### Title of image and video article
Maximum 20 words. Titles should be as short as possible while still informing the reader about the article content and engaging their interest.

Right Ventricular Marantic Endocarditis

### Authors
Maximum of 4 authors’ names and affiliations (include any others in the acknowledgements). The corresponding author’s email address must be provided.

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### Summary
A single paragraph of less than 200 words explaining why the images/videos are particularly notable or unique.

A 68 year-old female presented with chest pain and breathlessness. She had breast carcinoma treated 17 years ago, with further surgical excision for recurrence 7 years ago. Computerised-tomography (CT) demonstrated bi-lateral pulmonary embolism, with extensive lymphadenopathy and lung metastases. She was treated with therapeutic heparin. Echocardiography revealed a right ventricular mass attached to the tricuspid valve chordae (Panels/Videos A and B), which could be thrombus, marantic or infective vegetation. Blood cultures were negative. Lymph node biopsy showed malignant cells, likely of breast origin. Despite therapeutic anti-coagulation, echocardiogram three weeks after initial presentation demonstrated enlargement of the original mass and an additional mass (Panels/Videos C and D), implying that these were most likely marantic. We retrospectively reviewed the CT done at first presentation, which also demonstrated the original right ventricular mass (Panel E). She died from recurrent embolic cerebrovascular events, confirmed on MRI, within a month from initial presentation. In advanced stages of malignancy, marantic endocarditis or non-bacterial thrombotic endocarditis can develop in hypercoaguable states. It has a rapidly progressive course, with embolization of vegetations to other organs. The sterile vegetations consist of fibrin and platelets (1,2). Patients should be anticoagulated. In terminal cases, surgery rarely alters final outcome (2,3).

### Patient consent
Include a statement confirming that written informed consent has been obtained from the patient (or patient’s guardian) for publication of the submitted article and accompanying images/videos. Authors must also provide a signed copy of our consent form. If the patient is deceased, a consent form is not required (though we recommend consent is sought from a relative).

Patient deceased.
Author contributions and acknowledgements
Include a statement specifying the contribution of each co-author. If the author is not the named physician of the patient please clarify involvement in the oversight of the reported case, or confirm you have permission of the physician who is responsible for the patient.

Nigel Dewey – Writer of the article.

Dr Lal Hussain Mughal – Involved in the patient’s clinical management and treatment. Reviewed the article before submission.

Dr Andrew Houghton – Reviewed the article before submission.

Dr Jeffrey Khoo – Writer of the article. Consultant of the patient and therefore involved on patient’s clinical management and treatment. Permission has been given for the article. Reviewed the article before submission.

References
Maximum of 5. All references cited in the text must be included in the reference list and vice versa. Cite references in the text in numerical order. References should be formatted as follows:


Legends to images/videos
Image/video files should be uploaded separately during online submission.

Images: Panels A and B: Right ventricular mass (arrowed) attached to the tricuspid valve chordae apparatus on echocardiography, in apical 4-chamber view , and modified parasternal right ventricular inflow view respectively; Panel C and D: Repeat echocardiogram demonstrating enlargement of the original mass and an additional mass (longer arrow), in apical 4-chamber view, and modified parasternal right ventricular inflow view. Panel E: Right ventricular mass on computerised tomography at patient’s initial presentation.

Videos:
Video A: The initial right ventricular mass attached to the tricuspid valve chordae apparatus on echocardiography, in modified parasternal right ventricular inflow view.

Video B: The initial right ventricular mass attached to the tricuspid valve chordae apparatus on echocardiography, in apical 4-chamber view.

Video C: Repeat echocardiogram demonstrating enlargement of the original mass and an additional mass, in modified parasternal right ventricular inflow view.

Video D: Repeat echocardiogram demonstrating enlargement of the original mass and an additional mass, in apical 4-chamber view.
Panels A and B: Right ventricular mass (arrowed) attached to the tricuspid valve chordae apparatus on echocardiography, in apical 4-chamber view, and modified parasternal right ventricular inflow view respectively; Panel C and D: Repeat echocardiogram demonstrating enlargement of the original mass and an additional mass (longer arrow), in apical 4-chamber view, and modified parasternal right ventricular inflow view. Panel E: Right ventricular mass on computerised tomography at patient’s initial presentation.