

mimicking ventricular tachycardia. Electrophysiological study provided the definitive diagnosis and treatment.



Figure 3. Intracardiac ECG showing successful ablation (arrow)
ECG - electrocardiogram



Figure 4. ECG showing minimal preexcitation before ablation (left) and normal conduction after ablation (right)
ECG - electrocardiogram

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Incidental finding on coronary multidetector CT angiography; a quadricuspid aortic valve

Koroner multidetektör BT anjiyografide rastlantısal bir bulgu; kuadriküspit aort kapağı



A 46-year-old male patient was referred to our radiodiagnostic center for coronary multi-detector computerized tomographic angiography (MDCTA) to evaluate his atypical chest pain. He had history of hypertension, smoking and family history of coronary artery disease. His ECG was normal and echocardiography revealed mild aortic insufficiency.

The patient underwent 64-detector MDCTA. His coronary anatomy was normal. Interpretation of his images revealed the presence of quad-

ricuspid aortic valve (QAV) with 4 equal-sized, symmetric and morphologically normal cusps (Fig. 1), classified as type A according to Hurvitz and Roberts' description.

Subsequently, quadricuspid structure of the aortic valve with accompanying mild aortic insufficiency was demonstrated with echocardiographic reevaluation (Video 1-2. See corresponding video/movie images at www.anakarder.com). Aortic regurgitation was interpreted from the central coaptation line of 4 cusps. (Fig. 2).

QAV, as a very rare disorder even that may be missed by transthoracic echocardiography, should be kept in mind in MDCT interpretations which is a good modality to evaluate semilunar valves' rare morphological disorders.

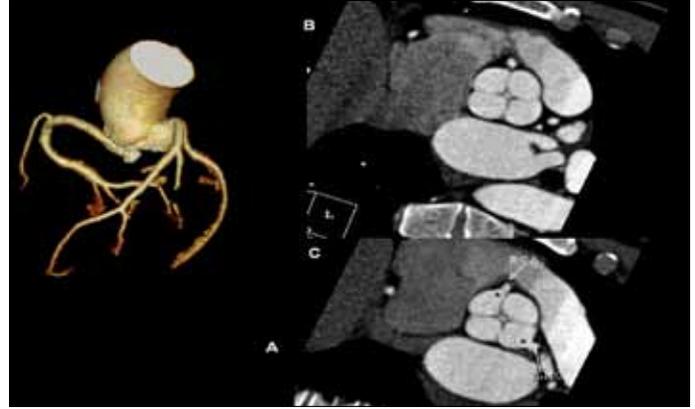


Figure 1. A) Coronary anatomy of the patient, B) Quadricuspid morphology of the aorta, C) Coronary ostiums

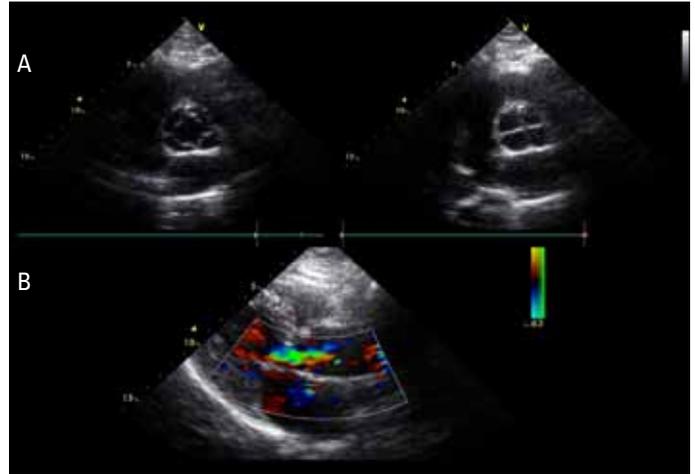


Figure 2. A) Quadricuspid morphology of aortic valve in transthoracic echocardiography, B) Aortic insufficiency in transthoracic echocardiography

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