

substantial and cannot be ignored.⁴ Clinicians should not rely on measures that prophylax against AF to protect patients from this devastating complication. Despite the challenges of the post-operative state, patients need to receive anticoagulants until their period of risk of atrial arrhythmia has passed.⁵

Finally, the efficacy of all of the proposed interventions needs to be examined in the context of risk and cost, neither of which are adequately addressed in this paper. Without knowing that a treatment reduces morbid or mortal events, it is impossible to justify whatever risk that intervention brings. Thus, a profligate policy of amiodarone prophylaxis seems unreasonable and unsupportable to us, despite what this meta-analysis tells us. The study cannot tell us if there is justification for using more aggressive measures in patients at highest risk for AF post-surgery, such as the elderly with valvular disease.

We consulted Webster's Ninth Collegiate Dictionary and discovered that the third definition of the prefix meta- was 'more comprehensive: transcending.' In this sense, Burgess *et al.* have helped us to 'transcend' what we know by applying sound statistical principles to an otherwise bewildering literature to provide insight—and for that they are to be congratulated. But we should not be prepared to make major changes in our therapeutic approach to post-operative patients until we can be convinced that any method of preserving sinus rhythm on a wholesale basis, or even in a significant subset, is worthwhile in terms of the

kinds of outcomes we really care about like heart failure, stroke, and death. Burgess *et al.* have helped us frame the question and now it is our job to think about ways to answer it.

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Clinical vignette

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A coronary embolus originating from the interatrial septum

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A 25-year-old woman was admitted for recurring left-sided chest pain of increasing intensity since 2 h. The initial ECG was unremarkable, but troponin I levels were elevated (2.2 µg/L). Thrombotic occlusion of the left circumflex artery was diagnosed by coronary angiography and successfully recanalized. Transthoracic echocardiography showed normal global left ventricular function with hypokinesia of the posterobasal segment. Transoesophageal echocardiography (TEE) demonstrated a double-layered interatrial septum, probably due to a remnant septum primum, forming a cavity between the two septal layers and an enclosed thrombus-like mass (0.5 × 0.6 cm, Panel A). The presence of a cavity within the interatrial septum was verified by magnetic resonance imaging (Panel C, arrow). Active smoking and hormonal contraception were the only identifiable thrombophilic risk factors. After 3 days of therapeutic anticoagulation, a repeat TEE exam showed complete resolution of the thrombus (Panel B) and no evidence for a patent foramen ovale with injection of a right-heart echo contrast agent. Injection of a left-heart contrast agent (Levovist®, Schering, Berlin, Germany) demonstrated perfusion of the interatrial septal cavity from the left atrium (Panel D). The presented case demonstrates a rare, previously unrecognized cause for thrombus formation within the interatrial septum in the absence of a patent foramen ovale and for peripheral embolism.

See online supplementary movies available at *European Heart Journal* online.

Panel A. Cavity between the two layers and a thrombus-like mass.

Panel B. Complete resolution of the thrombus.

Panel C. Magnetic resonance imaging.

Panel D. Perfusion of the interatrial septal cavity from the left atrium.

