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Giant coronary sinus of Valsalva aneurysm

A 29-year-old female was admitted to our hospital with nonspecific chest pain and dyspnea. Physical examination revealed systolic murmur. Laboratory findings were unremarkable. Transthoracic echocardiography revealed a cystic mass adjacent to the right atrium and ascending aorta that was believed to be a large aneurysm of right

coronary artery (RCA). Coronary computed tomography angiography (CTA) showed a relatively thin neck, bilobed, and giant aneurysm originating from the anterior right side of sinus of Valsalva, which measured 9 × 5 cm in diameter. There was eccentric calcification on the aneurysm wall. The aneurysm impressed the right ventricle and atrium and minimally displaced RCA (Fig. 1). These findings were confirmed with the catheter angiography (Fig. 2).

Sinus of Valsalva Aneurysm (SVA) is a rare entity that is most frequently observed in the right sinus. Associated cardiac anomalies are observed in most cases such as ventricular septal defect. It is usually asymptomatic if unruptured. In cases with ruptured SVA, fatal complications can be observed. Endovascular or open surgery is the choice of treatment.

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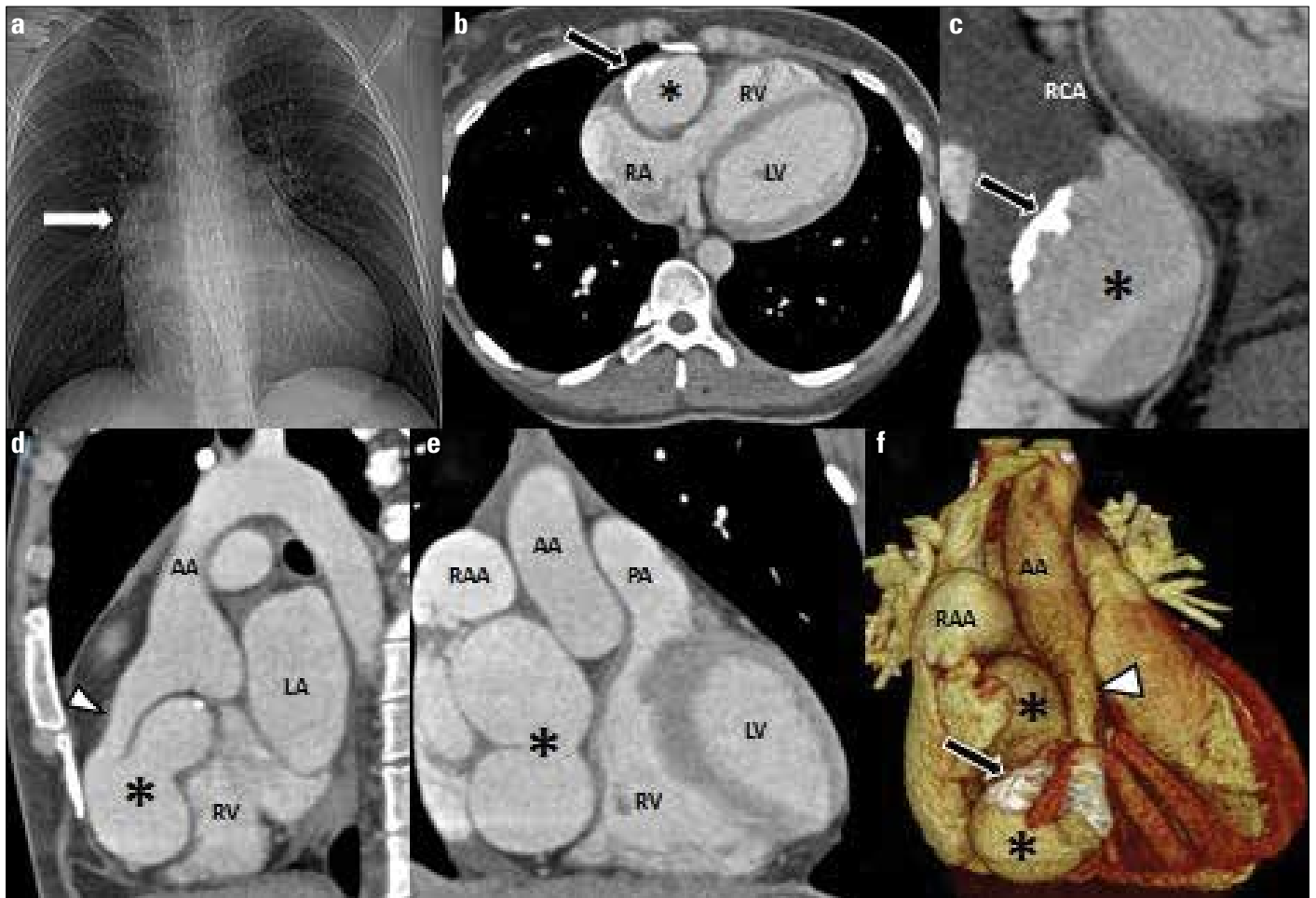


Figure 1. a-f. (a) Enlargement of the right hilum (arrow). (b) Axial CTA image shows SVA (*) and wall calcification (arrow). (c) Displaced RCA. (d) Sagittal and (e) coronal images show SVA with the adjacent structures and aneurysm neck (arrow head). (f) 3-D-CTA image shows orientation of the SVA

AA - ascending aorta; LA - left atrium; LV - left ventricle; PA - pulmonary artery; RAA - right atrial appendage

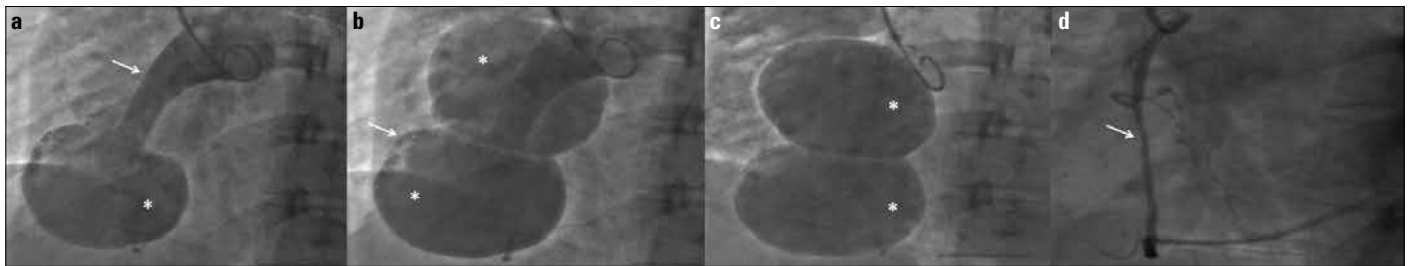


Figure 2. a-d. (a) Aortic angiography shows an aneurysm neck (arrow) and first sac (*). (b) Double sac (*) and aneurysm wall calcification (arrow). (c) Giant SVA (*). (d) Displaced RCA (arrow)

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Rapidly growing fungus ball on prosthetic valve: *Candida albicans* endocarditis

A 58-year-old woman presented with recent history of fever. She had history of prosthetic aortic and mitral valve implanted four years ago. Blood cultures were negative and transesophageal echocardiography (TEE) detected a large mass within the mitral prosthesis (Fig. 1a, Video 1). After seven days under antibiotherapy, repeated TEE revealed rapidly growing giant vegetation within the valve leaflets (Fig. 1b-d, Video 2, 3). Surgery was performed and rejection material showed fungus ball (Fig. 2a). Cultures and histopathological examinations (Fig. 2b, 3a, b) were positive for *Candida albicans*.

Candida albicans is one of the most important fungal pathogens, caused prosthetic valve endocarditis in our case, with predisposing factors such as major operations, prosthetic material, total parenteral nutrition, broad-spectrum antibiotics, diabetes mellitus, and immunosuppression. Our patient had parenteral nutrition and broad-spectrum antibiotics. A combination of surgical resection and antifungal drug therapy is the Gold standard for treatment.

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Video 1. Second transesophageal echocardiographic view at 0+

Video 2. X plan transesophageal echocardiographic view at 0+ and 90+

Video 3. 3-D transesophageal echocardiographic view at surgical position

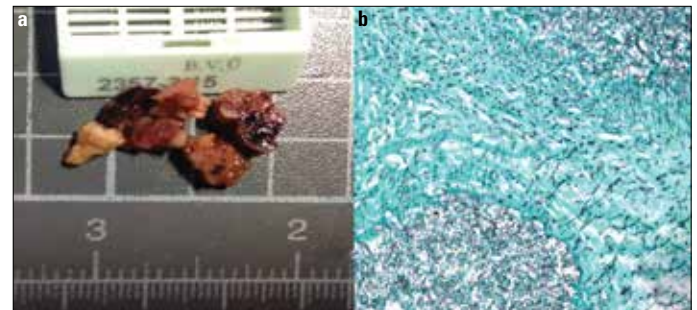


Figure 2. a, b. (a) Macroscopic view of fungus ball. (b) Histopathological view at 200x using Gomori methenamine silver staining for *Candida albicans*

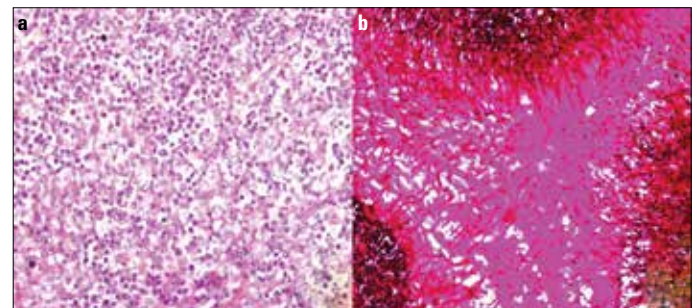


Figure 3. a, b. (a) Histopathological view at 200x using hematoxylin and eosin stained tissue section showing *Candida albicans* spores. (b) Histopathological view at 200x using periodic acid-Schiff staining for *Candida albicans* spores and hyphae

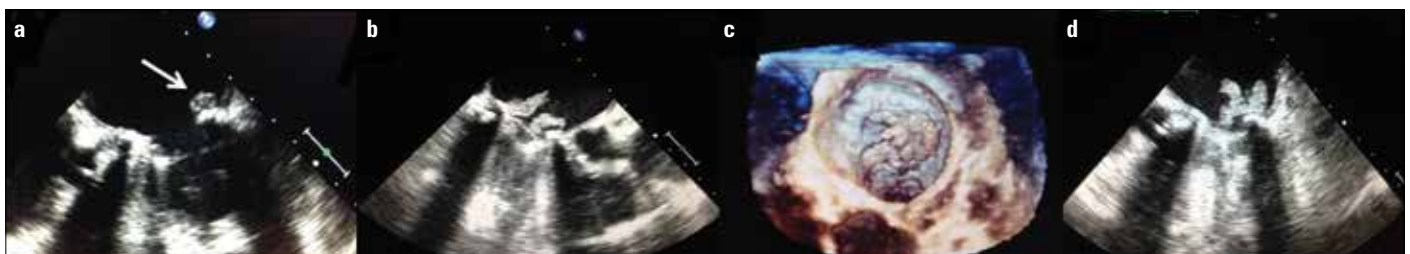


Figure 1. a-d. (a) White arrow shows first transesophageal echocardiographic exam at 20+. (b, d) Second transesophageal echocardiographic exam at 120+ & 20+ (c) 3-D transesophageal echocardiographic exam