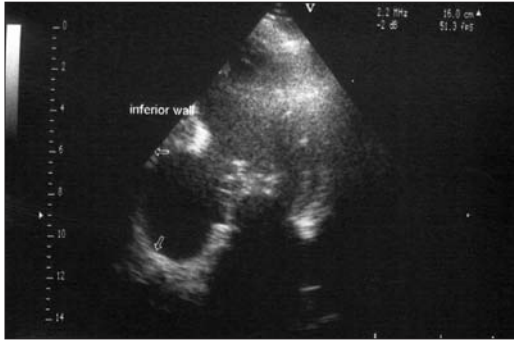


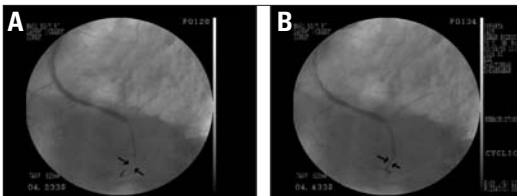
Sol ventrikül psödoanevrizmasına eşlik eden sağ koroner arter arka inen dalında kas bandı, sağ koroner arter ektazisi ve tıkaçıcı koroner arter hastalığı

Left ventricular pseudoaneurysm accompanied by muscular bridge of the posterior descending coronary artery, ectasia of the right coronary artery and coronary artery disease

Yaklaşık üç yıldır koroner arter hastalığı nedeni ile takipte olan yetmiş yaşında erkek hasta acil servise üç saatlik sıkıştırcı vasıfta, sol kola ve sırta yayımlı olan göğüs ağrısı ile başvurdu. Fizik muayenede genel durum iyi, bilinç açık, arteriyel kan basıncı 90/60 mm Hg, nabız sayısı 65 atım/dakika, düzenli idi. Apekte 2/6 şiddetinde pansistolik üfürüm mevcuttu. Elektrokardiyografide sinüs ritmi, V 2-6 derivasyonlarında ST segment depresyonu izlendi. Hasta ST-segment yükselmez akut koroner sendrom tanısı ile koroner yoğun bakıma yatırıldı. Kılavuzlara uygun olarak medikal tedavi başlandı. Yapılan ekokardiyografik incelemede Simpson yöntemiyle ejeksiyon fraksiyonu %40 olarak tespit edildi; septum, anteroseptal duvar akinetik, anteriör duvarın hipokinetik olduğu izlendi. İnferobazal bölgede dar boyunlu 40x53 mm boyutlarında psödoanevrizma ile uyumlu görünüm izlendi (Şekil 1). Hastaya yatışının altıncı gününde koroner anjiyografi yapıldı. Sol



Şekil 1. Transtorasik ekokardiyografide, apikal iki boşluk görüntüde izlenen psödoanevrizma



Şekil 2. (A) Sağ koroner arterin arka inen dalında sistolde %80 daralma yapan kas bandı görünümü. (B) Sağ koroner arterin arka inen dalının diyastolde görünümü

ventrikülografi çekilmedi. Ana koroner plaklı, sol ön inen koroner arterde birinci diyagonal dal (D1) öncesi %98 darlık, D1 başı %90 darlık ve D1 sonrası %70 darlık tespit edildi. Sol sirkumfleks arter ostealinde %80 darlık izlendi. Sağ koroner arter plaklı ve ektatik olduğu gözlemlendi. Ayrıca sağ koroner arter arka inen arterin distalinde %80 daralma yapan kas bandı izlendi (Şekil 2a, 2b, Video 1. Video/hareketli görüntüler www.anakarder.com'da izlenebilir). Acil operasyon kararı alınan hasta kalp damar cerrahisi servisine devredildi.

Literatürde koroner arter ektazisi, koroner kas bandı, koroner arter hastalığı ve sol ventrikülden psödoanevrizma birlikteliği bildirilmemiştir.

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A novel type of dual left anterior descending coronary artery in a patient with acute coronary syndrome

Akut koroner sendromlu bir hastada yeni tip ikili sol ön inen koroner arter

Here we described a new type of dual left anterior descending coronary artery (LAD) anomaly in patient with acute coronary syndrome. A 49-year-old male without cardiac history was admitted to our department with chest pain. Resting twelve-lead electrocardiogram showed sinus rhythm with inverted T waves in the precordial leads. His symptoms were persisted despite the optimal medical therapy then coronary angiography was performed. Coronary angiogram showed dual LAD anomaly. The more prominent LAD arose from aorta with separate ostium above the left main coronary artery. The short LAD arose from the left main coronary artery and ended after

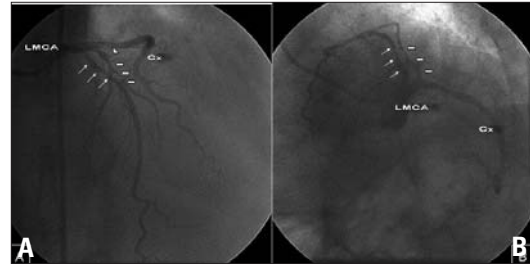


Figure 1. A and B panels demonstrate the presence of a dual LAD (long LAD showed with thin arrows, short LAD showed with thick arrows). The infarct-related artery was the first diagonal branch of the short LAD (arrowhead).

Cx - left circumflex artery, LAD - left anterior descending coronary artery, LMCA left main coronary artery

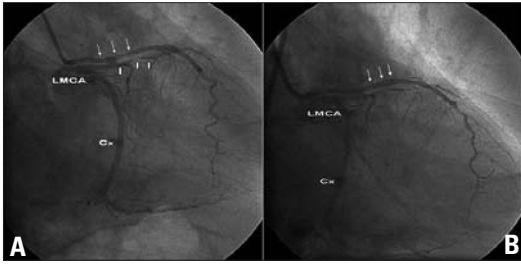


Figure 2. Stenosis of the proximal segment of long LAD (A) and after stenting with no residual stenosis (B)

Cx - left circumflex artery, LAD - left anterior descending coronary artery, LMCA left main coronary artery

1st septal perforator and 1st diagonal branch (Fig. 1, 2). The long LAD showed 70% stenosis at the proximal segment. The short LAD was a small-caliber vessel with severe stenosis after 1st septal perforator and 1st diagonal branch. The infarct-related artery was the first diagonal branch of the short LAD, which was found totally occluded with Thrombolysis In Myocardial Infarction Flow (TIMI) grade 0 flow (Fig. 1, panel A, arrowhead). Because the vessel was very small and short, we did not perform percutaneous coronary intervention to culprit lesion. One Taxus stent (3.5x20 mm, slow release, polymer based, paclitaxel-eluting Express stent, Boston Scientific, Natick, Massachusetts, USA) was directly implanted to the long LAD lesion successfully. Coronary angiogram after stent implantation showed no residual stenosis (Fig. 2, panel B).

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Right ventricular branch misdiagnosed as non-dominant right coronary artery

Non-dominant sağ koroner arter olarak yanlış tanı konulan sağ ventrikül dalı

A 48-year-old man was admitted to our hospital with exertional chest pain. According to the clinical records, his left anterior descending coronary artery (LAD) had been stented two years ago after anterior myocardial infarction. He had normal cardiovascular examination with an arterial blood pressure of 122/84 mmHg and heart rate of 87 beats per minute. Electrocardiography showed negative T waves in anterior precordial derivations. The patient did not accept the suggested coronary angiography (CAG). Furthermore, he was not able to tolerate exercise myocardial perfusion imaging with thallium-201; so we decided to perform multislice computed tomography (MSCT), which revealed a patent stent and non-occlusive plaques on LAD. Of interest, there was a discordance between reports of previous CAG and MSCT on the right coronary artery (RCA). Despite a non-dominant RCA reported by CAG (Fig. 1), MSCT

revealed a dominant RCA with its right ventricular branch (RVB) arising from right sinus of Valsalva separately (Fig. 2).

There may be problems in selective coronary artery cannulation during CAG especially in case of coronary anomalies, like in this case. It is obvious that RVB had been cannulated during CAG, and it was misinterpreted as a non-dominant RCA. In a retrospective analysis of the CAG images, it was shown that all cannulated arteries were non-dominant and left coronary arterial system did not give off any branch supplying inferior left ventricular wall.

Multislice computed tomography is a complementary diagnostic modality to CAG and should be considered especially, when proximal and ostial coronary anomalies are suspected.

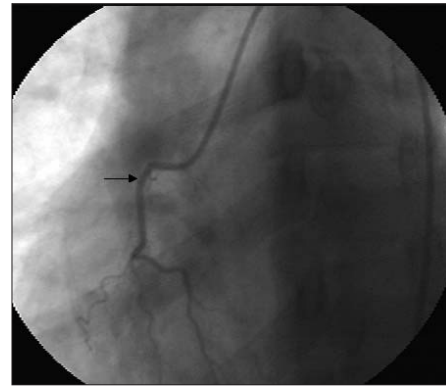


Figure 1. Selective angiography of RVB (arrow) of RCA, which was reported inaccurately as non-dominant RCA

RCA - right coronary artery, RVB - right ventricular branch



Figure 2. Multislice computed tomography imaging of RCA (thick arrow) and RVB (thin arrow) of RCA separately arising from right sinus of Valsalva

RCA - right coronary artery, RVB - right ventricular branch

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