HAS-BLED would allow clinicians to make an informed assessment of their individual patient's *potential* risk for bleeding per se (rather than guesswork) to be balanced against the stroke risk when management options are being considered.[108]

Conclusion

Substantial advances have been made in the field of stroke prevention in AF, including greater awareness of stroke and bleeding risk factors, as well in therapeutic options including better anticoagulation control with VKA therapy and the NOACs. All these new developments have driven a paradigm shift in offering effective stroke prevention (which is, oral anticoagulation), for AF patients with $\geq$1 stroke risk factors.

Thus, the practice shift recommended in the 2012 focused update of the ESC guidelines is timely, given the primary initial focus on identification of 'truly low-risk' patients with AF, instead of having undue emphasis with the identification of 'high-risk' patients. Once the 'truly low-risk' AF patients have been identified (who do not need any antithrombotic therapy), appropriate thromboprophylaxis can be offered to all other AF patients.

Conflict of interest: G.Y.H.L. has served as a consultant for Bayer, Astellas, Merck, Sanofi, BMS/Pfizer, Daiichi-Sankyo, Biotronik, Portola, and Boehringer Ingelheim, and has been on the speakers bureau for Bayer, BMS/Pfizer, Boehringer Ingelheim, and Sanofi Aventis.

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The list of references is available in the online version of this paper.

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Unusual aortic perforation after transcutaneous aortic valve implantation

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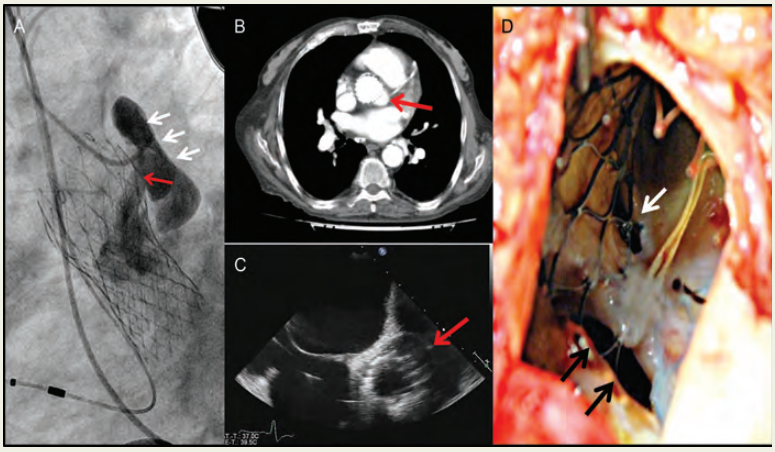

A 75-year-old patient was admitted for worsening of dyspnoea 10 months after transcatheter aortic valve implantation (26 mm CoreValve, Medtronic™). Echocardiography demonstrated an excellent function of the prosthetic valve. Since the patient's previous history included a coronary artery bypass surgery too, a diagnostic coronary angiography was performed to rule out graft failure. While approximating the ostia of the venous bypasses, the diagnostic catheter flapped through the integrity of the aortic wall. Contrast media was given carefully (*Panel A*, white arrows and Supplementary material online) revealing a para-aortic cavum. Computed tomography (*Panel B*) and transesophagealechocardiography (*Panel C*) confirmed the diagnosis of a false aneurysm. Despite the high surgical risk, surgery was considered mandatory. The intra-operative situs is shown in *Panel D* demonstrating the ostium of the left coronary artery (white arrow) and the ostium of the pseudoaneurysm (two black arrows). The regular position of the stent graft is shown in *Panel A* as well as the ostium of the false aneurysm (one red arrow). Surgical replacement of the CoreValve prosthesis by a mechanical valve and a Gore-Tex conduit was performed.

This is the first report of a false aneurysm of the ascending aorta most likely due to the friction of the commissures of the outflow part of the valve stent. Pre-procedural CABG had prevented overt rupture and, this way, had saved the patient's life.

Supplementary material is available at *European Heart Journal* online.