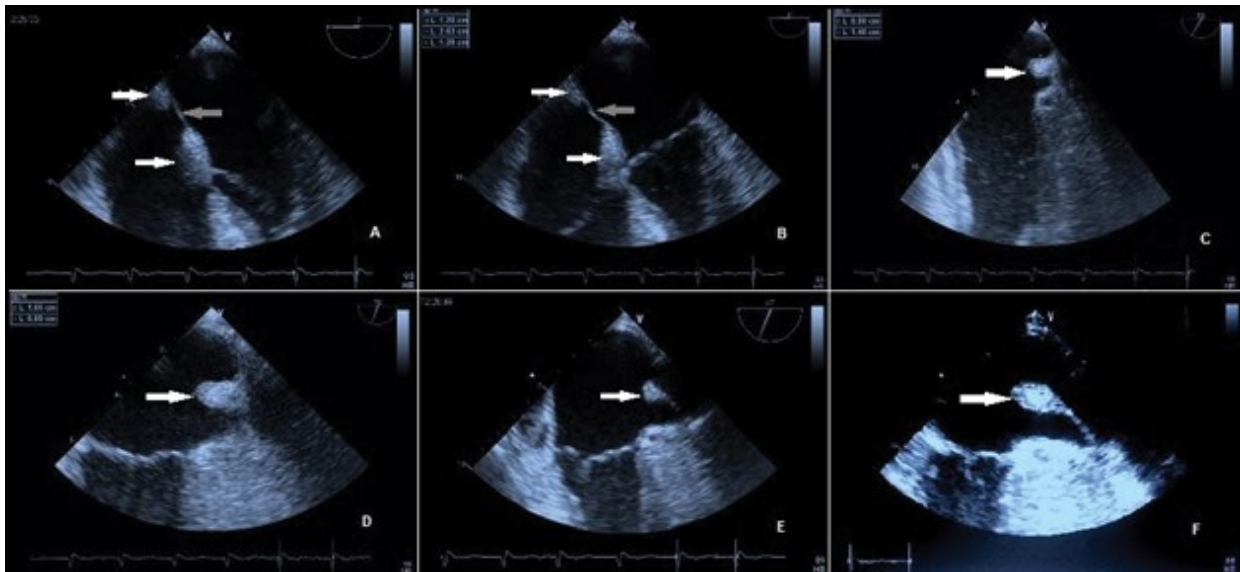


## Case Blog

### Title: Unusual Association of Cardiac Anatomic Variants and Pitfalls with a Simultaneous Presence of a Coumadin Ridge and a Lipomatous Hypertrophy of the Interatrial Septum

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**Figure 1:** Two-dimensional transesophageal echocardiography revealing: A-B: Lipomatosis interatrial septum (white arrows) with a spared fossa ovalis (Grey arrows); C-F: Prominent echodense structure (white arrows) adhering to lateral left atrial wall miming a thrombus, displayed and more individualized by two-chamber view thus evoking a Coumadin ridge localized in the junction of the left atrial appendage and the atrial insertion of the left upper pulmonary vein, typically looking like a cotton-tip applicator on this view. (A: mid-esophageal modified Four-chamber view in proto-diastole, transducer angle 0°; B: mid-esophageal modified Four-chamber view in mid-systole, transducer angle 0°; C-E: different views of mid-esophageal bicommissural view, transducer angle between 55° and 70°; F: mid-esophageal two-chamber view, transducer angle 98°).

**Keywords:** Echocardiography; Cardiac variants; Coumadin ridge; Lipomatous hypertrophy; Interatrial septum

### Case Presentation

An 89-year-old male was referred to the echo laboratory for further investigations of a 6-day history of high fever and wet cough. His past medical history was largely unremarkable and so was his cardiac physical examination. Electrocardiogram showed sinus rhythms with an incomplete right bundle branch bloc. He had a poor echogenic window in transthoracic echocardiography which revealed no significant valvular heart disease and no evidence of mobile echodense masses implanted in a valve or mural endocardium however it was suspicious for two echodense masses tributary to the lateral left atrial wall and the interatrial septum. Transesophageal echocardiography was performed and revealed two distinctive echo-dense globular thickening of the interatrial septum sparing the fossa ovalis with a characteristic “dumbbell” shape evoking a lipomatous hypertrophy of the interatrial septum (Figures 1A-1B), and an immobile prominence localized between the entrance of the left atrial appendage and the atrial insertion of the left upper pulmonary vein with a “Q-tip” sign evoking a Coumadin ridge separating this two structures (Figures 1C-1F, Supplementary movie 1). No others signs evoking infective endocarditis were found. The Diagnosis of upper respiratory tract infection was established and the patient was treated with antibiotics in the geriatric department with favorable evolution. He was discharged home 8 days after.

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