



Lamb's Excrescence is Not Always Benign: A Rare Cause of STEMI

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INTRODUCTION

- Lamb's Excrescences (LE) are mobile, thin, filiform strands seen on echocardiogram at sites of valvular coaptation.
- These are mostly found during workup for cryptogenic stroke.
- Rarely, LE has been associated with myocardial infarction, pulmonary embolism and/or valvular obstruction.
- Optimal management of LE in the setting of myocardial infarction is unclear.

CASE PRESENTATION

- A 39-year-old male, with no known medical history presented to our ER with 2 hours of angina.
- EKG revealed inferolateral ST elevations and troponins were elevated (2.87 ng/ml) consistent with STEMI.
- Angiography revealed 100% occlusion of the distal left posterolateral artery; percutaneous coronary intervention was attempted without success due to small size of the culprit vessel.
- Workup for hypercoagulable disorders including Libman-Sacks endocarditis, antiphospholipid syndrome and inherited thrombophilia were negative.
- TTE revealed a 0.9cm x 0.6cm mobile mass on the left ventricular aspect of the left coronary cusp of the aortic valve.
- Dual antiplatelet therapy, heparin followed by a transition to coumadin, a statin and a beta blocker were initiated.
- Surgical excision of the mass was completed one month later. Gross pathology and histology following surgery confirmed a diagnosis of LE rather than PFE.

DISCUSSION

- There is a paucity of data to guide management of LE, especially in patients with myocardial infarction.
- To our knowledge, only one other case associating STEMI with LE has been reported.
- The choice between surgical resection, anticoagulation and conservative management depends on individual thromboembolic, bleeding, and peri-operative risks as well as patient preference.

CONCLUSION

- In young patients with low estimated peri-operative risk, surgical resection seems to be a preferable approach over extended full dose anticoagulation.
- Further prospective data are needed to define optimal treatment strategies in this population.

IMAGES

(A) ECG showing ST elevation in the inferolateral leads (B) LAO caudal projection during LHC revealing an occluded LPL branch, with otherwise normal coronary arteries. (C) TEE mid-esophageal short axis view demonstrating proximity of the mass to the LM ostium (D) Same image as 1C in 3D. (E) Intra-operative photos demonstrating the mass attached to the LCC of the aortic valve. (F) Histologic evaluation of the mass revealing non-branching papillary projections of avascular fibroblastic tissue with a single-layered endothelial lining, lacking atypia.

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