ing from a part posterolateral branch and continued to be an extension of this artery to form a mesh of small collaterals, which opacified the pulmonary artery branches (Video 1. See corresponding video/movie images at www.anakarder.com). After PEA, he was asymptomatic and pulmonary hypertension relieved. These fistulas may be considered as collaterals to perfuse the occluded or narrowed pulmonary arteries.

Video 1: Right coronary angiogram at AP cranial view demonstrated dual coronary artery fistulas originating from the conus branch and posterolateral branch of RCA and parallel running along lung territory with multiple drainage sites

AP - antero-posterior, RCA - right coronary artery

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Broken guidewire during primary percutaneous coronary intervention

Primer perkütanöz koroner girişim sırasında kopan kılavuz tel

A 68-year-old female patient was admitted to emergency room with acute anterior myocardial infarction. Her coronary angiography revealed an acute total occlusion in the ostial segment of the left anterior descending coronary artery (LAD) (Fig. 1). The lesion was successfully crossed with a floppy guidewire (Fig. 2) and then predilated with balloon. Because of the close proximity of the lesion to the left main coronary artery (LMCA), a second guidewire was tried to send to the left circumflex artery (CX). The tip of the guidewire became curved while trying to pass the CX. Then it was thought to change the guidewire with another one. The tip of the second guidewire was broken inside the guiding catheter while pulling back but it was not understood during the procedure. Then another guidewire was passed to CX. A bare metal stent was sent to the lesion in LAD. When the stent arrived to the lesion area, the broken tip of the guidewire was seen at the end of the stent as a ring and entrapped over the culprit lesion (Fig. 3). The stent was crossed within

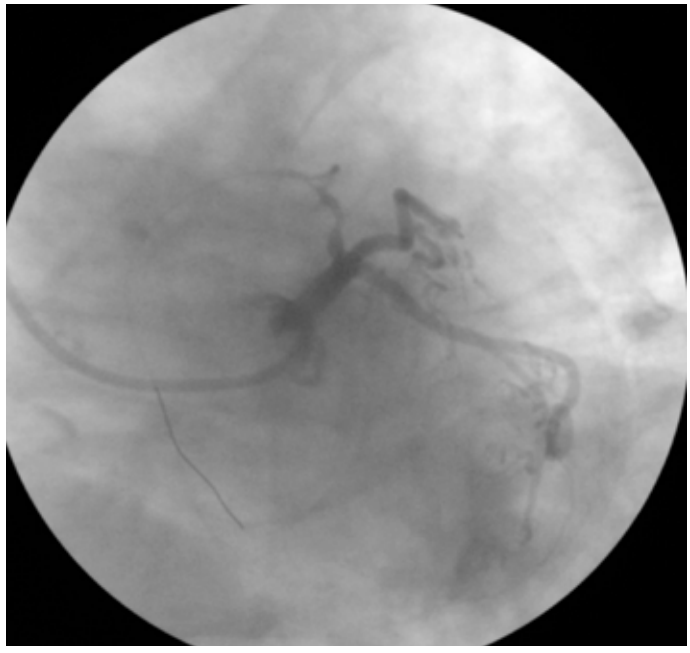

Figure 2. The totally occluded lesion of the left anterior descending coronary artery was successfully crossed with a floppy guidewire

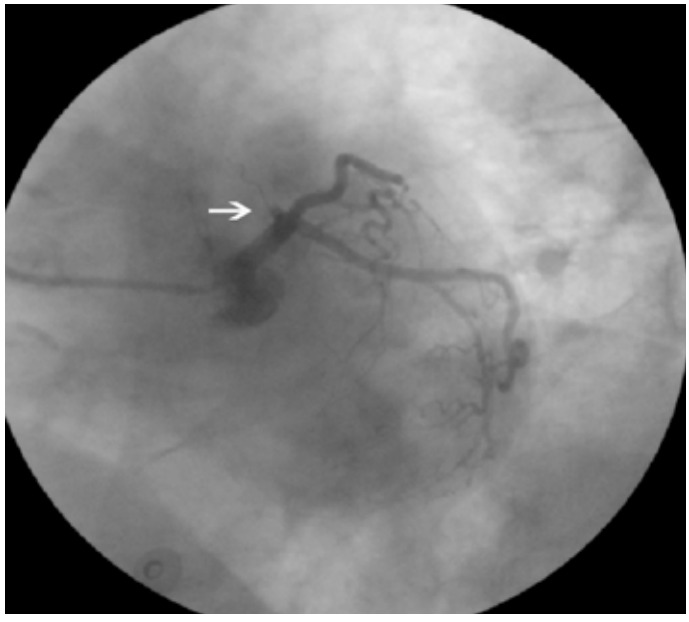

Figure 1. The left caudal coronary angiographic image shows totally occluded left anterior descending coronary artery (white arrow)

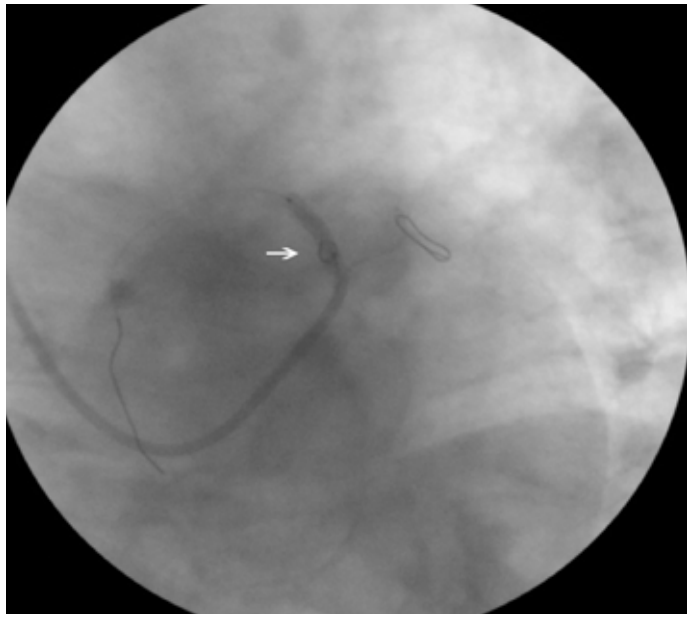

Figure 3. Coronary angiography view of a broken part of the floppy guidewire entrapped at the lesion site as a ring (white arrow)

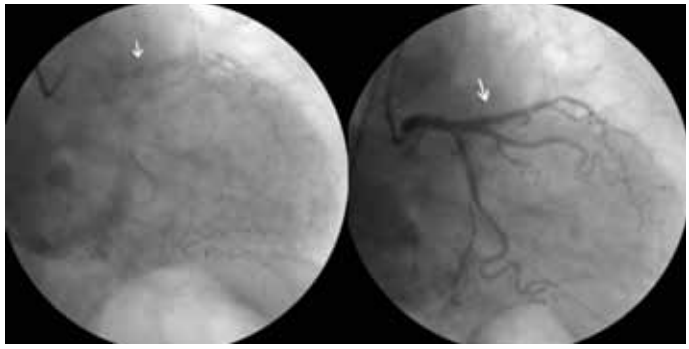

Figure 4. The entrapped guidewire is seen as a ring (white arrow) around the stent after successful stent implantation

the ring and then inflated. Thus by this maneuver, the culprit lesion and the entrapped guidewire were stented successfully (Fig. 4, Video. See corresponding video/movie images at www.anakarder.com).

Video 1: The entrapped guidewire is seen as a ring (white arrow) around the stent after successful stent implantation

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Giant cardiac structure in thoracic cavity

Toraks boşluğunda dev kardiyak yapı

A 52-year-old male patient with a history of mitral valve replacement due to rheumatic valve disease was admitted to our clinic with shortness of breath. Heart sounds revealed metallic 1st heart sound and normal 2nd heart sound without any murmur. Breath sounds were not heard over the lower and middle zones of the right lung with dullness on percussion. Telecardiography was remarkable with a cardiac silhouette filling almost all portions of middle and lower parts of thorax on the right side. He had also double contour shape in the cardiac silhouette, which is a sign of left atrial dilatation (Fig. 1). Transthoracic echocardiography demonstrated an ejection fraction of 38% and left ventricular end- diastolic diameter of 60 mm. The most important finding was in the left atrium. It had a dimension of 182x181 mm on apical four-chamber view (Fig. 2, Video 1. See corresponding video/movie images at www.anakarder.com). Functions of prosthetic mitral valve were normal.

Ball-like mass image of the left atrium filling right hemithorax completely and left hemithorax partially showed an interesting image on telecardiography. In addition, left atrial dilatation was clearly visualized on the telecardiography.

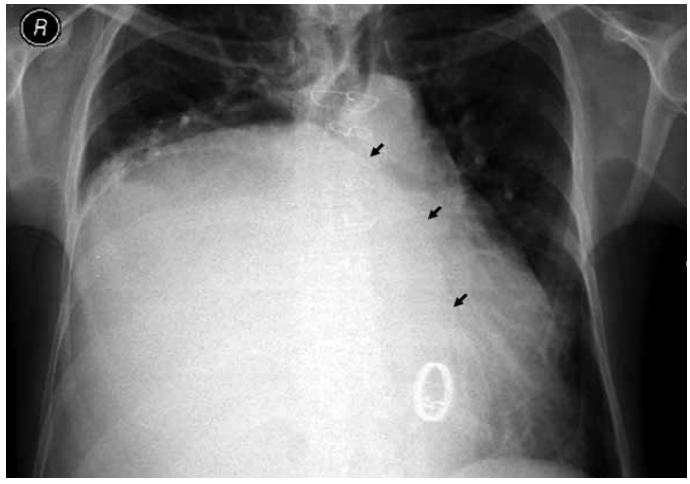

Figure 1. Telecardiography of the patient showing left atrial dilatation (arrows showing left atrial dilatation)

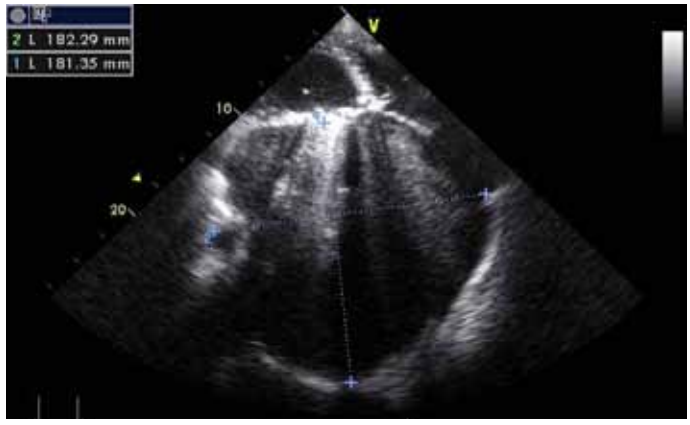

Figure 2. Apical four- chamber echocardiography view demonstrating severe dilatation of left atrium

A giant left atrium is a rare and well-known entity associated with mitral valve disease. It can be misdiagnosed from telecardiography as a mass lesion or pleural or pericardial effusion especially in unstable patients. Pleurocentesis and biopsy can be dangerous. When such a cardiomegaly is detected in telecardiography, an appropriate differential diagnosis must be made by using modalities like echocardiography and thorax computed tomography.

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Video 1: Modified apical four- chamber echocardiography view demonstrating severe dilatation of left atrium

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