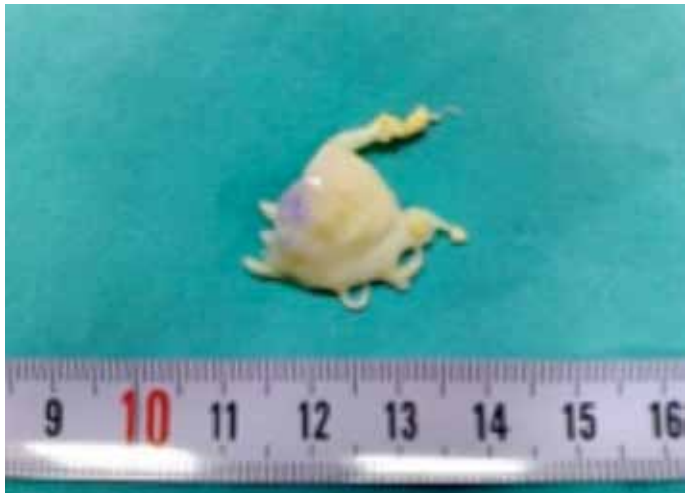

Şekil 3. Cerrahi sonrası çıkarılan P2 materyali izlenmektedir

dırıldı. Mitral kapak prolapsının ekokardiyografik incelemesinde mitral yapraklarındaki miksomatöz değişiklikler ve nodüler kalınlaşmaların mitral kapakta yalancı kitle imajına neden olabileceği ayırıcı tanıda düşünülmelidir.

Video 1: Transtorasik ekokardiyografi apikal dört boşluk görüntülemede mitral kapak posteriyor yaprakçığının ekojenitesi artmış kitle imajı izlenmektedir

Video 2: Transtorasik ekokardiyografi apikal dört boşluk renkli Doppler görüntülemede mitral kapakta ileri düzeyde mitral yetersizliği izlenmektedir

Video 3-5: Midözefagial görüntülemede mitral kapak posteriyor yaprakçığının ekojenitesi artmış kitle imajı izlenmektedir

Video 6: Midözefagial renkli Doppler görüntülemede mitral kapakta ileri düzeyde ekzantrik mitral yetersizliği izlenmektedir

Murat Sünbül, Tarık Kıvrak, Bülent Mutlu
Marmara Üniversitesi Eğitim ve Araştırma Hastanesi, Kardiyoloji Kliniği, İstanbul-*Türkiye*

Yazışma Adresi/Address for Correspondence: Dr. Murat Sünbül
Marmara Üniversitesi Eğitim ve Araştırma Hastanesi, Kardiyoloji Kliniği, Pendik, İstanbul-*Türkiye*
Tel: +90 216 625 47 19 Faks: +90 216 657 07 05
E-posta: drsunbul@yahoo.com.tr
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Differential clubbing in an adult patient with patent ductus arteriosus and small ventricular septal defect

Patent duktus arteriyosus ve küçük ventriküler septal defekti olan erişkin hastada diferansiyel çomaklaşma

A 27-year-old male patient was admitted to our clinic with advancing fatigue and dyspnea since last six months. On physical examination he was asthenic in appearance. No significant murmurs were heard on cardiac auscultation and lungs were clear. There was prominent clubbing of toes compared with fingers (Fig.1, 2). Oxygen saturation was 96-98% on fingers and 84-85 % on toes. Electrocardiography showed sinus rhythm with P pulmonale and huge R wave in V1 (Fig. 3). On echocardiography, left chambers were normal in size and function. Right atrium, right ventricle and pulmonary artery were dilated. Estimated systolic pulmonary artery pressure (SPAP) was 110 mmHg while simultaneous systemic pressure was 110 mmHg. Suprasternal images were not diagnostic for patent ductus arteriosus (PDA). However, PDA and Eisenmenger syndrome were suspected clinically and heart catheterization was planned. Heart catheterization revealed SPAP was 110 mmHg and aortic systolic pressure was 115 mmHg. On ventriculography, small ventricular septal defect was detected and aortography revealed large PDA (Video 1-2. See corresponding video/movie images at www.anakarder.com). There were oximetric step-up in right ventricle and pulmonary artery. Pulmonary vasoreactivity test with adenosine was negative. According to heart catheterization, patient was diag-

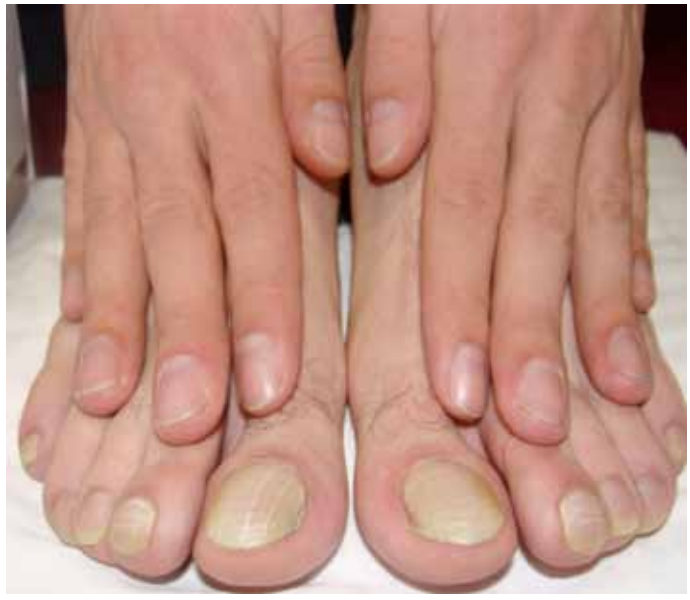

Figure 1. Prominent clubbing of toes compared with fingers

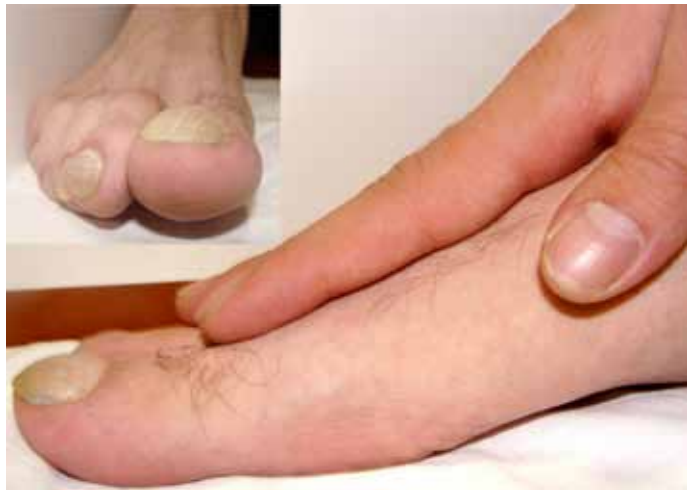

Figure 2. Note the bulbous enlargement of toes. Angle between nail plate and skin is lost

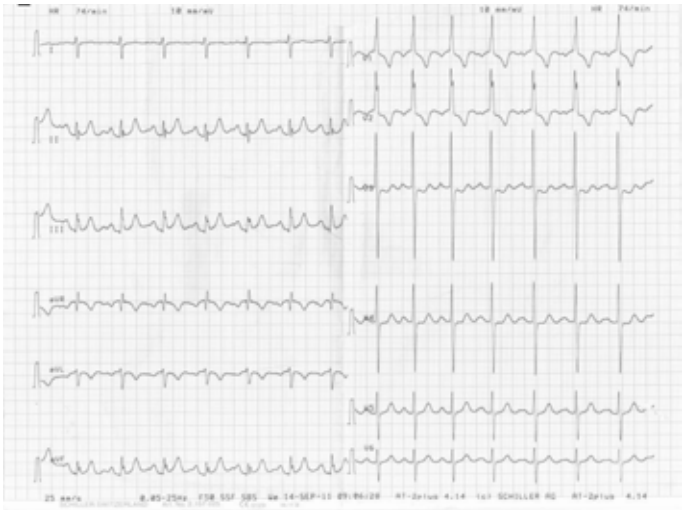

Figure 3. Electrocardiogram showing sinus rhythm with P pulmonale and huge R wave in V1 lead

nosed as large PDA, small ventricular septal defect and Eisenmenger syndrome. As in this case, differential clubbing and desaturation is an important diagnostic clue for PDA complicated with Eisenmenger syndrome where auscultatory and echocardiographic signs of PDA are diminished.

Serkan Duyuler, Pınar Türker Bayır, Omaç Tüfekçioğlu
From Clinic of Cardiology, Türkiye Yüksek İhtisas Hospital, Ankara-*Turkey*

Address for Correspondence/Yazışma Adresi: Dr. Serkan Duyuler
Türkiye Yüksek İhtisas Hastanesi, Kardiyoloji Kliniği, Sıhhiye, Ankara-*Türkiye*
Phone: +90 312 306 11 34 Fax: +90 312 312 41 20
E-mail: serkanduyuler@yahoo.com
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