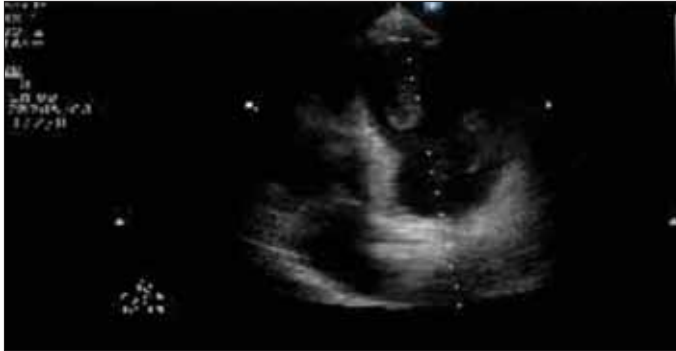
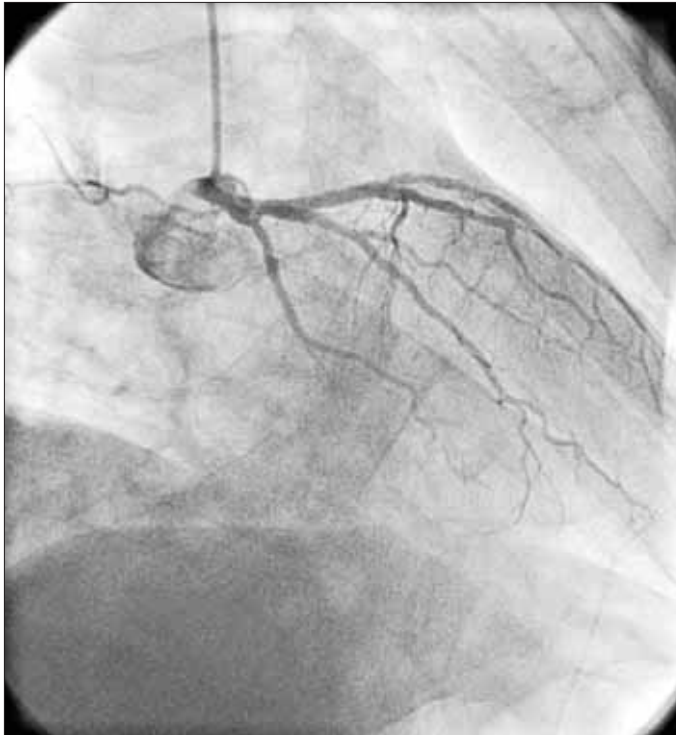


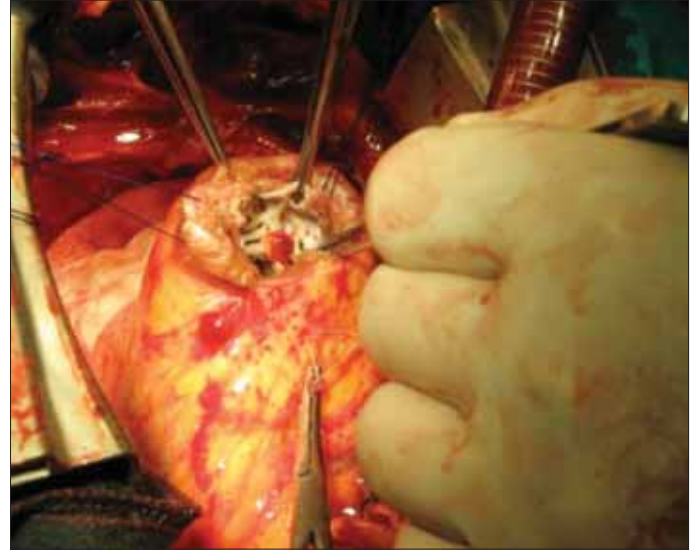
nildi. Tekrarlayan tromboemboli etiolojisini araştırmaya yönelik transtorasik ekokardiyografi yapıldı. Sol ventrikül fonksiyonları ve duvar hareketleri normaldi. Sol ventrikül apeksinde 3.5x1.4 cm boyutlarında, saplı ve hareketli, heterojen görümlü kitle tespit edildi (Şekil 1, Video 1. Video/hareketli görüntüler [www.anakarder.com](http://www.anakarder.com)'da izlenebilir). Trombolitik tedavi uygulanması açısından yüksek risk faktörleri bulunması (yaşlı ve serebrovasküler hastalık öyküsü), nedeniyle cerrahi ile kitle eksizyonu planlandı. Anjiyografide sol ön inen arterin 1. diyagonal (D1) sonrası önemli darlık yapmayan musküler köprüleme, D1 başında %50 darlık mevcuttu (Şekil 2). Kalp Damar Cerrahisi Kliniği tarafından kardiyopulmoner baypas altında sol ventrikülotomi yoluyla apikal kitle eksizyonu yapıldı (Şekil 3). Patolojisi aterom plağı üzerine yerleşimli trombüs olarak yorumlandı. Hiperkoagülabiliteye neden olabilen herhangi bir patolojiye rastlanmadı. Sol ventrikül fonksiyonlarının korunduğu durumlarda da sol ventrikül kavitesinde trombüs görülebilir. Komplikasyonları önlemek açısından erken dönem trombolitik veya cerrahi tedavi uygulanmasının katastrofik sonuçları önleyeceği kanaatindeyiz.



Şekil 1. Transtorasik ekokardiyografide, apikal 4 boşluk görüntüde sol ventrikül apeksinde kitle görünümü



Şekil 2. Koroner anjiyografide sağ kaudal görüntüde sol ön inen ve sol sirkumfleks arterlerin görünümü



Şekil 3. Sol ventrikül apeksindeki kitlenin operasyon esnasındaki görüntüsü

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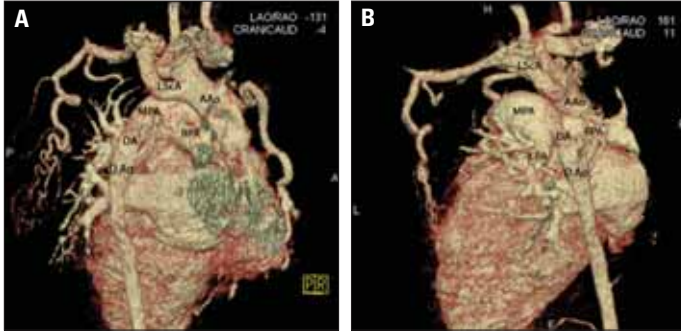
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## Interrupted aortic arch with intact ventricular septum: a multidetector CT angiography evaluation

*Ventriküler septumun intakt olduğu kesintili arkus aorta: Çok detektörlü BT anjiyografi ile değerlendirme*

Interrupted aortic arch with intact ventricular septum is a rare severe congenital heart defect defined as a complete loss of luminal and anatomic continuity between ascending and descending aorta without ventricular septal defect. A 8-year-child referred to our center for cardiac operation from Irak. Preoperative echocardiographic evaluation showed enlarged left ventricular dimension is and severely diminished systolic function. Aortic valve was found to be bicuspid with mild gradient. Aortic arcus was interrupted below the left subclavian artery. Large patent ductus arteriosus was established to be supplying the descending thoracic aorta. The patient underwent the heart catheterization for the hemodynamic study. Pulmonary artery pressure was measured to be 80 mmHg and resistance- 17.4 WU. However, angiography failed to show aortic arch and vascular structure. Multidetector computed tomography angiography (MDCTA) showed interruption of the

aortic arch just distal to the left subclavian artery and continuation of the main pulmonary artery into the descending aorta through the ductus arteriosus (Fig. 1 A-B and Video 1. See corresponding video/movie images at [www.anakarder.com](http://www.anakarder.com)). We considered that the patient was inoperable due to irreversible pulmonary hypertension and severe left ventricular dysfunction. MDCTA can be used for minimally invasive diagnosis of the aortic arch pathology as an alternative to conventional angiography.



**Figure 1 A-B. Reconstructed 3D volume-rendered images shows interruption of the aortic arch just distal to the left subclavian artery, continuation of the main pulmonary artery into the descending aorta through the ductus arteriosus and also well developed aortic collateral vessels**

AAo - ascending aorta, DA - ductus arteriosus, DAo - descending aorta, LPA - left pulmonary artery, LScA - left subclavian artery, MPA - main pulmonary artery, RPA - right pulmonary artery

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## Sternal wire reaction with wire's skin exposure and its treatment in a patient who underwent coronary bypass surgery

*Koroner baypas cerrahisi geçirmiş bir hastada tüm tellerin ciltten görünümü ile sternal tel reaksiyonu ve tedavisi*

Our case was an 80-year-old male. His past medical history was significant for chronic obstructive pulmonary disease (COPD) and hypertension. He had undergone coronary artery bypass surgery 3 years ago. After the discharge, he had attended only the 1st week control throughout these years. According to his history, redness of the

skin started on the 3<sup>rd</sup> month postoperatively. Suppurative discharge was also seen from time to time. The wires became exposed within 18<sup>th</sup> postoperative month. However, he did not apply to any health institution. He was admitted to our clinic with complaints of exposed wires and tenderness on chest. Physical examination showed 3 wires in a "figure-of-eight" appearance. Two of these wires were disrupted. No purulent discharge was observed (Fig. 1). Chest X-ray confirmed these findings (Fig. 2). After preoperative preparations, our patient was taken to the operating room. Under local anesthesia, three sternal wires were removed (Fig. 3). Antibiotherapy was initiated. Control chest X-ray confirmed that all the wires were removed (Fig. 4). Postoperative period was event-free and our patient was then discharged.



**Figure 1. Image of skin exposure of the sternal wires**



**Figure 2. Chest X-ray showing the sternal wires**