A 51-year-old woman with known rheumatic aortic and mitral valve disease developed progressive exertional angina. Cardiac catheterization demonstrated severe aortic stenosis, mild aortic insufficiency, moderate mitral stenosis, and normal left ventricular function. Cardiac catheterization was not associated with chest pain or ECG changes suggesting coronary embolism during the procedure. Coronary arteriography (A) showed two bizarre intraluminal filling defects (arrows) narrowing the proximal left anterior descending coronary artery (LAD) and a large circumflex marginal (LCx) branch by about 80%. The patient underwent an aortic valve replacement, open mitral commissurotomy, and aortocoronary bypass grafting to the LAD and LCx (Dr S. Chawla). B shows the intraluminal calcium embolus (arrow) as seen through the wall of the marginal branch. This was removed by direct arteriotomy; however, attempts at removing the proximal LAD embolus with a Fogarty catheter were unsuccessful. Otherwise, the coronary arteries appeared perfectly normal. C shows the calcified aortic valve and the arrow points to the calcium emboli removed from the LCx branch. The patient has done well after surgery.

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Images in cardiovascular medicine. Multiple coronary emboli from a calcified rheumatic aortic valve.
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