weeks of flucloxacillin and benzyl-penicillin. Surveillance blood-cultures were negative over a 3-month period and had recovered to baseline.

Conclusion: This case highlights for the first known time that chronic FDG uptake can be observed for up to 30 years following AVR and MVR in non-infected prosthetic valves.

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A Case of Erdheim-Chester Disease: An Exceptional Rare Disease With Multiple Cardiovascular Manifestations

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Background: Erdheim–Chester (EC) disease is a rare multi-system disease characterised by the abnormal proliferation of histiocytes.

Case Presentation: Mr X, a 66-year-old male, presented with shortness of breath. A transthoracic echocardiogram revealed a large pericardial effusion with tamponade physiology. A pericardiocentesis was performed, with the fluid showing abundant histiocytes. Subsequently, a cardiac MRI(CMR) showed the right atrium was diffusely thickened with a material that exhibited late gadolinium enhancement (LGE). This material extended into the right atrio-ventricular groove and encased the right coronary artery. There was also thickening of the thoracic aorta. A fluorodeoxyglucose (FDG) positron emission tomography (PET) scan showed the thickened areas to have significant uptake. There were also FDG avid sclerotic patches in the bilateral lower limb long bones. A bone biopsy was CD163 positive, langerin negative and BRAF V600E mutation positive, thus consistent with the diagnosis of EC. He was stabilised on dabrafenib, which specifically targets the BRAF V600E mutation. During his clinical journey, his left ventricle ejection fraction declined to 30% with patches of LGE on CMR. He also received an implanted cardiac defibrillation after a polymorphic ventricular tachycardia arrest and junctional bradycardia. Long-term follow-up has showed the EC to be stable On PET scan, however he has developed atrial fibrillation made complicated by recurrent gastro-intestinal bleeding.

Discussion: We have presented a case of EC, a rare histiocyte disease with multiple cardiac features including tamponade, cardiac chamber and vascular infiltration, cardiomyopathy and electrical instability. Right atrial pseudomass; atrio-ventricular groove and right pericoronary infiltration are considered classic features.

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A Case Report on the Importance of Multimodal Imaging and Multidisciplinary Management for Myocardial Infarction With Non-Obstructive Coronary Artery Disease (MINOCA)

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Background: Myocardial infarction (MI) with non-obstructive coronary artery disease (MINOCA) are a heterogenous phenomena with a prevalence of 5–10% of all MIs. Left ventricular (LV) aneurysms can develop post transmural infarcts with complications including heart failure, thrombus formation, malignant arrhythmias and valvular dysfunction.

Case: A 32-year-old female without significant medical history presented with sudden onset chest pain and was diagnosed with an aborted ST-elevation myocardial infarction with raised troponin biomarkers of 64,000. Coronary angiography revealed normal coronary arteries with left ventriculogram revealing an abnormal LV outpouching. Subsequent transthoracic echocardiogram, computer tomography and magnetic resonance imaging (MRI) defined this structure as an inferobasal LV aneurysm measuring 14x9x16 mm, positioned below the mitral valve annulus with associated mild-moderate mitral regurgitation. MRI confirmation of a left circumflex territory infarction, deemed this to be a post MI LV aneurysm with the presence of a patent foramen ovale (PFO) on transoesophageal echocardiography the likely precipitant for coronary thromboembolism. A multidisciplinary heart team was convened and deemed surgical correction indicated. The patient proceeded to cardiopulmonary bypass surgery with a median sternotomy and transeptal approach via the PFO requiring detachment of the posterior mitral valve leaflet (PMVL) to gain access to the LV aneurysm. This allowed full thickness plication of the aneurysm with subsequent mitral valve repair using a 34 mm Physio II ring and a PMVL bovine pericardial patch prior to PFO closure at completion.

Discussion: Prognosis in MINOCA is extremely variable, with the use of multimodality imaging and a multidisciplinary team approach often required to diagnose and risk stratify this complex and diverse cohort.

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