in
their discussion to a well-known and more frequent aetiology of left ventricle pseudoaneurysm, that is, post-traumatic left ventricular pseudoaneurysm [3]. Penetrating injuries into the heart or blunt thoracic trauma are the second most common cause of left ventricle pseudoaneurysm after extensive myocardial infarction. The possible mechanisms of pseudoaneurysm formation after chest injury include contusion of the myocardial wall, coronary artery injury with secondary myocardial necrosis, and intramyocardial dissecting haematoma.

The authors stated that the possible mechanism for pseudoaneurysm formation in their patient was a coronary artery septic embolism. However, this cumbersome complication may also result from a local spread of the infected endocardium to the nearby myocardium. Myocardial abscesses, pseudoaneurysms of the ventricle, and free cardiac ruptures rarely complicate infective endocarditis. Rupture of the myocardial abscess is often fatal, but when the rupture is contained by scar tissue, this entity is known as a post-infective endocarditis pseudoaneurysm. Complete surgical resection with closure of the pseudoaneurysm neck remains the mainstay of therapy, can be curative, but carries a significant risk of mortality and morbidity. In a recently published retrospective study, Dudiy et al. [3] demonstrated that endovascular closure of the left ventricular pseudoaneurysm was a feasible and safe alternative for high-risk surgical candidates and they concluded that individualized management contingent on the anatomic characteristics of pseudoaneurysm and patient comorbidities were paramount.

Both the diagnosis and management of pseudoaneurysm of the left ventricle have evolved from more invasive to less invasive strategies, paralleling the advent of sophisticated imaging tools and the development of transcatheter therapies.

Conflict of interest: none declared.

References