Mobile Aortic Atheroma Leading to a Cerebrovascular Accident

Rami N. Khouzam, MD

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


From the Division of Cardiovascular Diseases, Farmington Heart Center, Farmington, NM. The online-only Data Supplement can be found with this article at http://circ.ahajournals.org/cgi/content/full/119/5/e192/DC1. Correspondence to Rami Khouzam, MD, 480 Cerrillos Dr, Farmington, NM 87401. E-mail khouzamrami@yahoo.com

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