mobile thrombus (2.4x2.5 cm) in the left atrial appendage (Fig. 1). The patient underwent surgery, which included removal of the thrombus from the left atrium and replacement of mitral valve with a 27-mm bileaflet mechanical valve. The patient was discharged without any complication.

Ligation of the left atrial appendage (LAA) is commonly performed during mitral valve surgery because of the LAA is a frequent site of clot formation in patients with mitral valve disease, especially in those with atrial fibrillation. We have reported a case of ball thrombus developed in a mitral stenosis patient with ligated left atrial appendage.

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A prominent Chiari network prolapsing into right ventricle

Sağ ventriküle prolabe olan belirgin Chiari ağı

A 42 years old male patient was referred to our clinic for palpitations. Physical examination revealed a low intensity systolic murmur at the mitral valve area. His heart rate was 65 beats/min and his blood pressure was 130/80 mm Hg. Electrocardiography showed sinus rhythm and normal axis. Echocardiography revealed a freely mobile, thin, filamentous structure in the right atrium, moving rapidly in and out of the right ventricle through the tricuspid orifice (Fig.1, 2, Video 1. See corresponding video/movie images at www.anakarder.com).

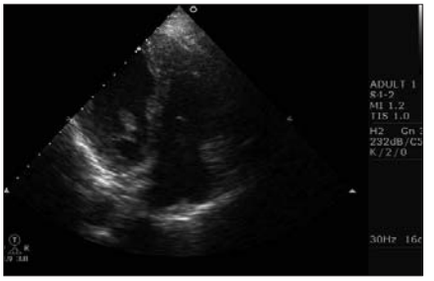

Figure 1. Echocardiographic view of Chiari network prolapsing through tricuspid orifice into right ventricle

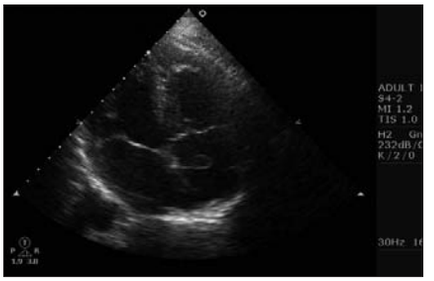

Figure 2. Echocardiographic view of Chiari network in right atrium

Chiari network is a congenital remnant of the right valve of the sinus venosus and first described by Hans Chiari in 1897. Its prevalence is estimated to be around 2% in the general population. Although Chiari network is often considered clinically insignificant it may be associated with persistence of patent foramen ovale, formation of atrial septal aneurysm, catheter entrapment, paradoxic embolism, infective endocarditis and atrial tachyarrhythmias. It also poses diagnostic difficulties during echocardiography where it could be confused with right atrial thrombi, tumors, right heart vegetations, flail tricuspid leaflet, or a ruptured chordae tendinae.

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Management of an enlarging pericardial cyst

Büyümüş perikardiyal kistin tedavisi

A 37- year old man was referred to our institution from another hospital. On his examination, an abnormal structure adjacent to the right cardiac border was detected on plain chest roentgenogram (Fig. 1). Computerized tomography (CT) revealed a round, homogenous mass with dimensions of 4x6 cm, which was adjacent to the right cardiac border (Fig. 2). Echocardiography demonstrated a cystic mass adjacent to the right atrium. According to these results; the mass was considered as a benign pericardial cyst and routine follow-up was decided. The patient was invited for medical evaluation in every three months. At the second year of follow-up, CT and echocardiography showed a gradual enlargement in the mass size up to 6 x 8.5 cm. The patient was found to have effort related angina, along with the mild compression of the mass on right atrium, which was detected by echocardiography. As a result; surgical excision of the mass was planned to relieve his symptoms and to rule out malignancy.

The patient underwent operation. Following median sternotomy, the mass was explored. It was a cystic structure, filled with clear yellow fluid and attached to the right side of the pericardium with a generous fat pad.

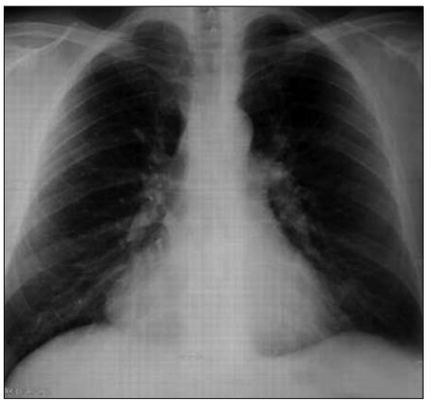

Figure 1. Chest X-ray image of a mass at the right cardiophrenic sinus

The fluid was aspirated first (Fig. 3). The cyst was totally excised with surrounding fat tissue (Fig. 4). Histological examination revealed a benign pericardial cyst, lined with a single layer of typical cuboidal mesothelial cells. The patient had an uneventful hospital course and was discharged at the 6th postoperative day.

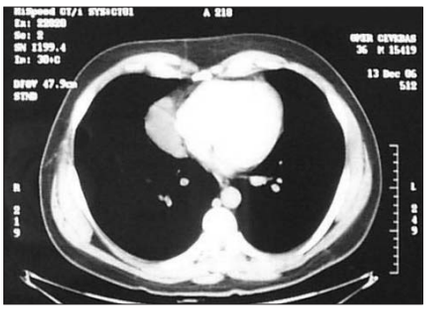

Figure 2. Chest-computed tomography scan showing a cystic mass at the right cardiophrenic sinus

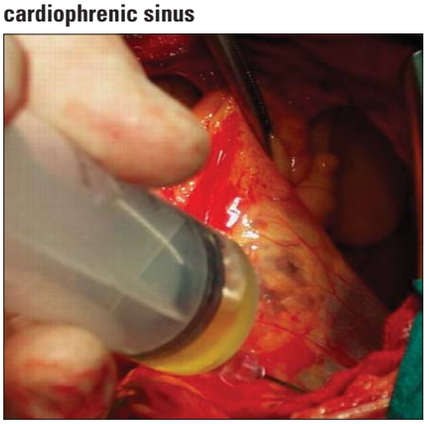

Figure 3. Intraoperative aspiration of the fluid within the cyst

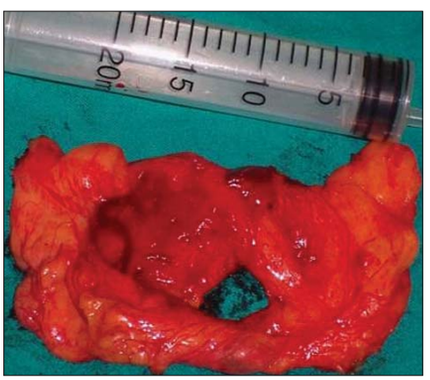

Figure 4. The gross view of the excised cyst, with the fat pad around it

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Giant aneurysm of the ductus arteriosus

Dev duktal anevrizma

Aneurysm of ductus arteriosus (ADA) is characterized by a localized saccular or tubular dilatation of the ductus arteriosus and is a rare lesion that can be associated with sever complications such as thromboembolism, rupture, infection, erosion, compression of adjacent structure and death. Although there were many reported adults and children with symptoms related to ADA, recently published case reports suggest that congenital ADA may be more common than observed postnatally, with the majority of affected fetuses being asymptomatic at birth.

Diagnostic tools are transthoracic and/or transesophageal echocardiography, digital subtraction angiography (DSA), magnetic resonance imaging (MRI), 3D computed tomography (CT) scanning on clinically suspected patients.

Although regression of ADA after indomethacin treatment was clearly demonstrated by 3D CT scan, because of critical location and the high incidence of complications, it should be surgically corrected when diagnosed.

In patients with patent ductus arteriosus (PDA) infective endarteritis is an important reason for hospital admission, with a higher incidence of 4,8 patients / 1000 hospital admissions in children aged < 16 years admitted to a pediatric cardiology referral center.

Previously healthy 13 year-old boy was referred to the hospital for a high fever and poor general condition. Physical examination and l aboratory studies showed stenotic bicuspid aortic valve, dilatation of the ascending aorta, discrete coarctation at the isthmic localization, PDA, aneurysmatic structure at the posterior of ascending aorta and endarteritis with no vegetation at any localization (Fig. 1). Surgical

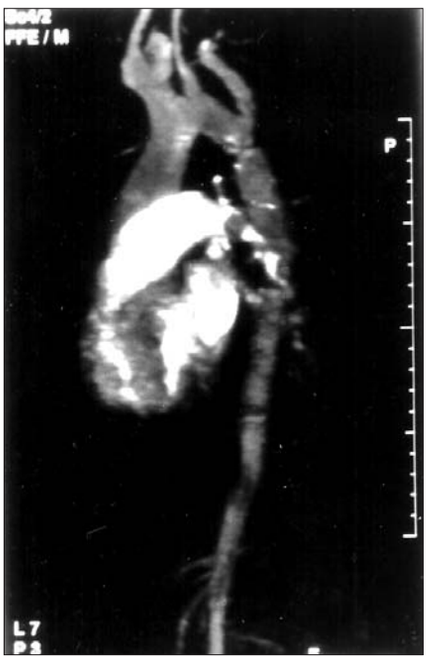

Figure 1. Left lateral digital subtraction angiography (DSA) view of the aneurism. Note the visualization of main pulmonary artery, aneurysm, isthmic coarctation and post-coarctational aortic dilatation when contrast medium was given at the isthmic localization of the aorta