dilatation were observed (Fig. 1C). Moreover, aortic root was found to be smaller than the arch of aorta, and measured to be 2 cm at the sino-tubular junction (Fig. 1D-F). On catheterization, a peak-to-peak gradient of 70 mmHg was found at the level of pulmonary infundibulum (Fig. 1E). Surgical operation was planned for the symptomatic severe aortic stenosis and pulmonary stenosis. Aortic root was repaired using a synthetic graft and mechanical prosthetic valve replacement was done. Muscular resection and repair with a pericardial patch were performed for pulmonary infundibular stenosis. The post-operative follow-up was uneventful, and he was discharged one week later.

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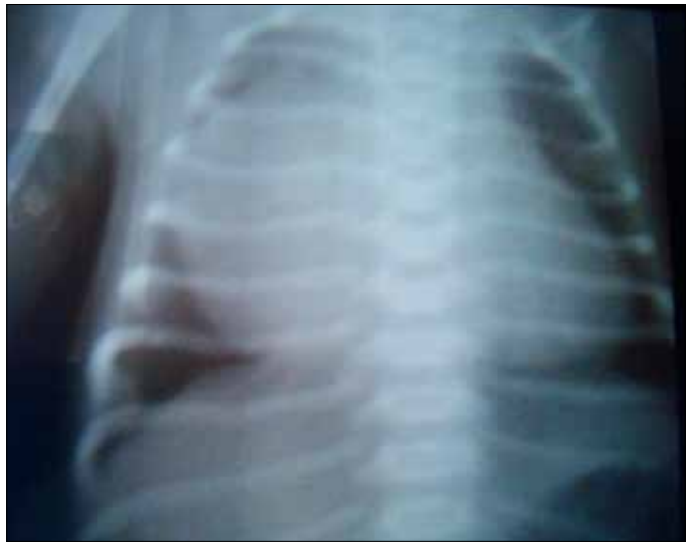

Figure 1. Chest X-ray postero-anterior view depicting gross cardiomegaly with normal lung fields

Congenital giant aneurysm of the right atrium

Doğumsal dev sağ atriyum anevrizması

A seven days old asymptomatic male neonate was referred to our center for evaluation of a heart murmur detected on routine physical examination. Vital signs were entirely normal. Cardiovascular examination revealed a normal first and second heart sound and a grade 2/6 systolic murmur at the left lower sternal border. The 12-lead electrocardiography showed regular sinus rhythm with normal right ventricular predominance. The P wave was normal. A chest radiography showed marked cardiomegaly with normal pulmonary vascularity (Fig. 1). A two- dimensional echocardiogram showed normal segmental anatomy. The right atrium was extremely dilated (Fig. 2), with an area of 14 cm^2, for a left atrial area of 2.1 cm^2. An atrial septal defect of 8 mm with left -to -right shunt was present. The tricuspid valve annulus measured 1.3 cm without stenosis, nor apical displacement. There was a trivial tricuspid incompetence with a pressure gradient of 25 mmHg. The rest of the echocardiography was normal. Angiography was done and revealed no additional information. There was slow flow inside the aneurysm with no evidence of thrombus. Treatment with aspirin as an antiplatelet agent was initialized.

Giant aneurysm of the right atrium is a very rare cardiac anomaly of unknown origin. Right atrial aneurysms may be asymptomatic, however, some patients come to medical attention because of arrhythmias or intracavitary thrombi. To prevent potential arrhythmias and thromboembolic complications, the patient was scheduled for early surgical reduction of the right atrium and closure of the atrial septal defect on elective basis. The atrium was opened through the aneurysm and the atrial septal defect was closed by direct suture. The aneurysm was completely excised and the anterior right atrial wall was reconstructed with a patch of autologous pericardium. Pathologic examination of the resected tissue showed extreme wall thinning, absence of the myocardium, central aneurismal formation and focal endocardial fibrosis consistent with idiopathic dilatation of the right atrium. The post operative course was uneventful; the child was discharged home on the 5th post-operative day.

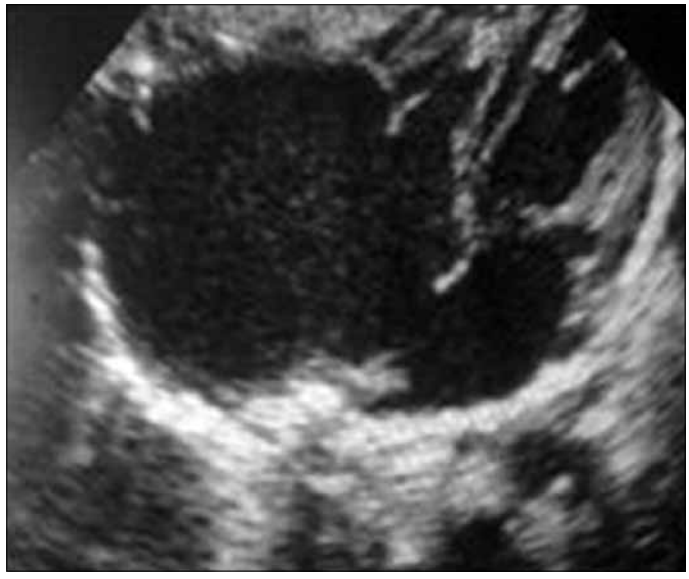

Figure 2. Apical 4-chamber echocardiographic view of a massive RA aneurysm
RA - right atrium

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