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CASE REPORT

Case Report: Successful revascularization in massive pulmonary embolism with a large protruding thrombus and dilated cardiomyopathy [version 1; peer review: 1 approved with reservations]

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Abstract

Pulmonary embolism is a potentially life-threatening condition. Despite advances in diagnostics, lack of consensus and delays in determining the diagnosis of pulmonary embolism are still important problems. We report the diagnosis and management of a 37-year-old man suffering from massive pulmonary embolism, a large protruding thrombus, and dilated cardiomyopathy. Echocardiography showed dilatation of all cardiac chambers, a large protruding thrombus in the right atrium to the inferior vena cava, impaired left and right ventricular systolic function, and global hypokinetic of the left ventricle with eccentric left ventricular hypertrophy. A thoracic computerized tomography scan showed pulmonary embolism with infarction. The patient's blood pressure was 60/40 mmHg and heart rate was 110 bpm. The patient was diagnosed with high-risk acute pulmonary embolism. We gave him hemodynamic support and reperfusion therapy with a loading dose of 250,000 units of Streptokinase followed by 100,000 units/hour for 24 hours. After revascularization, the patient's hemodynamic condition improved. The diagnosis of acute pulmonary embolism is based on clinical symptoms, hemodynamic changes, or radiological examination. Unstable hemodynamic underlies high-risk stratification. Hypotension or shock results from obstruction of the pulmonary artery which causes increased right ventricular afterload and acute right ventricular dysfunction. Reperfusion with thrombolysis therapy could provide good outcomes in this patient. Prolonged anticoagulation should be given to prevent the recurrence of venous thromboembolism.

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Any reports and responses or comments on the article can be found at the end of the article.

Keywords

Massive pulmonary embolism, large protruding thrombus, unstable hemodynamic, reperfusion

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Introduction

Venous thromboembolism, a clinical presentation of deep vein thrombosis (DVT) or pulmonary embolism, is the third most commonly found acute cardiovascular syndrome after myocardial infarction and stroke¹. Pulmonary embolism is a potentially life-threatening condition. Most patients die from pulmonary embolism within the first few hours of the event. Despite advances in diagnostics, delay in determining pulmonary embolism diagnosis is still a significant problem².

Pulmonary embolism contributes to approximately 300,000 deaths per year in the United States³. This makes pulmonary embolism one of the high-rank causes of cardiovascular death. In six European countries with a total population of 454.4 million, more than 370,000 deaths were related to venous thromboembolism in 2004. Of these patients, 34% died suddenly or within a few hours of the acute event, before therapy could be administered⁴. Clinicians should be better able to recognize the signs and symptoms of acute pulmonary embolism; thus, diagnosis and management can be determined quickly and accurately to reduce patient mortality. This case report presents successful revascularization of a massive pulmonary embolism with large intracardiac thrombus and dilated cardiomyopathy.

Case presentation

A 37-year-old Indonesian man was referred to the emergency department of Dr. Soetomo General Hospital, Indonesia, in June 2019, with complaints of shortness of breath and swollen legs. His occupation was a farmer. Two months earlier, the patient went to the public health center for a prolonged cough ($\pm$ 5 months), which was sometimes accompanied by shortness of breath. In the public health center, acid-fast bacillus (AFB) testing was performed with a negative result. Based on a chest radiograph, the doctor decided to give group 1 anti tuberculosis drugs through the public health center. The treatment prescribed was fixed dose combination, 4 tablets daily taken orally, with composition of each tablet as follows: Rifampicin 150 mg, Isoniazid 75 mg, Pirazinamide 400 mg, and Ethambutol HCl 75 mg. Thus, in the emergency department, he was referred to the pulmonology department with a diagnosis of pulmonary tuberculosis.

In addition, the patient also had a history of deep vein thrombosis (DVT) of the left inferior limb; the patient had had a thrombectomy a month before his referral to the hospital. The complaints of swollen leg were slightly reduced at that time; however, had recurred again, accompanied by swelling on his right limb.

The patient had been diagnosed with diabetes mellitus and heart disease one month before admission. He received subcutaneous injection of 8 units insulin aspart three times a day before meals, captopril 6.25 mg every eight hours orally, spironolactone 25 mg once daily orally, digoxin 0.25 mg once daily orally, codeine 10mg every eight hours orally, and rivaroxaban 15 mg every twelve hours orally.

When admitted to the pulmonary ward, the patient complained of shortness of breath, accompanied by pain and swelling in both legs. His blood pressure was 120/80 mmHg, pulse 128 bpm, respiratory rate 26/minute, and SpO₂ 99% with 3 lpm nasal cannula. Physical examination revealed jugular venous distention, bilateral basal rales, hepatomegaly, and pitting edema in both lower extremities.

In laboratory findings, serum electrolytes revealed hypokalemia (K: 3.3 mmol/L; normal range 3.5–5.1 mmol/L), serum protein showed hypoalbuminemia (albumin: 3.1g/dL; normal range 3.4–5.0 g/dL), while other parameters were between normal limits. An electrocardiogram (ECG) showed sinus tachycardia rhythm 125 bpm, right-sided frontal axis, horizontal axis clockwise rotation, and slow progression of R waves at V1–V4 (Figure 1). A chest X-ray showed cardiomegaly, pulmonary congestion, and minimal bilateral pleural effusion (Figure 2). Echocardiographic examination revealed moderate mitral regurgitation (dilated mitral annulus), dilatation of all cardiac chambers (LVIDd 5.8 cm), visible thrombus in IVC to RA, decreased left and right ventricular systolic function (EF teich 35%, TAPSE 1.3 cm), and global hypokinetic of the left ventricle with eccentric LVH. The scans from a transthoracic echocardiogram (TTE) showing thrombus is shown in Figure 3 and Figure 4.

A chest CT scan (Figure 5) showed right pulmonary artery embolism at $\pm$ 5.9 cm from bifurcation on the anterior side of the intermediate right bronchus; emboli on the left pulmonary artery bifurcation and the left pulmonary artery basal part; multiple right intraatrial hypodense lesions not showing contrast enhancement leading to a visualization of the right intraatrial thrombus; pulmonary infarction in the lateral-posterior segment of the base of the inferior lobe of the right lung, the lateral-posterior segment of the base of the inferior lobe of the left lung, and the anterior segment of the superior lobe of the left lung; and superior vena cava thrombus at VTH level 1-5. Figure 6 shows the protruded thrombus in the right atrium passing through the tricuspid valve. TTE also showed the position of the thrombus moving from the inferior vena cava towards the right atrium (Figure 7). The movement of the large protruding thrombus can be seen in supplementary video files 1–3^{5–7}.

In the course of the assessments, no clinical, laboratory, or radiological signs of pulmonary tuberculosis were found. Eventually, the patient was transferred to the cardiology ward with the assessment of dilated cardiomyopathy + acute decompensated heart failure + deep vein thrombosis of the right and left inferior limbs + right atrial thrombus + pulmonary embolism + type II diabetes mellitus. During three days of treatment, the patient received 20 mg of Furosemide by intravenous injection every eight hours, Spironolactone 50 mg once daily orally, Ramipril 5 mg once daily orally, low-dose Bisoprolol started at 1.25 mg once daily orally, subcutaneous injection of Enoxaparin 60 mg every twelve hours, and subcutaneous injection of 6 units insulin aspart three times daily

Figure 1. Electrocardiogram (ECG) of the patient.

Figure 2. Chest X-ray of the patient.

before meals. However, in the course of this treatment in the cardiology ward, the patient suddenly complained of shortness of breath accompanied by chest pain and cold sweat. His blood pressure became 60/40 mmHg, heart rate 110 bpm, and respiratory rate 28–30/minute, thus showing hemodynamic instability and shock. Therefore, he was reassessed as having high risk acute pulmonary embolism, and the patient was transferred to the cardiovascular care unit (CVCU) for observation and reperfusion therapy.

In the CVCU, we gave the patient hemodynamic support with Norepinephrine starting at 50 nanograms/kg/minute by titration. Reperfusion was carried out by giving a loading dose of 250,000 units of Streptokinase intravenously for 30 minutes, followed by 100,000 units of Streptokinase per hour for 24 hours with intravenous continuous pump. After revascularization, the patient's hemodynamic condition improved until vasopressors/inotropic drugs could be tapered off. TTE also showed the disappearance of the large protruding thrombus (supplementary video files 4–5)^{8,9}. After the patient's condition was stable, he was transferred to the cardiology ward until the patient was discharged after one week of thrombolytic treatment. In his discharge, rivaroxaban was prescribed at a daily dose of 20 mg as an oral anticoagulant for at least three months.

One week after discharge, the patient made a follow-up visit at the cardiology outpatient clinic. At that time, it was found that the patient's symptoms and exercise tolerance had improved, and his shortness of breath and swollen leg were reduced. The patient's adherence to treatment was good, and there was neither sign of minor nor major bleeding due to the use of anticoagulants. Anticoagulant therapy was continued, accompanied by therapy for heart failure according to guideline-directed medical therapy (GDMT) for heart failure with reduced ejection fraction (HFrEF).

Discussion

Pulmonary embolism is a critical medical emergency. It can lead to rapid deterioration of hemodynamic condition with high

Figure 3. Transthoracic echocardiogram (TTE) showing thrombus in the right atrium.

Figure 4. Transthoracic echocardiogram (TTE) showing thrombus in the inferior cava vein.

morality rate¹⁰. Pulmonary embolism usually arises from thrombus originating from the deep venous system in the inferior limb. After heading to the lungs, a large protruding thrombus can attach to the branching of the main pulmonary artery or lobar branches, causing massive pulmonary embolism and hemodynamic disorders. This case report is unique as it showed

massive pulmonary embolism due to a large protruding right-sided heart burden thrombus, which is rarely found in normal cases. This condition led to hemodynamic instability of the patient. This case also showed how immediate thrombolytic therapy could make the large thrombus disappear and provide a better outcome in such a patient. Pulmonary thromboembolism

is not a basic disease in itself; instead, it is a complication of the underlying venous thrombosis¹¹. On vascular ultrasound examination in the present case, thrombi were found in the common femoral vein as well as the right and left popliteal veins. From the echocardiographic examination, the presence of thrombi in the inferior vena cava and the right atrium was also found. The limitation of this case report was the unexplained etiology of hypercoagulability of this patient.

Clinical symptoms

The classical presentations of pulmonary embolism are pleuritic chest pain, sudden onset, shortness of breath, and hypoxia. However, most patients with pulmonary embolism have no apparent symptoms. Conversely, symptoms can vary from sudden hemodynamic collapse to progressive shortness of breath. A

diagnosis of pulmonary embolism should be suspected in patients with respiratory symptoms that cannot be explained by other alternative diagnoses¹².

One of these hemodynamic instability manifestations indicates a high-risk acute pulmonary embolism¹³: (1) cardiac arrest; (2) obstructive shock; and (3) persistent hypotension. In this patient, clinical symptoms included shortness of breath, tachycardia, chest pain, coughing, signs of inferior extremity DVT, tachypnoea, bilateral basal rhonchi, neck venous distention, minimal bilateral pleural effusion, and hemodynamic disorders. This patient had an obstructive shock, therefore, he was classified into a high-risk acute pulmonary embolism.

Management

All patients with pulmonary embolism need immediate risk stratification. Thrombolytic therapy should be given to patients with acute pulmonary embolism with clinical hypotension (systolic pressure <90 mm HG) who do not have a high risk of bleeding. Thrombolysis in these patients should not be delayed because of the potential for irreversible cardiogenic shock. Thrombolytic therapy is recommended in certain patients with acute pulmonary embolism indicating a high risk of hypotension at initial clinical presentation or after starting anticoagulants. Assessing the severity of pulmonary embolism, prognosis, and bleeding risk determines whether thrombolytic therapy can be given. Thrombolytic therapy is not recommended for most patients with acute pulmonary embolism that is not associated with hypotension¹⁴. Primary reperfusion therapy - in most cases systemic thrombolysis - is the treatment of choice for patients with high-risk pulmonary embolism (with hemodynamic instability). Surgical pulmonary embolectomy or percutaneous

Figure 5. Chest CT scan of the patient.

Figure 6. Transthoracic echocardiogram (TTE) showing protruded thrombus in the right atrium passes through the tricuspid valve.

Figure 7. Transthoracic echocardiogram (TTE) comparison showing the position of the thrombus moving from the inferior vena cava towards the right atrium.

catheter-directed treatment is an alternative reperfusion option in patients with contraindications to thrombolysis¹³.

Before conducting thrombolysis therapy, several absolute and relative contraindications must be considered. Absolute contraindications for thrombolysis are¹³: (1) history of hemorrhagic stroke or stroke of unknown cause; (2) ischemic stroke during the last six months; (3) neoplasms of the central nervous system; (4) major trauma, surgery or head injury in the past three weeks; (5) bleeding diathesis; and (6) active bleeding. While relative contraindications are: (1) transient ischemic attacks in the last six months; (2) the use of oral anticoagulants; (3) pregnancy or the first week postpartum; (4) non-compressible puncture sites; (5) traumatic resuscitation; (6) traumatic hypertension (systolic blood pressure > 180 mmHg); (7) severe/advanced liver disease; (8) infectious endocarditis; and (9) active peptic ulcer.

Acute right heart failure with low cardiac output is the leading cause of death in patients with high-risk acute pulmonary embolism. Long-term anticoagulation is very important for preventing the recurrence of DVT or pulmonary embolism, as even if a patient has been administered anticoagulants, DVT and pulmonary embolism still often recur. Apixaban, dabigatran, rivaroxaban, and edoxaban are alternatives to warfarin as the prophylaxis and treatment of pulmonary embolism. Apixaban, edoxaban, and rivaroxaban inhibit factor Xa, while dabigatran is a direct inhibitor of thrombin¹⁵.

All patients with pulmonary embolism must be given anticoagulants for more than three months. The use of novel oral anticoagulants (NOAC) is considered to have a lower risk of bleeding than vitamin K antagonists. However, treatment with NOAC still has risks. Phase III clinical trials in venous thromboembolic patients with extended therapy show that major bleeding rates are around 1% and clinically relevant non-major bleeding is around 6%^{16,17}.

In our patient, after the diagnosis of acute pulmonary embolism had been established, thrombolysis was the first choice. Reperfusion was carried out by giving a loading dose of 250,000 units of Streptokinase intravenously for 30 minutes, then followed by 100,000 units of Streptokinase per hour for 24 hours. Hemodynamic support was performed by giving Norepinephrine from 50 nanograms/kg/minute by titration.

Conclusion

We reported the case of a 37-year-old man with massive pulmonary embolism caused by a large protruded thrombus and dilated cardiomyopathy. The diagnosis of acute pulmonary embolism was based on clinical symptoms, hemodynamic changes, echocardiographic examination, and a chest CT scan. Unstable hemodynamic conditions classified this patient in the high-risk stratification. Hypotension or shock resulted from acute right ventricular dysfunction due to the obstruction of the pulmonary artery embolus, which caused an increase in right

ventricular afterload. Inotropic agents or vasopressors with Norepinephrine were needed to improve the hemodynamic profile. Successful revascularization was performed by thrombolysis with Streptokinase, which gave good outcomes in this patient. In conclusion, early diagnosis, risk assessment, and prompt treatment are important to treat patients with massive pulmonary embolism due to a large protruding thrombus. Hemodynamic deterioration, such as hypotension and shock, should be monitored in patients with massive pulmonary embolism to reduce mortality. Reperfusion therapy should be administered soon for patients with high-risk pulmonary embolism after assessing indication and contraindication for thrombolytic treatment. The problem with the current management of pulmonary embolism is when to start reperfusion therapy in patients with intermediate-high risk. Further research is needed to determine the right management and immediate prompt treatment in such patients.

Data availability

All data underlying the results are available as part of the article and no additional source data are required.

Videos

Video 1. Movement of the large protruding thrombus (1)

1 Data File

<https://dx.doi.org/10.6084/m9.figshare.13475550.v1>⁵

Video 2. Movement of the large protruding thrombus (2)

1 Data File

<https://dx.doi.org/10.6084/m9.figshare.13475721.v1>⁶

Video 3. Movement of the large protruding thrombus (3)

1 Data File

<https://dx.doi.org/10.6084/m9.figshare.13475760.v1>⁷

Video 4. Disappearance of large protruding thrombus after revascularization (4)

1 Data File

<https://dx.doi.org/10.6084/m9.figshare.13475799.v1>⁸

Video 5. Disappearance of large protruding thrombus after revascularization (5)

1 Data File

<https://dx.doi.org/10.6084/m9.figshare.13475844.v1>⁹

Consent

Written informed consent for publication of their clinical details and clinical images was obtained from the patient.

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Henry Sutanto

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In this case report, Dr. Susilo and colleagues reported a case of a man with pulmonary embolism (PE), right atrial (RA) thrombus and dilated cardiomyopathy (DCM). In general, the manuscript showed nicely the rapidly progressing PE into hemodynamic instability, which was immediately corrected following the administration of thrombolytic agent. However, I have some major and minor comments to be addressed by the authors, including the completeness of data.

- **Overall, the authors need to highlight the distinctiveness of this case, which is not well-defined in the current version of the manuscript.** It is currently unclear why this case is different than the other PE cases? The fact that one of the thrombi is located in the RA does help to stress the importance of this case report.
- **I would suggest the authors to arrange and discuss the data more systematically, and provide complete history and supporting data in the manuscript.** For example, the patient was diagnosed with diabetes mellitus and heart disease 1-month before admission. Which heart disease? What about the glycemic status prior to and after admission? Was the diabetes controllable?
- **The time course of clinical and laboratory parameters is lacking.** For example, it is currently unclear about the ejection fraction after discharge and during the follow-up visit? What about the hypercoagulable state and so on? These values are important to report in this manuscript.
- Here, the authors explicitly mentioned three observed phenomena in the title: 1) PE; 2) RA thrombus and 3) DCM. However, **the manuscript mainly focused on the PE and RA thrombus with a very limited discussion regarding DCM and its correlation with the other observed pathologies.** Please clarify the reason and adapt the discussion accordingly elaborating the potential interactions between those pathologies.
- In addition to the clinical presentations, please include the ECG recordings and other data

justifying the diagnosis of acute PE during the shock event.

- The authors are requested to speculate on the origin of the RA thrombus. Is it primarily from the RA or is it a migrating thrombus? Was there any evidence of situations facilitating thrombus formation, such as hypercoagulability, atrial fibrillation, tricuspid valve disease, and so on prior to the incident? Provide some supporting data (e.g., lab results, etc.).
- The authors mentioned that the etiology of hypercoagulability in this patient is unknown. However, laboratory results showing hypercoagulability were not reported. Please add them into the study. What about the link between diabetes and hypercoagulable state, which has been discussed by many other publications? Please discuss this.
- Was left ventricular (LV) noncompaction observed in this patient? Elaborate your arguments.
- The rationale of DCM diagnosis in this patient is unclear. The authors need to provide a table containing checklist of clinical, imaging, and genetic data supporting this diagnosis. The authors can benefit from the paper by Mestroni et al. (Eur Heart J. 1999)¹ or Mathew et al. (Echo Res Pract. 2017)².
- Please confirm the nature of DCM in this patient? Familial or acquired? Include the family pedigree if there is an evidence of inherited DCM.
- Patients with DCM have a high risk of sudden cardiac death. Please explain the reason why in this patient, implantable cardioverter defibrillator (ICD) was not (planned to be) implanted? Moreover, the patient was hypokalemic, which poses to a bigger risk for life-threatening cardiac arrhythmias. Please also clarify the approach has been done to fix this problem.
- The authors mentioned in the abstract that echocardiography showed dilation of all cardiac chambers. However, no quantitative assessment of the atrial diameter provided. Please add.
- I am still not sure why anti-tuberculosis drugs were prescribed while AFB test was negative? Is there any involvement of these drugs on the clinical presentation of the patient?
- What is the rationale of administering rivaroxaban in the patient prior to the hospital admission? Was that due to the DVT? Please speculate on the reason why thrombi still persisted after rivaroxaban therapy (perhaps could also be supported by patient's lab results)?
- In Figure 5, please add some details / labels on the abnormalities observed in the CT scan, including the location of thrombi in the pulmonary artery.
- Avoid using numbers 1), 2), 3) in the text. Convert them into words: first, second, etc. if necessary.
- In the abstract: "*We gave him ...*" please change into passive sentence similar to the rest of the manuscript.

- In the abstract: please add the administration route of streptokinase.
- Please convert the incidence of PE in six EU countries in the introduction into 1 in XXX. The way the authors reported the epidemiological data is not common.
- “*be better able to*” should be “*be able to better ...*”
- “*... determined quickly and accurately to reduce **patients’** mortality*”
- “*the patient had **undergone** a thrombectomy a month before ...*”
- “*SpO2 99% with 3 lpm nasal cannula*” should be “*3 liter per minutes oxygen via nasal cannula*”.
- “*moratality*” should be “*mortality*”

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Is the background of the case’s history and progression described in sufficient detail?

Partly

Are enough details provided of any physical examination and diagnostic tests, treatment given and outcomes?

Partly

Is sufficient discussion included of the importance of the findings and their relevance to future understanding of disease processes, diagnosis or treatment?

Partly

Is the case presented with sufficient detail to be useful for other practitioners?

Partly

Competing Interests: No competing interests were disclosed.

Reviewer Expertise: Cardiovascular disease, cardiogenetics, cardiac arrhythmias, arrhythmogenesis, inherited arrhythmia syndromes, computational modeling and bioinformatics.

I confirm that I have read this submission and believe that I have an appropriate level of

expertise to confirm that it is of an acceptable scientific standard, however I have significant reservations, as outlined above.

Author Response 27 Jan 2021

Citrawati Wungu, Airlangga University, Surabaya, Indonesia

Thank you for your review. We have made revision according to your suggestions. These are our explanations regarding the comments:

1. We have added the distinctiveness of this case, that this was a rare case of protruded thrombus in the right atrium passing through the tricuspid valve which position moving from the inferior vena cava towards the right atrium, causing a massive pulmonary embolism and dilated cardiomyopathy.
2. We have added the history and supporting data as suggested.
3. We have added the explanation of the ejection fraction which had not improved at the follow-up visit. Ejection fraction was not an indicator for discharge in such patient. We have stated in the last paragraph of discussion section that the limitation of this case report was the unexplained etiology of hypercoagulability of this patient.
4. In this case report we did not focus on the DCM. However, DCM increases the risk of intracardiac thrombus which causes hypokinetic condition (venous stasis), a part of Virchow's triad.
5. ECG in PE is less specific. The most common ECG finding in the setting of a pulmonary embolism is sinus tachycardia. S1Q3T3 is a specific pattern in PE, however, this pattern only occurs in about 10% of people with pulmonary embolisms and is similar to the ECG findings of a **left posterior fascicular block, or LPFB** (Mohammed and Elsayed, 2020).
6. It was a migrating thrombus from proximal femoral vein. The patient had a history of proximal bilateral femoral deep vein thrombosis (DVT) of the left inferior limb proven by ultrasonography examination and the patient had had a thrombectomy a month before his referral to the hospital. The complaints of swollen leg were slightly reduced at that time; however, had recurred again, accompanied by swelling on his right limb. He had no atrial fibrillation or tricuspid valve disease.
7. Endothelial abnormalities undoubtedly play a role in the enhanced activation of platelets and clotting factors seen in diabetes. Coagulation activation markers, such as prothrombin activation fragment 1+2 and thrombin-anti-thrombin complexes, are elevated in diabetes. The plasma levels of many clotting factors including fibrinogen, factor VII, factor VIII, factor XI, factor XII, kallikrein, and von Willebrand factor are elevated in diabetes. Conversely, the level of the anticoagulant protein C (PC) is decreased. The fibrinolytic system, the primary means of removing clots, is relatively inhibited in diabetes due to abnormal clot structures that are more resistant to degradation and an increase in plasminogen activator inhibitor type 1 (PAI-1). Increased circulating platelet aggregates, increased platelet aggregation in response

to platelet agonists, increased platelet contractile force (PCF), and the presence of higher plasma levels of platelet release products, such as beta-thromboglobulin, platelet factor 4, and thromboxane B(2), demonstrate platelet hyperactivity in diabetes (Carr, 2001). However, our opinion is that the extensive thrombosis condition in this patient was not solely due to his diabetes. Hypercoagulability conditions can be related to genetic disorders, for example: Factor V Leiden (the most common), Prothrombin gene mutation, deficiencies of natural proteins that prevent clotting (such as antithrombin, protein C and protein S), elevated levels of homocysteine, elevated levels of fibrinogen or dysfunctional fibrinogen (dysfibrinogenemia), elevated levels of factor VIII (still being investigated as an inherited condition) and other factors including factor IX and XI, abnormal fibrinolytic system, including hypoplasminogenemia, dysplasminogenemia, and elevation in levels of plasminogen activator inhibitor (PAI-1) (Khan and Dickerman, 2006; Jan, 2020). However, we acknowledge that the weakness of this case report was that we did not have data for any genetic abnormalities.

8. There were no signs of LV noncompaction in this patient. No family history data was obtained. The Echo result did not show any trabeculations.
9. No genetic data available. DCM was diagnosed based on clinical and structural abnormalities by echocardiography. We found large ventricular enlargement with global hypokinetic and reduced ejection fraction.
10. ICD is indicated in heart failure patients with reduced EF (EF < 35) and no improvements with optimal medical treatment based on GDMT (Ponikowski *et al.*, 2016). In this patient we found high burden intracardiac thrombus, thus it will be so dangerous for us to perform ICD. It can make the thrombus escape and migrate, thus we focus on the emergency and gave GDMT as the optimal treatment.
11. We have added atrial diameter as follows: LA mayor 6.4 cm, LA minor 4.7 cm; RA mayor 5.5 cm, RA minor 4.5 cm, RVDB 3.2 cm.
12. In the public health center, the doctor diagnosed the patient with clinical TB with negative AFB, however, in the course of the assessments in the hospital, no clinical, laboratory, or radiological signs of pulmonary tuberculosis were found, thus the patient was transferred to the cardiology ward.
13. Rivaroxaban was prescribed as a DVT therapy that has been known before by the referring doctor. Persistent thrombus may be due to the patient's hypercoagulability condition. However, we cannot give more specific conclusions regarding this matter due to limited data and laboratory examination results.
14. We have inserted the arrow to the figure. In manuscript we have stated that the CT scan showed right pulmonary artery embolism at ± 5.9 cm from bifurcation on the anterior side of the intermediate right bronchus.
15. We have made changes to the formatting as suggested.

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