cross-sectional area of 93×98 mm and formation of inner arterial wall thrombus that compressed the trachea and esophagus, causing displacement of the esophagus and tracheal stenosis. Three original arterial bifurcation branches from the aortic arch were initiating from the aortic pseudoaneurysm, with the proximal part of the left common carotid artery narrowing down (Fig. 1a, 1b).

Statistically, spontaneous giant pseudoaneurysms seldom occur in patients without a history of operation, trauma, or hypertension; however, the patient in this case developed suppression of the trachea with a 2-month history of lasting thoracic pain. Because the patient lived in a remote area, he did not seek any form of regular treatment during the 2 months, which may have resulted in the huge spontaneous pseudoaneurysm. Surgery is the first-line treatment for spontaneous pseudoaneurysm, whereas interventional occlusion can also be used when surgery is not possible (1). Unfortunately, despite the large number of possible convenient and efficient therapeutic remedies, the patient and his family denied any form of treatment. During a telephonic follow-up, we found that the patient had died the same day of hospital discharge.

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An unusual cause of aortic regurgitation: accessory mitral valve

Accessory mitral valve (AMV) is a rare congenital cardiac anomaly that has been reported in 1 in 26,000 people in an echocardiography series. Most cases of AMV are associated with other cardiac abnormalities. Although patients with AMV are usually asymptomatic, syncope, exercise intolerance, and chest pain are described in patients with left ventricular outflow (LVOT) obstruction. Here we present the case of an asymptomatic child with a diagnosis of AMV using transesophageal echocardiography (TEE) images.

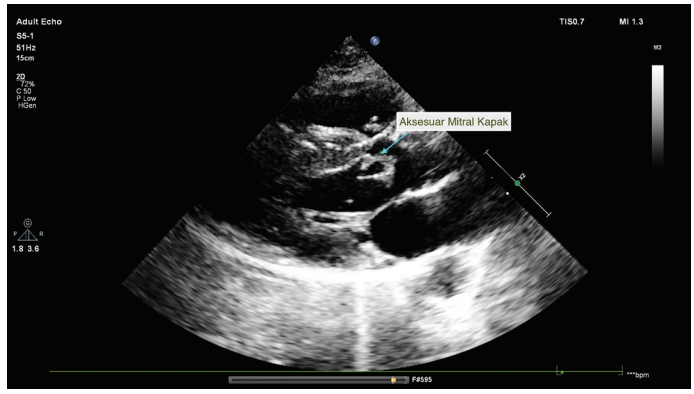

Figure 1. There is an accessory mitral valve image in TTE window

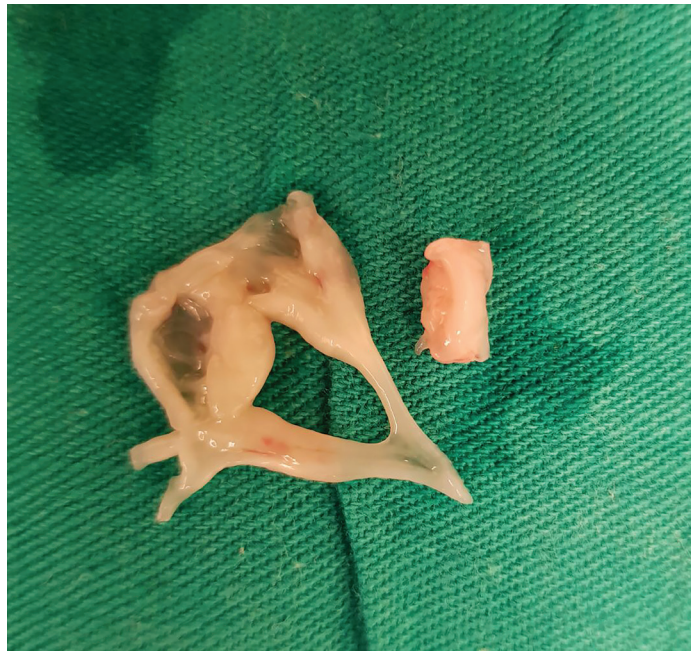

Figure 2. Post- operative photo of the accessory mitral valve

A 17-year-old boy was diagnosed with suspected AMV during the evaluation of a cardiac murmur. Because he had no other associated anomalies, aortic regurgitation (AR), or LVOT obstruction, he had been followed up for 8 years by serial transthoracic echocardiography. However, the last echocardiography revealed a mild AR. Therefore, TEE was performed to confirm the diagnosis. AMV was clearly demonstrated without LVOT obstruction (Fig. 1 and Video 1). Surgical excision of AMV was performed because of new development of AR (Fig. 2). There was no AR and mitral regurgitation in the postoperative period.

Surgical excision of AMV has some difficulties and can be complicated because after initiation of cardiopulmonary bypass,

the redundant tissue is not clearly seen, making it mandatory to perform ventriculotomy. Furthermore, intraoperative TEE is strongly recommended to prevent mitral valve damage in such patients.

In conclusion, this case was presented because of its rarity. We emphasize that AMV should be kept in mind in patients with AR.

Video 1. Scene of the accessory mitral valve in TEE window.

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