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Management of Ventricular Pseudoaneurysms

LETTER TO THE EDITOR

To the Editor,

We read with great interest the article titled ''Huge Pseudoaneurysm Presenting with Silent Myocardial Infarction and Stroke'' by Şaşmaz et al[1] published in *Anatol J Cardiol* 2024; 28(6):E-24–E25. We would like to present our impressions and evaluations. The authors stated that the patient was discharged with medical treatment within 5 days. On the other hand, insufficient information is provided regarding the kind of medical treatment. Furthermore, there is no explanation provided for the lack of an angiography during the patient's course of treatment, despite the fact that the type and time frame of the myocardial infarction are undetermined. Dual antiplatelet treatment should be started, as indicated for acute care syndromes. Furthermore, as far as is known, administering acetylsalicylic acid during the first 48 hours after acute ischemic stroke lowers the risk of mortality and disability and is advised for patients who will not undergo thrombolysis. However, it is unclear if oral antiplatelets other than acetylsalicylic acid are effective in the treatment of acute ischemic stroke and are not indicated. Furthermore, there is no evidence that anticoagulants like heparin are useful in the treatment of acute stroke, as compared to acute myocardial infarction.[2] Therefore, we wish to ask the authors how they managed the patient's antithrombotic and anticoagulant therapy?

Ventricular pseudoaneurysms were formerly believed to have a 30-45% rupture risk. Surgery is the first course of therapy to be considered since pseudoaneurysms have an intrinsic high chance of rupturing. It is provided to patients under case-by-case cautious supervision. Yeo et al[3] demonstrated that in a group of 52 patients with ventricular pseudoaneurysms who were monitored for a median of 4 years, 42 patients had surgery, although it is noteworthy that 10 patients who were treated conservatively did not have a rupture. Large or acute pseudoaneurysms during myocardial infarction are more likely to need repair, despite a lack of randomized controlled evidence on this topic.[4,5]

Additionally, we would want to ask respectfully of the authors how often did they contact the patient for follow-up appointments after discharge to assess the likelihood of pseudoaneurysm rupture.

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