



Is MINOCA Syndrome Causing Fatal Left Ventricular Aneurysms Less Innocent than It Appears?

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Myocardial infarction with non-obstructive coronary arteries (MINOCA) is clinically defined by the universal acute myocardial infarction (AMI) criteria, absence of obstructive coronary artery disease ($\geq 50\%$ stenosis), and no overt cause for the presentation at angiography.¹ The underlying causes of MINOCA vary widely. However, excessive focus on determining etiology has resulted in limited clinical efforts.² Consequently, unexplained cases of MINOCA present challenges in risk stratification. Recent studies show that cardiac magnetic resonance imaging (CMR) identifies underlying causes in 87% of patients with MINOCA.³ Given difficulties in CMR access, potential evaluation issues, rising healthcare costs, and economic constraints, diagnostic challenges have gained precedence.

Several studies indicate that MINOCA has a consistently better prognosis than AMI.^{1,3-5} However, MINOCA's diverse etiologies⁶ complicate generalization of findings for diagnosis and treatment, meaning prognosis is not as benign as it may seem. Patients with MINOCA frequently experience recurrent symptoms, with 16% reporting worsening or persistent chest pain within 5 years.⁷ Some patients progress to occlusive coronary artery disease,⁸ so persistent chest pain should not be assumed to be MINOCA-related.

Left ventricular aneurysms, a potentially fatal condition, can lead to heart failure, systemic embolism, ventricular arrhythmia, and cardiac rupture, typically following AMI. The likelihood of aneurysm

development increases with prolonged symptom-balloon time after AMI, and correlating symptom-balloon time with the patient's syntax score enhances predictive value.⁹

While left ventricular apical aneurysms are rare in MINOCA,¹⁰ they have not previously been reported to cause left ventricular basal pseudoaneurysms. A left ventricular basal pseudoaneurysm with intraoperative imaging (Figure 1a-f) was identified in a 40-year-old female with chest pain diagnosed with non-ST-elevation myocardial infarction. Normal coronary arteries were observed, leading to a MINOCA diagnosis. A left ventricular basal pseudoaneurysm was confirmed by cardiac computed tomography and CMR, leading to referral for surgical treatment.

Post-AMI left ventricular aneurysms are associated with more complications, longer hospital stays, higher costs, and lower discharge likelihood.⁹ However, data on ventricular aneurysms post-MINOCA are lacking. With improvements in MINOCA diagnosis and growing professional interest, we anticipate more knowledge and experience on MINOCA and its complications.



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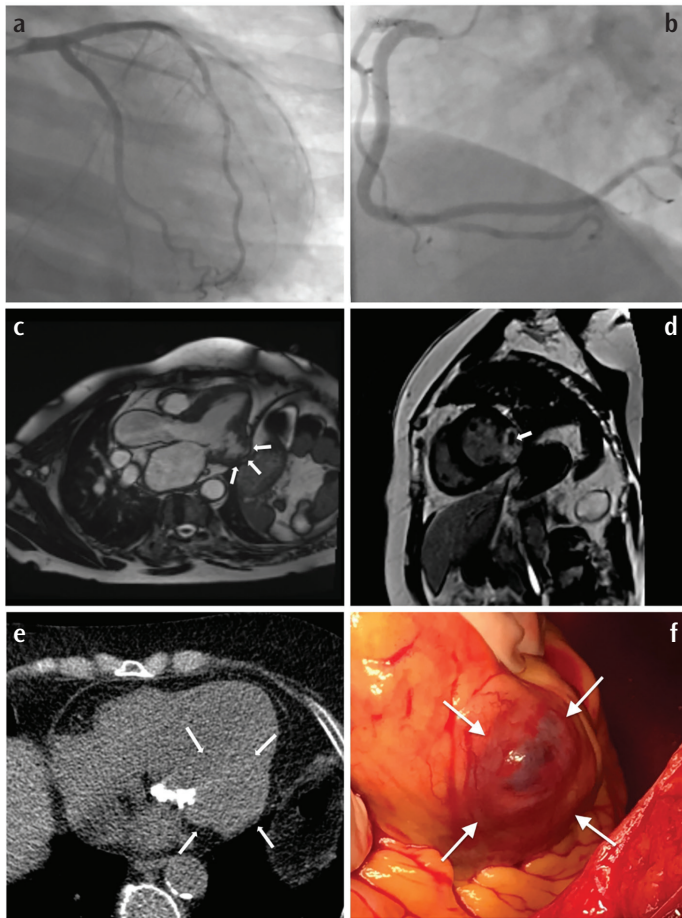


FIG. 1. (a, b) Coronary angiography shows normal coronary arteries. (c) A 3-chamber image reveals a left ventricular aneurysm (arrows) measuring 41×23 mm. (d) A short-axis late gadolinium enhancement image shows a non-enhanced lesion (arrow) within the aneurysm sac, possibly thrombus or calcification. (e) Non-contrast CT shows no calcification within the aneurysm sac (white arrows), suggesting the lesion is thrombus (note: calcifications in the image are on the mitral valve). (f) Intraoperative image of the left ventricular basal pseudoaneurysm. CT, computed tomography.

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