Figure. Diffusion-weighted sequence (A) showing an acute right posteromedial thalamic infarction. fluid-attenuated inversion recovery (B and C) sequences disclosing additional subcortical lesions that did not exhibit restricted diffusion and therefore were unlikely to be acute.

VIDEO

Cardiac saddle embolus

Sylvia M. Zuniga, MD; and Alejandro A. Rabinstein, MD, Miami, FL

A 74-year-old man with a history of hypertension and recent multiple abdominal surgeries presented with transient vertical diplopia, left-sided weakness, and persistent left-side numbness. Examination of eye movements and motor system was normal, but he had left hypoesthesia. MRI showed acute right posteromedial thalamic infarction (figure, A). Magnetic resonance angiograms of brain and neck did not reveal any significant vascular disease. Transthoracic echocardiogram revealed a large intracardiac thrombus. Lower extremity duplex disclosed thrombosis of the right femoral and popliteal veins. The patient was taken to the

operating room for removal of the thrombus, confirmed with intraoperative transesophageal echocardiogram (video), but no thrombus was found upon opening the heart. Intraoperative abdominal angiogram revealed thrombosis of the left superior and inferior mesenteric and left renal arteries, indicating that the thrombus had likely fragmented in multiple emboli (figure, B and C). Despite emergent mesenteric artery thrombectomy and partial bowel resection, the patient died from the complications of extensive intestinal ischemia.

We believe this patient's small subcortical infarct was due to embolism to a branch of the right posterior cerebral artery, perhaps the thalamic-subthalamic artery. This case illustrates that even life-threatening sources of embolism can present with small subcortical strokes.¹

Address correspondence and reprint requests to Dr. Alejandro A. Rabinstein, 1150 MW 14th street, Suite 304, Miami, FL 33101; e-mail: arabinstein@med.miami.edu

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