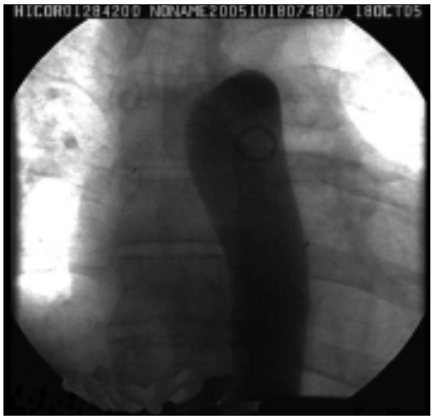

Figure 1. Severe coarctation of aorta diagnosed during injection of the contrast agent in the descending aorta

Figure 2. Coronary angiography showing left anterior descending coronary artery and circumflex coronary artery lesions (arrows)

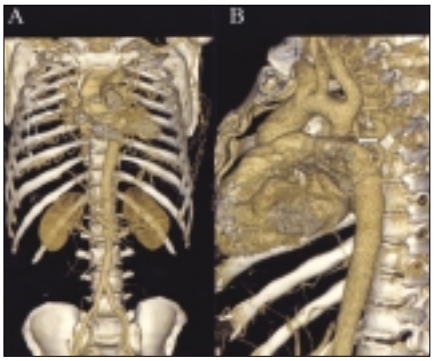

Figure 3. Computerized tomographic angiography images showing collateral arteries (A, arrows) and coarctation of aorta (B, arrow)

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Calcified giant congenital non-coronary sinus Valsalva aneurysm ruptured into the left ventricular outflow tract

Sol ventrikül çıkış yoluna rüptüre olan konjenital sinus Valsalva anevrizma olgusu

A 42-year-old man with a six-month history of congestive heart failure (NYHA II) was referred to our hospital for evaluation. A calcified giant sinus Valsalva aneurysm (ASV) was detected with transesophageal echocardiography (TEE), computed tomography (CT) and angiography (Fig.1-2, Video 1. See corresponding video/movie images at www.anakarder.com). The aneurysm extended for 8.5 cm in length including the ascending tract, the arch and the descending tract of the aorta. Moreover, severe aortic valve regurgitation and mild mitral and tricuspid regurgitations have been noticed.

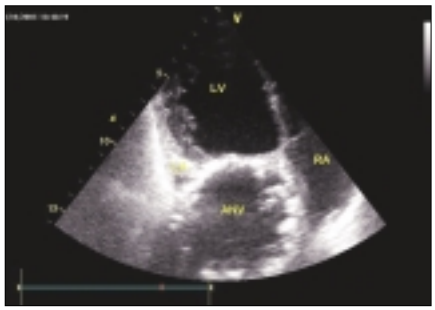

Figure 1. The echocardiographic view of the sinus of Valsalva aneurysm

ANV- aneurysm of sinus Valsalva, LA- left atrium,
LV- left ventricle, RA- right atrium

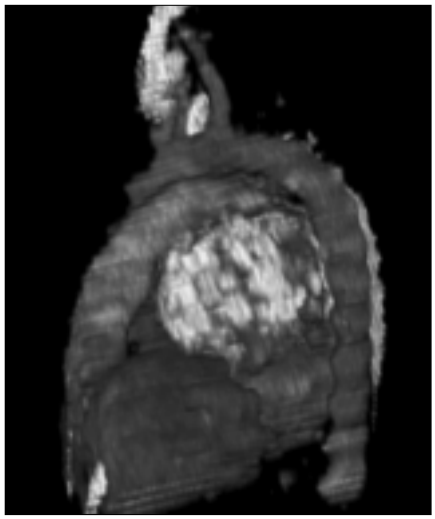

Figure 2. A giant calcified aneurysm completely filling space between ascending aorta, descending aorta and pulmonary artery is seen on computed tomography

During the operation (Fig.3), a 0.3x1.0 cm defect was found in the non-coronary sinus communicated with aneurysm. Degeneration of non-coronary leaflet, presumably caused by aortic regurgitation, was seen. A Gore-Tex patch was used to close the outlet of the aneurysm at the non-coronary sinus. A metallic aortic valve was replaced. Before the weaning of the cardiopulmonary bypass, a severe mitral regurgitation was noticed on the control TEE. Therefore, a metallic

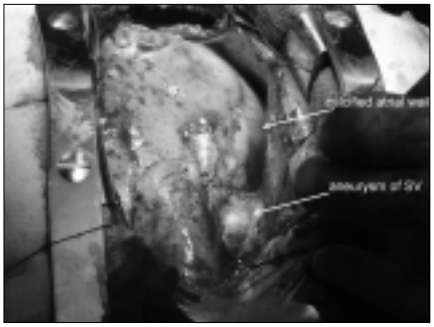

Figure 3. Intraoperative view of a calcified aneurysm right to the aorta. Advanced calcification is seen through the right and left atrial walls

mitral valve replacement was replaced. Further complications including an important hemorrhagic diathesis reliably caused by long cross-clamping time (260 minutes totally), occurred and lead to the death of a patient.

We describe our experience in the therapeutical management of a calcified ASV. We believe that the calcification of aneurysm wall is a factor that could contribute to increase mortality rate.

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Coronary to pulmonary artery fistula associated with significant coronary atherosclerosis

Ciddi koroner aterosklerozun eşlik ettiği koroner arter fistülü olgusu

A 47-year-old man with history of smoking was admitted to our institution having exercise dyspnea and substernal chest pain for 3 months. He had no history of cardiac disease or trauma and his physical examination was normal. The 12-lead electrocardiogram revealed T wave inversion in leads V4–V6. The exercise treadmill stress test showed ST depression of 1.5 mm in leads V1-6. Coronary angiogram demonstrated a coronary artery fistula (CAF) originating from the proximal left anterior descending coronary artery superior to a critical atheromatous stenosis (Fig. 1), draining into the pulmonary artery (Fig. 2. Video 1. See corresponding video/movie images at www.anakarder.com). The patient was planned to undergo coronary surgery.

Among coronary vessel anomalies CAF is the rare entity(1). Although it is suggested that coronary arterial atherosclerosis affects patients with CAF in the same way as in normal humans (2); the combination of fistula and significant obstruction of the same coronary artery is by far a less frequent phenomenon (2-3). Myocardial ischemia resulting from fistula steal phenomenon cannot be clinically distinguished from that of coronary atherosclerosis, if these conditions coexist in the same patient. Although noninvasive imaging may facilitate the diagnosis and identification of the origin and insertion of CAF, coronary angiography is necessary to show the presence of concomitant atherosclerosis (4).

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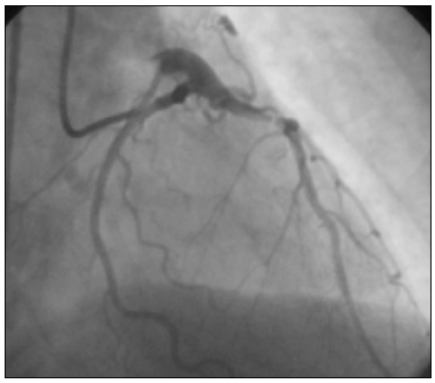

Figure 1. A coronary artery fistula is originating from the proximal left anterior descending artery

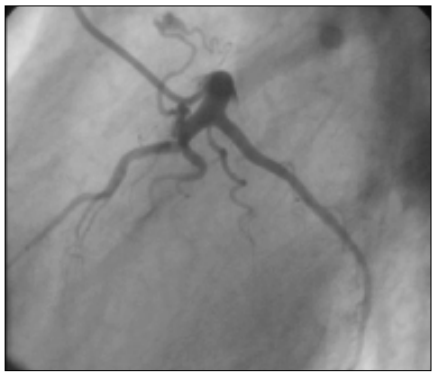

Figure 2. The coronary artery fistula is draining into the pulmonary artery

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Aortopulmonary window associated with anomalous right coronary artery: a rare combination

Anormal sağ koroner arter ile aortopulmoner pencere birlikteliği görüntülenmesi

A 4-month-old boy was admitted to our department with dyspnea and clinical findings of congestive heart failure. He had no family history of cardiac disease and consanguineous marriage. At prenatal period, he had no risk factor for developing congenital heart disease. On