

Figure 2. Microscopic histopathological image of excised mitral valve tissue, vegetation with fibrin-platelet thrombi (A. Original magnification x10, B. Original magnification x40)

sis of atrial myxoma. Microscopic examination of the excised material revealed that myxoid degeneration and large vegetation with fibrin-platelet thrombi (Fig. 2). During the follow-up, pancytopenia (hemoglobin 10.9 gr/dL, leukocyte 3400/ μ L, platelet 22000/ μ L) and acute renal failure (creatinine 1.9 mg/dL) were emerged. Analysis of serologic markers showed that LA was positive, ACA IgM-G and antiphospholipid antibody were high. The patient was diagnosed with secondary APS. The medical therapy was optimized with immunosuppressive agents and warfarin. Her further clinical course was uneventful.

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Double-chambered right ventricle associated with ventricular septal defect and subaortic stenosis in an adult

Erişkinde subaortik stenoz ve ventrikül septum defekti ile birlikte çift odacıklı sağ ventrikül

Double-chambered right ventricle (DCRV) is a relatively uncommon congenital cardiac defect.

In a 47-year-old man admitted to our unit for chest pain, a Doppler transthoracic echocardiogram (TTE) was performed, showing: middle right ventricle (RV) hypertrophy, dividing the cavity into two chambers, with significant intraventricular gradient (85 mmHg) (Fig. 1, 2); dilatation of RV outlet part and of pulmonary artery trunk with mild pulmonary regurgitation; perimembranous ventricular septal defect (VSD) (7 mm) with moderate left to right shunt and interventricular gradient of 88 mmHg; subaortic spur with mild left ventricle output tract obstruction (systolic



Figure 1. TTE parasternal short-axis view of a muscular band dividing the RV into two chamber and the dilatation of RV outlet part
RV - right ventricle, TTE - transthoracic echocardiography



Figure 2. TTE parasternal short-axis view: the aliasing phenomena in the middle part of the right ventricle, as result of significant intraventricular gradient, is seen
TTE - transthoracic echocardiography

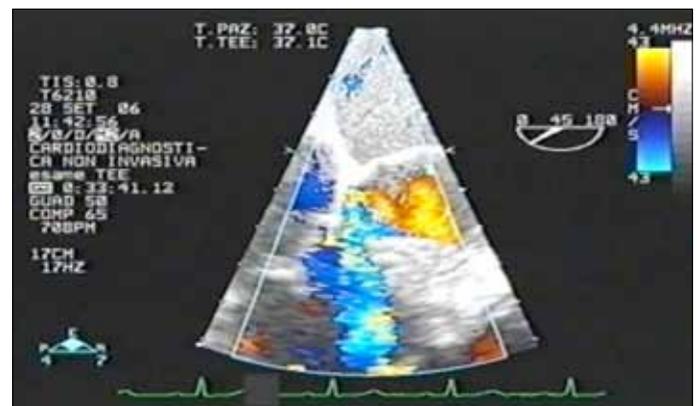


Figure 3. TEE 4-chamber view, 45°: perimembranous VSD with moderate left to right shunt is seen
TEE - transesophageal echocardiography, VSD - ventricular septal defect

anterior movement of the mitral valve, midsystolic notch on aortic valve, gradient of 14 mmHg); fibrocalcification of aortic cusp and mild-moderate regurgitation; mild LV hypertrophy with normal systolic and diastolic function; mild dilatation of right and left atrium; mild tricuspid regurgitation and normal pulmonary artery pressure.

Subsequently, a transesophageal echocardiogram (TEE) was performed (Fig. 3, 4), confirming the result of the TTE.

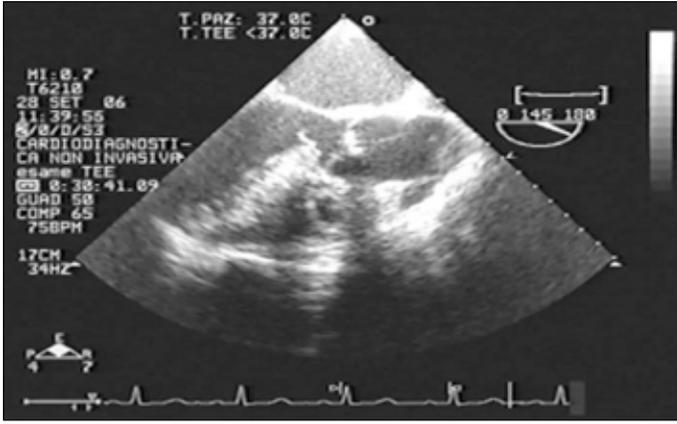


Figure 4. TEE 3-chamber view, 145°: subaortic spur and fibrocalcification of aortic cusp are seen

TEE - transesophageal echocardiography

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Left main coronary artery compression by a giant pulmonary artery aneurysm associated with large atrial septal defect and severe pulmonary hypertension

Büyük bir atriyal septal defekt ve ciddi pulmoner hipertansiyon ile ilişkili dev bir pulmoner arter anevrizması nedeniyle oluşan ana koroner arter basısı

A 27-year-old woman having exercise intolerance, shortness of breath and substernal chest pain was admitted to our institution. On admission, physical examination revealed, a blood pressure of 110/60 mmHg, 2/6 mid-systolic murmur at the apex, 3/6 systolic murmur in the tricuspid area and fixed splitting of the second heard sound during all respiration phases. Chest X-ray showed cardiomegaly and a prominent bilateral pulmonary artery enlargement (Fig.1). Transthoracic echocardiography was performed for the first time in her life, and it revealed an 1.8 cm in size prominent secundum type atrial septal defect with severe pulmonary hypertension and dilated right cardiac chambers (Fig. 2, Video 1. See corresponding video/movie images at www.anakarder.com). Moreover a giant pulmonary artery aneurysm (5.3 cm) was seen on the parasternal short-axis view. She

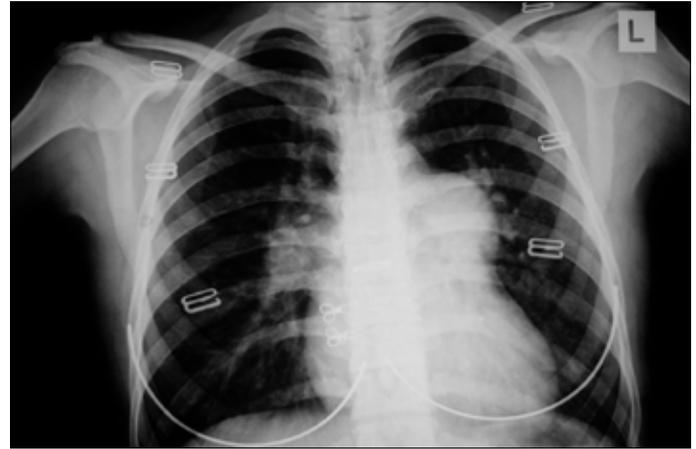


Figure 1. Chest X-ray image of a prominent bilateral pulmonary artery enlargement

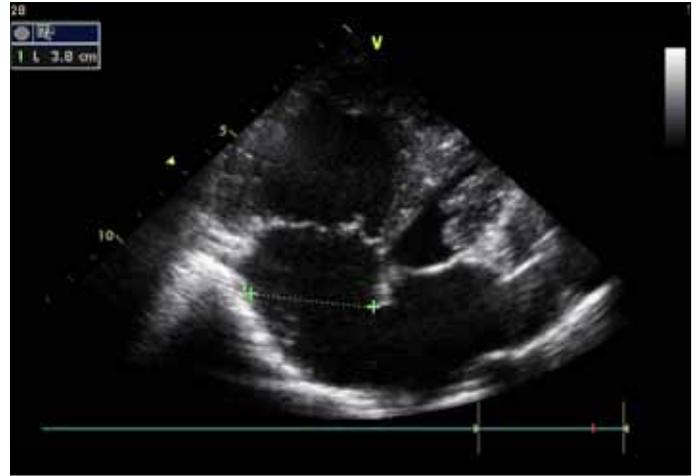


Figure 2. Apical four-chamber echocardiographic view of large atrial septal defect and dilated right cardiac chambers



Figure 3. Coronary angiography view of that a 95% occlusion of left main coronary artery