This is a case of a 76-year-old woman with a history of hypertension, coronary artery disease, dyslipidemia (total cholesterol: 273 mg/dL, low-density lipoprotein: 174 mg/dL, triglycerides: 297 mg/dL, high-density lipoprotein: 40 mg/dL), and abdominal aortic aneurysm after open surgical repair 3 years previously. She presented with a transient ischemic attack that manifested as difficulty with word finding and left hemiparesis. Magnetic resonance imaging of the brain was unremarkable. In an attempt to depict a potential source of embolism, a transesophageal echocardiogram was performed that revealed a large mobile atheroma of \( \approx 1.0 \times 3.0 \) cm in the aortic arch (online-only Data Supplement Movie). Treatment in the form of anticoagulation therapy using heparin and coumadin was initiated with no recurrence for 6 months. Of note, atorvastatin was increased from 10 mg to 40 mg once a day. A few case series have cited the role of lipid-lowering agents in the treatment of aortic atheroma in patients with hyperlipidemia, which conceivably may induce plaque regression.\(^1\)\(^-\)\(^3\)

With the widespread use of transesophageal echocardiogram, aortic atheroma has been recognized as a potential source of arterial embolization. All mobile masses seen have been mostly formed of thrombi. High risk of stroke (up to 27\%) has been detected in patients not taking oral anticoagulation (including those taking antiplatelet therapy).

For patients with aortic plaques \( \geq 4 \) mm thick, treatment with oral anticoagulants reduced the risk for embolic events; combined events were 6 times more likely to occur in the antiplatelet group. Patients with mobile plaques experienced a reduction in both combined events and mortality with anticoagulant therapy.\(^4\)\(^,\)\(^5\)

Disclosures

None.

References

Mobile Aortic Atheroma Leading to a Cerebrovascular Accident
Rami N. Khouzam

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