

(10mg/day) was also ordered to control the ventricular rate. When the INR value was 2.5, heparin was stopped. Coumadin treatment adjusted to INR value to be 3-4. The patient was followed by echocardiography. It was determined that a loss of sensation in the left arm not to persist long.



Figure 1. Transesophageal echocardiography view of the large thrombus in left atrial appendix, floating and erratically moving in left atrium

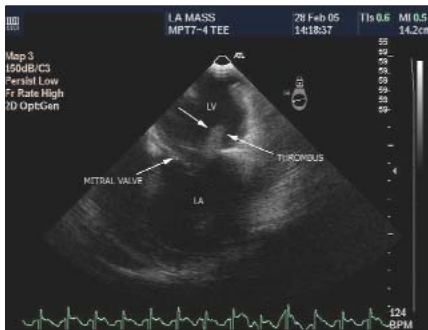


Figure 2. Transesophageal echocardiography view of the thrombus entrapping to the left ventricle through the mitral valve

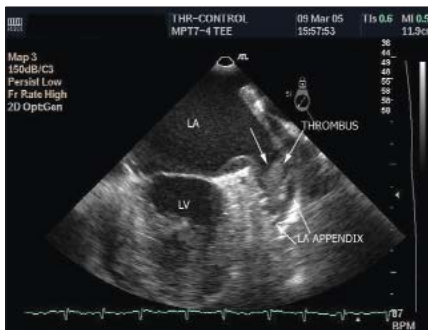


Figure 3. Transesophageal echocardiography at the 11th day of the therapy shows partly resolved thrombus in left atrial appendix



Figure 4. Transesophageal echocardiography at the end of the 2nd month of the therapy shows highly resolved thrombus adjacent to the appendix wall

Follow-up TEE was carried out at the eleventh day of therapy. It was determined that left atrial thrombus was clearly resolved and it was only observed in left atrial appendix (Fig. 3). Therefore, the patient was discharged with coumadin, aspirin and clopidogrel. The INR value was checked to be 3-3.5 weekly. The TEE repeated two months later showed thrombus only in form of thin layer adjacent to the appendix wall (Fig. 4).

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Asymptomatic accessory mitral valve tissue diagnosed by echocardiography

Ekokardiyografi ile teşhis edilmiş bir asemptomatik aksesuar mitral kapak dokusu olgusu

A 52-year-old man was referred to our hospital because of an apical first degree pansystolic murmur heard on routine cardiac examination. The patient was free of cardiac symptoms and his electrocardiogram and telecardiogram showed no pathology. Transthoracic echocardiography showed cyst-like formation on the anterolateral mitral chordae without pressure gradient across the mitral valve and subaortic region (Fig. 1, 2). Transesophageal echocardiography demonstrated this formation was an accessory mitral valve tissue with a mild regurgitation (Video 1. See corresponding video/movie images at www.anakarder.com). The surgical procedure was not considered and it was decided that the patient would be followed by periodical echocardiographic examinations and aspirin was prescribed.

The accessory mitral valve tissue (AcMV) is an anomaly of embryological development of the endocardial cushion. The accessory mitral valve is usually associated with complex cardiac congenital malformations and very rarely seen as an isolated congenital anomaly. The most common clinical presentation is symptomatic left ventricular outflow tract (LVOT) obstruction occurring as a result of mass effect in the early years of life or progressing gradually due to the continued accumulation of fibrous tissue within the LVOT and generally becomes symptomatic as dyspnea on exertion, chest pain, syncope or very rarely cerebrovascular accident. Echocardiography is a useful diagnostic tool for an accurate

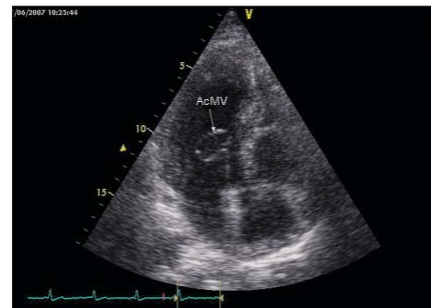


Figure 1. Transthoracic echocardiography shows the accessory mitral valve tissue (AcMV) on the anterolateral mitral chordae in 2-dimensional view

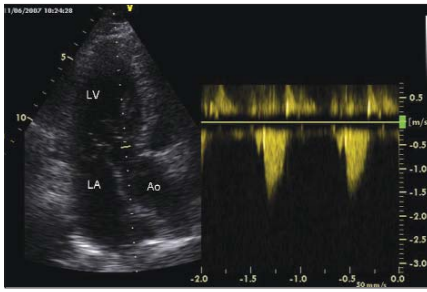


Figure 2. Transthoracic echocardiography demonstrates the accessory mitral valve tissue without subaortic obstruction in 2-dimensional view

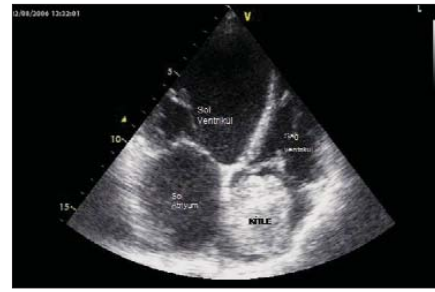


Figure 1. Four-chamber view of transthoracic echocardiogram showing large mass in the right atrium

visualization. Patients with AcMV causing considerable LVOT obstruction should be operated, however prophylactic removal should not be attempted in patients with no or mild obstruction and no other associated congenital anomalies. These patients should be followed by periodical echocardiographic examinations for catching any change in the LVOT obstruction.

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was 2.0. Also, alpha-fetoprotein titer was high. Abdominal ultrasound indicated an enlarged liver with hyperechogenic multiple nodules throughout the parenchyma. Hepatocellular carcinoma was diagnosed after gastroenterology consultation.

Hepatocellular carcinoma is the most common primary malignant liver tumor. Although pericardial involvement is frequent, IVC and right atrium extension of primary tumor is a rare finding, reported in 1% to 4% of cases. These kinds of intracavitary tumours are associated with symptoms of obstruction, embolization along with fatigue and listlessness.

Thrombus originating from lower extremity, renal cell carcinoma, leiomyoma, leiomyosarcoma and pancreatic adenocarcinoma have to be considered in differential diagnosis of intracavitary masses.

Hepatocellular carcinoma with right atrial extension causing clinical deterioration in a patient with ischemic cardiomyopathy

İskemik kardiyomiyopatili hastada klinik bozulmaya neden olan sağ atriyal yayımlı hepatosellüler karsinoma

A 60-year-old man was admitted to our clinic with a 2 month history of fatigue, malaise, edema in both legs, abdominal distention and weight loss. He had a history of coronary artery bypass surgery two years ago. He was being followed as an outpatient with ischemic cardiomyopathy and chronic hepatitis B carrier.

On physical examination, he was cachectic, and had pallor. His scleras were icteric and prominent jugular veins were present. Cardiac auscultation revealed an apical 2/6 pansystolic murmur radiating to the axilla. A palpable tender liver extending 6 to 7 cm below the subcostal plane in midclavicular line and ascites were noted during abdominal examination. He also had 2+ pitting pretibial edema.

Transthoracic echocardiography, performed because of deterioration of the clinical status, demonstrated depressed left ventricular systolic function and a huge mass in the right atrium (Fig. 1, Video 1. See corresponding video/movie images at www.anakarder.com). In the subcostal view, this mass was extending from inferior vena cava (IVC) through the right atrium (Fig. 2, Video 2. See corresponding video/movie images at www.anakarder.com). Laboratory tests showed that hemoglobin and trombocyte counts were within the normal range, but erythrocyte sedimentation rate was 66 mm/hour. Serum alaninaminotransferase and aspartataminotransferase levels were elevated and prothrombin time INR



Figure 2. Subcostal view of transthoracic echocardiogram showing mass extending from the inferior vena cava to right atrium
IVC - inferior vena cava, RA- right atrium

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Incidentally found pulmonary aspergilloma in a patient with dilated cardiomyopathy

Dilate kardiyomiyopatili bir hastada tesadüfen bulunan pulmoner aspergilloma

A 46-year-old man with dilated cardiomyopathy was referred to our center for refractory heart failure despite of optimal medical therapy. For the assessment of cardiac output, pulmonary vascular resistance, and