A previously healthy 33-year-old man was admitted to Saku Central Hospital Advanced Care Center with suspected infective endocarditis. He had a 2-month history of dyspnea on exertion and cough. Trans-thoracic and transesophageal echocardiography showed severe mitral valve stenosis with a mitral valve mass measuring 12×11 mm attached to the posterior leaflet (Figure 1A, B). Mitral valve mean pressure gradient was elevated to 16 mmHg and MVA was reduced to around 1.0 cm². The orifice of the mitral valve was located in the lateral site, and both anterior and posterior commissures were fused and unclear. There was also mild tricuspid valve regurgitation, but no other valve stenosis, regurgitation, septal defect, hypoplastic left heart, or abnormal structure

Adult Case of Parachute-Like Asymmetrical Mitral Valve Complicated by Mitral Stenosis and Thrombus Formation

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Figure 1. (A) Four-chamber and (B) 2-chamber transesophageal echocardiography showing a hyperechoic mass (12×11 mm; yellow arrows). (C) Two-chamber and (D) short axis magnetic resonance imaging showing two similarly sized papillary muscles, namely, an anterolateral papillary muscle (dotted yellow arrows) and a posteromedial papillary muscle (dotted red arrows). LA, left atrium; LV, left ventricle; RA, right atrium; RV, right ventricle.
There has been one other reported case of infective endocarditis associated with PLAMV, but this is the first case of PLAMV complicated by thrombus formation. Because the present mitral valve stenosis had been mild during childhood, the patient had been asymptomatic and had never been diagnosed with heart murmur or any other physical findings. Thrombus formation occurred in the left atrium (LA) as a result of LA stasis due to mitral valve stenosis, and might have led to severe mitral stenosis and symptomatic heart failure.

Disclosures
The authors declare no conflict of interest.

References