A 60-year-old female presented to the outpatient clinic for atypical chest pain. She had a previous history of hypertension, diabetes mellitus and dyslipidemia. She also had a long history of chronic adrenal insufficiency as consequence of Cushing disease surgery. Her current medications included olmesartan, sitagliptin, metformin, simvastatin and prednisone. A cardiac computed tomography was requested (Panel A, C, E and G). No significant coronary artery stenoses were detected, however left ventricular analysis showed a marked hypertrabeculation. Thereafter, a cardiac magnetic resonance (Panel B, D and F) was performed. Hypertrabeculation (asterisks) was consistent with noncompaction cardiomyopathy. No myocardial fibrosis was detected by late gadolinium enhancement. Notably, both studies revealed a striking diffuse visceral lipomatous hypertrophy, including hypertrophy of the epicardial fat (yellow arrows). Interestingly, the epicardial fat splitted the ventricular septum (red arrows) producing a separation of both ventricles.

The patient had no familiar history of cardiomyopathies. The familial echocardiographic screening was negative. No arrhythmias were detected in a 24-hours Holter ECG recording. Chest pain episodes diminished and the patient was asymptomatic at 6-month follow up.

This is the first report of an epicardial lipomatous hypertrophy separating the ventricular septum. This also represents the first description of noncompation cardiomyopathy associated with lipomatous hypertrophy of the epicardial fat. The infrequency of both clinical entities suggests that this association probably is not a play of chance but rather that they might be linked by a unique unknown pathologic pathway.
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