Left atrial myxoma migrating to left ventricle in diastole

Diyastolde ventriküle geçen sol atriyal miksoma

A 46 years old female patient had progressive respiratory distress and palpitation in the last two months. On physical examination, the patient had 2/5 systolic murmur at mitral valve, pretibial edema (++) and the pulse rate was 110/min. Electrocardiography findings were as following: normal sinus rhythm, p mitrale at D1-2 aVR, t (-) at V1-6 derivations. Postero-anterior chest X-Ray demonstrated significant pulmonary conus and increase in cardiothoracic index. A left atrial mass originating from septum with a diameter 3.5x4.7 cm and grade 4 tricuspid valve insufficiency were determined by transthoracic echocardiography. Pulmonary arterial pressure was 140 mmHg. Patient underwent coronary angiography and ventriculography examinations. Coronary arteries were normal, however on ventriculography; a left atrial mass originating from septum and migrating to ventricle in diastole, and mitral valve insufficiency (grade 2) were detected (Fig. 1-2, Video 1. See corresponding video/movie images at www.anakarder.com).

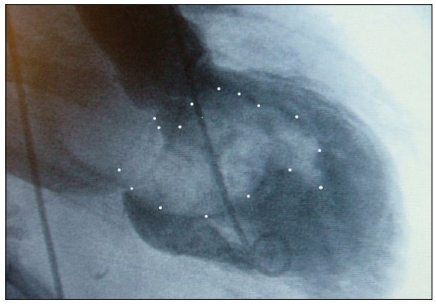

Figure 1. Ventriculography view of a left atrial mass during systole

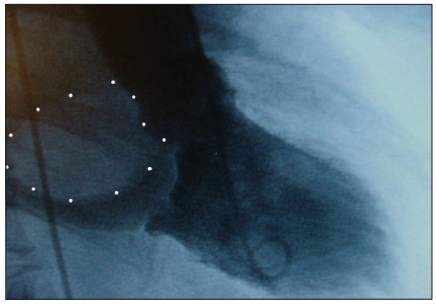

Figure 2. Ventriculography view of a left atrial mass migrated into left ventricle during diastole

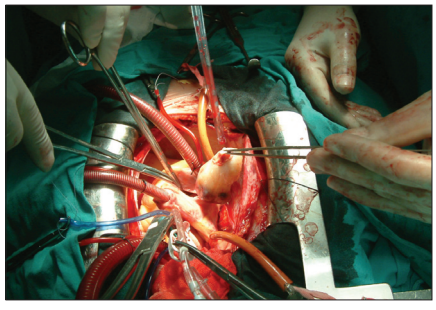

Figure 3. Intraoperative view of the 4.0x6.5 cm mass (myxoma) originating from atrial septum

The patient underwent an elective operation with aorta-bicaval cannulation into cardiopulmonary pump. We made right and left atriotomy and resected 4.0x6.5 cm mass from fossa ovalis with septum where it was clinging to (Fig. 3).

Pericardial patch was used to repair the septal defect. Mitral valve was found to be normal and the insufficiency on ventriculography was noted to be due to the migration of the mass. De-vega annuloplasty was applied to tricuspid valve. Atriotomies were closed, and the operation was completed without any complications. The patient was discharged on post-operative day 7. The pathological diagnosis was - myxoma.

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Repair of ascending aortic aneurysm in a patient with lipomatous hypertrophy of the interatrial septum

İnteratriyal septumda lipomatöz hipertrofi ile birliktelik gösteren assandan aort anevrizmasının tamiri

A 67-year-old female patient was referred to our clinic with increasing shortness of breath on exertion. The past medical history was unremarkable, except for obesity (weight, 90 kg) and atrial fibrillation. She was hemodynamically stable and her physical examination was normal. The echocardiographic examination revealed an ascending aortic aneurysm (AAA) with a diameter of 5.5 cm and a finger-like right atrial mass, suggestive of a right atrial tumor (Fig. 1).

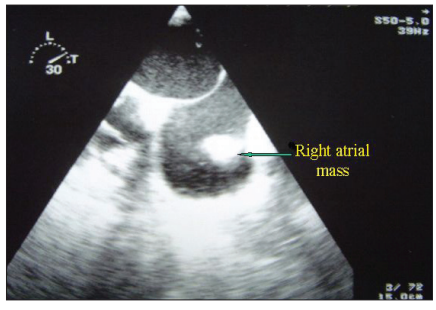

Figure 1. Echocardiographic view of right atrial mass

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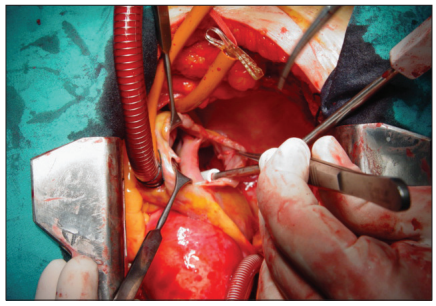

Figure 2. Operative view of right atrial mass and ascending aortic aneurysm

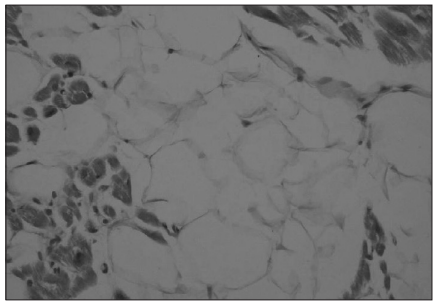

Figure 3. Histopathology showing accumulation of adipose tissue with mature adipocytes

A standard right atriotomy revealed a tumor (2.5 cm in diameter) arising from the interatrial septum and protruding into the right atrial cavity. The mass was extending superiorly and had a second attachment at the medial aspect of the superior cavo-atrial junction (Fig. 2). The tumor was completely resected due to its suitable anatomy (Video 1. See corresponding video/movie images at www.anakarder.com). The ascending aorta was completely transected above the sinotubular junction. A 28 mm Dacron graft was used to perform supracoronary ascending aortic replacement. Pathologic examination of the specimen revealed the typical pattern of lipomatous hypertrophy with large accumulation of adipose tissue (Fig. 3).

This is the first case reporting the combination of ascending aortic aneurysm and lipomatous hypertrophy.

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Abdominal aortic aneurysm with rupture into the inferior vena cava

Vena kava inferiyor'a rüptüre olan abdominal aort anevrizması

A 65-year-old man referred to our institute with an emergent situation. Physical examination revealed sinus tachycardia (130 beats/min), hypotension (90/35 mmHg), large pulsatile mass in abdomen, hemoglobin: 10.1 gr/dl. We considered abdominal aneurysm rupture and performed

Figure 1. Computerized tomography view of aorto-caval fistula

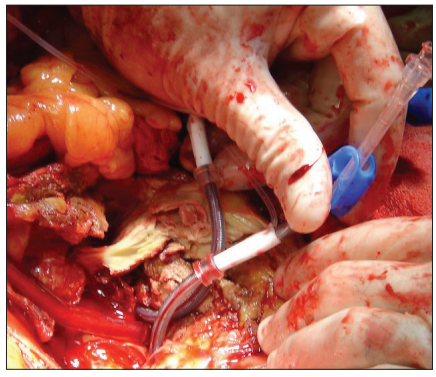

Figure 2. Intraoperative view of balloon expandable catheter

computerized tomography scanning. It showed juxta-renal abdominal aortic aneurysm (AAA) and long segment aorto-caval fistula (Fig. 1). The patient emergently was taken to operating room. Firstly, we opened abdomen and revealed big AAA (more than 10 cm), then we prepared aneurysm but we could not take it on cross-clamp inside abdomen. The incision was extended to thoracic level (9. cartilage) and we took on cross-clamp above diaphragm. When we opened aneurysm sac, suddenly and rapidly bleeding occurred, we controlled caval bleeding with balloon catheter and performed proximal aortic anastomosis with 18/9 aorta-iliac graft on renal arteries (Jotec Inc. Minnesota, USA). We took off aortic cross clamp and repaired caval injury with 2x8 cm. Dacron patch. Aorto-caval fistula is very rare complication of AAA and this pathology can be repaired with endovascular graft replacement. In this case, caval injury was in a long segment and we had to use Dacron patch for inferior vena cava. We used expandable balloon catheter for cessation of bleeding in this case. It was very useful and life saving procedure and we repaired tear of inferior vena cava without bleeding complications easily (Fig. 2).

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