pathological masses in that age group\(^4,5\). It is relatively rare in the pediatric population. The symptoms are nonspecific and, due to the rarity of this condition in pediatric patients, etiologies such as appendicitis, diverticulitis, and renal colic are more likely explanations for the clinical symptoms than is ovarian torsion. Ultrasound is the first-line imaging modality in any case of acute abdomen.

One study showed that ultrasound has a positive predictive value of 87.5% and a specificity of 93.3% for the diagnosis of ovarian masses, as well as having other advantages such as low cost, easy accessibility, and no radiation\(^6\). On gray-scale imaging, the affected ovary appears enlarged, increasing to up to 28 times its original size\(^7\). The diagnostic criteria for enlarged ovaries include an ovarian diameter of > 4 cm or volume > 20 mL in women of reproductive age and > 10 mL in postmenopausal women\(^8,9\). Cystic or solid masses can also be identified on ultrasound. Cysts can show wall thickening. Free fluid can be seen in the pelvic cavity. The twisted vascular pedicle is typically seen as an echogenic round or beaked mass with multiple concentric, hypoechoic, target-like stripes. It can also appear as an ellipsoid or tubular mass with internal heterogeneous echoes, depending on the plane of orientation. Although color Doppler typically shows the absence of arterial flow, the presence of arterial flow does not rule out the possibility of torsion, because the arteries are affected at a later stage and there can be arterial supply from the uterine arteries as well. The twisted vascular pedicle can give rise to the whirlpool sign on color Doppler.

Asymptomatic apical aneurysm of the left ventricle with intracavitary thrombus: a diagnosis missed by echocardiography

**Dear Editor,**

We report the case of a 63-year-old male, with a history of acute myocardial infarction (AMI) and angioplasty 10 years prior, who was asymptomatic at presentation. He stated that he had not undergone routine clinical follow-up and was therefore submitted to echocardiography for functional evaluation. Moderate dilation and dysfunction of the left ventricle (LV) were detected, although with limitation in the evaluation of the apex, without information on the presence of an aneurysm or thrombus. Coronary computed tomography angiography (CCTA) was performed in order to identify in-stent restenosis, and the images showed apparent subocclusion distal to the stent in the anterior descending artery (Figure 1A) and a large aneurysm with parietal thinning in the anterior/anteroseptal medial segments, septal/anterior apical segments, and apex of the LV. It was not possible to detect significant systolic ballooning, because there was a large thrombus lining the intracavitary portion and that was confused with normal wall thickness of the LV. The thrombus had an organized appearance, albeit without signs of calcification, and was markedly hypodense, with a fixed aspect and no contrast enhancement, which had likely made it difficult to identify in the initial (echocardiographic) assessment (Figures 1B and 1C).

Ventricular aneurysm is a serious complication of transmural myocardial infarction (occurring in 5–38% of cases), being the most common mechanical complication, typically evolving to physical limitations and having a negative impact on quality of life\(^1,4\). It is defined as myocardial ventricular wall thinning and dilation, with distinct margins, leading to akinesia or dyskinesia of one or more myocardial segments during ventricular contraction\(^1,2,5\). It typically affects the anteroapical region of the LV, because the blood supply of the anterior wall is highly

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http://dx.doi.org/10.1590/0100-3984.2016.0227

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**Figure 1. A:** CCTA with a reconstruction curve showing probable subocclusion downstream of the stent (arrow). **B,C:** Cardiac computed tomography of the heart in the longitudinal axial plane, in a pseudo-two-chamber view, showing the region of the LV aneurysm with marked thinning of the medioapical anterior wall (2 mm thick - orange) and normal thickness in the anterior basal segment. Note the large thrombus simulating normal wall thickness of the LV (green).
Letters to the Editor

Bouveret syndrome and its imaging diagnosis

Dear Editor,

An 84-year-old female patient with hypertension reported pain in the upper abdomen accompanied by immediate postprandial nausea and vomiting, without gas or stool elimination for three days. The physical examination showed that she was afebrile, with a distended abdomen, pain upon deep palpation of the upper abdomen, and no signs of peritoneal irritation. A conventional X-ray of the abdomen (Figure 1A) showed air in the duodenal region, suggesting the diagnostic hypothesis of a cholecysto-duodenal fistula.

Ultrasonography (Figure 1B) showed echogenic foci within the wall of the duodenum, with a distended duodenum in the duodenal bulb, suggesting the imaging diagnosis of Bouveret syndrome.

The diagnosis of Bouveret syndrome can be suspected on the basis of conventional X-ray findings, especially if the gallstone is impacted in the duodenum or the pyloric antrum. However, a more reliable diagnostic approach is through contrast-enhanced imaging of the upper digestive tract (Baran et al., 2003). Contrast-enhanced imaging of the duodenal bulb may show hyperdense foci within the duodenal bulb, suggesting the imaging diagnosis of Bouveret syndrome.

In conclusion, Bouveret syndrome is a rare cause of intestinal obstruction due to large-scale impaction of a gallstone in the duodenum. Therefore, a high index of suspicion and careful clinical evaluation are necessary to diagnose this condition.

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http://dx.doi.org/10.1590/0100-3984.2016.0199

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