

**Figure 3. Electrocardiogram after radiofrequency ablation therapy**

sinus rhythm, short P-R interval, wide QRS complex and typical delta waves of WPW syndrome. Although laboratory examination revealed troponin I: 0.22 ng/mL, CK: 145-220 U/L, MB: 33-44 ng/mL, these findings were primarily attributed to longstanding tachycardia. No structural abnormality was found in echocardiographic examination. Coronary angiography was normal. Electrophysiologic study was performed and an accessory pathway located anterolaterally was identified. Radiofrequency ablation was performed for the accessory pathway. Typical ECG findings disappeared after ablation. Although it is rare, in differential diagnosis of wide QRS complex tachycardia, WPW Syndrome with AF should be kept in mind.

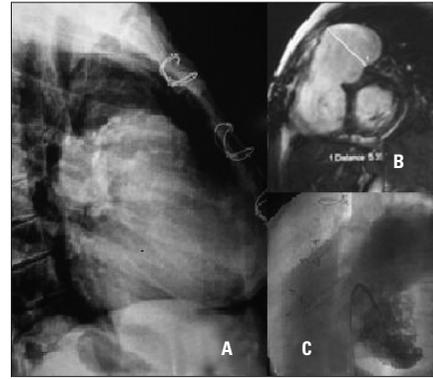
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## Aneurysm of right ventricular outflow tract with pulmonic stenosis 28 years after atrial septal defect repair

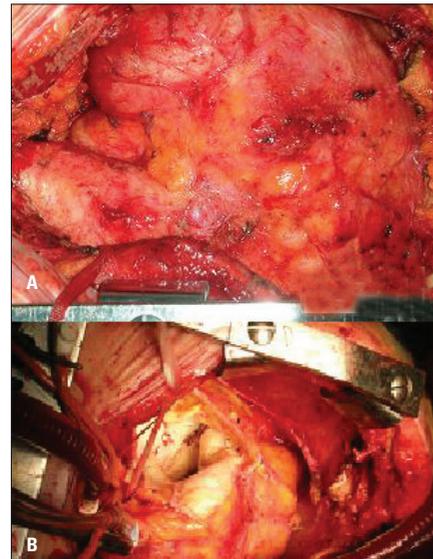
*Atrial septal defekt onarımından 28 yıl sonra  
görülen sağ ventrikül çıkım yolunda anevrizmatik  
genişleme ve pulmoner stenoz*

A 36-year-old woman with dyspnea and fatigability was referred to our clinic due to aneurysmal enlargement of right ventricular outflow tract (RVOT) and main pulmonary artery (MPA) after her two operations in 1978, both supposedly for atrial septal defect repair. Her echocardiography, cardiac magnetic resonance imaging and right heart catheterization all demonstrated severely enlarged RVOT and pulmonary trunk; the latter



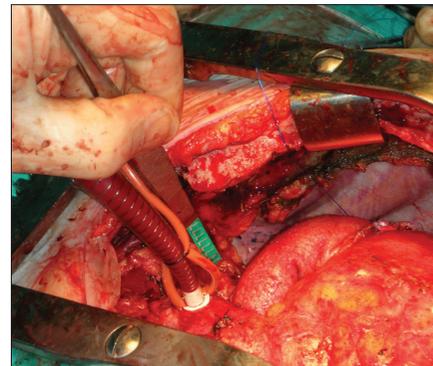
**Figure 1A-C. Preoperative radiology of the patient. (A.) Lateral chest radiography. (B.) Note that the main pulmonary artery on magnetic resonance imaging sized 5.35 cm in diameter. (C.) Right heart catheterization. Note that RVOT and MPA are severely enlarged; branch pulmonary arteries are not visible due to lack of contrast passage through the stenotic segment.**

MPA- main pulmonary artery, RVOT- right ventricular outflow tract



**Figure 2A-B. Surgical view following complete median sternotomy. (A.) Note the prominent RVOT and the MPA. (B.) Incision over RVOT extending to MPA**

MPA- main pulmonary artery, RVOT- right ventricular outflow tract



**Figure 3. RVOT reconstruction with bovine jugular vein valved conduit**

MPA- main pulmonary artery, RVOT- right ventricular outflow tract

showed a peak systolic 90 mmHg gradient at valvular level, severe tricuspid and pulmonary regurgitation (Fig. 1A-C.). Intraoperatively, severely enlarged RVOT and MPA were observed to be reconstructed with a heavily calcified synthetic material back in 1978 (Fig. 2A.) and it was encroaching on MPA just distal to valvular level while causing regurgitation through the semilunar valve due to inadvertent enlargement (Fig. 2B) (Video 1. See corresponding video/movie images at www.anakarder.com). Reconstruction of RVOT and the MPA to the level of pulmonary bifurcation was achieved with a 22 mm Contegra® (Medtronic, Inc., Minneapolis, MN, USA) valved conduit (Fig. 3.). She was discharged after an uneventful postoperative course on aspirin on day 7 without any complications.

Since the first successful use of human tissue graft valves for RVOT reconstruction, various prosthetic conduits have been developed. Patch material over RVOT was not identifiable in our patient due to heavy calcification leading to a cumbersome proximal anastomosis. Contegra® has been advocated for its "off-shelf availability", wide range of conduit size, surgical pliability and encouraging short to mid-term results in addition to favorable hemostatic characteristics. Bovine jugular vein valved conduits may offer an optimal alternative when widely-accepted homografts are not available for in RVOT reconstruction in the adult.

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## Extrapleural hematoma, a rare post-operative complication of coronary bypass grafting with left internal mammary artery

*Sol internal mammaryal arterin kullanıldığı koroner baypas greft operasyonu sonucunda gelişen nadir bir komplikasyon-ekstraplevral hematom*

Extrapleural hematoma is a rare but life threatening complication caused by the blood collection between parietal pleura and endothoracic fascia. Generally seen after chest traumas, the complication may rarely be seen as a result of iatrogenic procedures such as central venous catheterization and coronary bypass graft (CABG) operation.

A 52-year-old man was admitted to our hospital for follow-up control 5 days after the CABG surgery. In his history, he had been suffered an

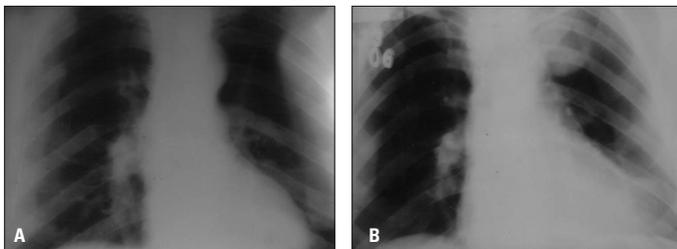


Figure 1. (A) A normal chest X ray imaging obtained before the coronary artery bypass surgery. (B) Postero-anterior chest roentgenogram demonstrating an intense, round, homogeneous density, 5x5cm in size, in the upper zone of the left hemithorax



Figure 2. Chest computed tomography imaging of aloculated extrapleural effusion in the left apical hemithorax

anterior myocardial infarction and multi-vessel disease coronary artery diseases was documented on coronary angiography. Thus, he had been revascularized by left internal mammary artery (LIMA) to left anterior descending artery (LAD) graft and two saphenous venous grafts to circumflex and right coronary arteries. On the follow-up chest X-ray, we observed an intense, round, homogeneous density, 5x5cm in size, which was absent before the CABG surgery (Fig. 1A-1B). Chest computerized tomography revealed a loculated extrapleural effusion in the left superior hemithorax. (Fig. 2) An extrapleural hematoma developed after LIMA-LAD CABG surgery in this case. Because the patient was asymptomatic and hemodynamically stable, we left the extrapleural hematoma for spontaneous resolution. After the 2 months follow-up, we observed that the hematoma fully disappeared. A simple chest X-ray was the diagnostic imaging method in a rare and life threatening case.

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## Early detection of retained surgical sponge by the lateral chest radiography

*Yan göğüs radyografisi ile unutulmuş cerrahi gazlı bezin erken tespiti*

Postoperative retention of a foreign body is rare but well-recognized complication. They cause either an aseptic reaction without significant symptoms or an exudative reaction which results in early but nonspecific symptoms. We describe a case of extracardiac mass in a patient submitted to an open-chest coronary artery bypass operation. At postoperative period, plain radiography of the chest revealed a hypodense mass with a thick peripheral rim, characteristic whirl-like pattern, suggestive of foreign body on the right heart border (Fig. 1). The lateral radiographic projection showed a radiopaque marker confirming a retained sponge (Fig. 2). On computerized tomography scan, an inhomogenous,