defect. On the other hand, aneurysm formation has the potential complications of thromboembolism, arrhythmia, endocarditis, right ventricular outflow tract obstruction. Echocardiographic evaluation is important in diagnosis of ventricular septal aneurysm and its complications.

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Primary stenting of the anomalous left main coronary artery originating from right coronary sinus: multislice computerized tomography angiography imaging

Sağ koroner sinüsten çıkan sol ana koroner artere primer stentleme girişimi: Çok kesitli bilgisayarlı tomografi anjiyografi görüntülemesi

A 50-year-old man presenting with acute myocardial infarction (AMI) was urgently transferred to the catheterization laboratory. We were unable to cannulate the left main coronary artery (LMCA). Aortography demonstrated that the LMCA was originating from the right coronary sinus and was totally occluded (Fig. 1A. Video 1. See corresponding video/movie images at www.anakarder.com). During intervention, JR-4 catheter did not provide sufficient backup, so we changed it with the hockey stick guiding catheter. Crossing total occlusion, the lesion was predilated, afterwards a 3.5x20 mm "bare metal stent" was implanted into the LMCA. Subsequent angiography demonstrated TIMI III flow and good myocardial contrast blush (Fig. 1B, Video 2. See corresponding video/movie images at www.anakarder.com). The patient was followed up in the coronary care unit for 48 hours and discharged 5 days later. At the sixth-month control, coronary multislice computerized tomography (MSCT) angiography demonstrated that the LMCA was coursing in the dorsal wall of the aorta and subsequently, between aorta and left atrium (retroaortic course) (Fig. 2A-B). This congenital anomaly is subclassified into four types based on the relationship of the LMCA to the great vessels: septal, anterior free wall, retroaortic and interarterial courses. The first three are considered benign, while the last one causes symptoms, which vary from angina to syncope or sudden cardiac death. Coronary MSCT angiography revealed also restenosis of the implanted stent. Conventional coronary angiography confirmed restenosis and coronary artery bypass surgery was performed successfully.

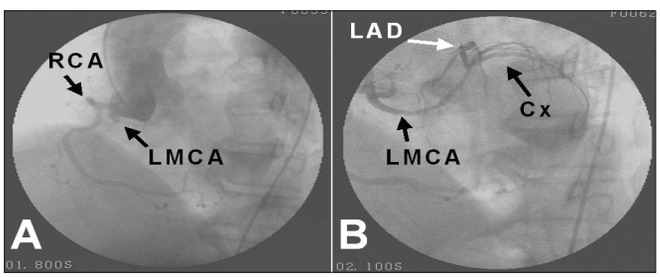

Figure 1. A) Aortogram in the LAO projection before primary percutaneous intervention. (B) Selective left coronary angiogram in the LAO projection after stenting
Cx -circumflex coronary artery, LAO - left anterior oblique, LMCA - left main coronary artery, RCA - right coronary artery

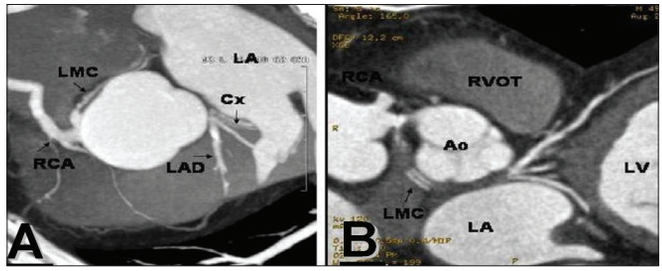

Figure 2. Coronary MSCT angiographical images of the stented LMCA
LMCA - left main coronary artery, MSCT - multislice computerized tomography

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Coincidentally determined floating right ventricular thrombus in a patient with coronary artery disease

Koroner arter hastalığı olan bir hastada tesadüfen tespit edilmiş olan yüzen sağ ventriküler trombus

A 65-year-old male patient presented to our hospital with complaints of unstable angina pectoris. The coronary angiography revealed 60% stenosis of the left main coronary artery, 80% stenosis of the left anterior descending artery (LAD) and a total occlusion of the right coronary artery (RCA). Transthoracic echocardiography before the surgery disclosed a floating right ventricular mass attached to the subvalvular apparatus of the tricuspid valve, moving in and out through the pulmonary valve in each systole and diastole (Video 1. See corresponding video/movie images at www.anakarder.com).

The patient was accepted for surgery urgently. Initial access to the thrombus was tried to be gained via an incision through right atrial wall. However, exploration through tricuspid valve failed to detect any thrombus inside the right atrium and ventricle. The mass lesion was thought to be embolized to the pulmonary artery during the surgical intervention. Coronary artery bypass grafting was performed on the LAD, RCA and the obtuse marginal branch. After the release of cross-clamp, main pulmonary artery was opened and embolectomy was performed using Fogarty

catheter. We also aspirated both right and left pulmonary arteries on a beating heart. The removed material was proved to be an organized thrombus in the pathological examination (Fig. 1). Although the postoperatively performed lower extremity venous Doppler ultrasound imaging revealed to be normal, we presumed that this thrombus originated from the iliac venous system. He is still symptom-free at the end of the fourth month following surgery.

Right heart thrombus requires urgent therapeutic approach for the delay in treatment increases the rate of mortality. We emphasize the importance of echocardiographic imaging studies before cardiac surgery and surgical exploration and embolectomy is a safe choice for floating right heart thrombus treatment.

Figure 1. The removed organized thrombi from the pulmonary artery and its branches

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A case of cardiac valvular dysplasia

Bir kardiyak valvüler displazi vakası

Cardiac valvular dysplasia (CVD) affects about 3% of the population. Familial inheritance has been demonstrated as autosomal and X-linked transmission.

A 16 year-old boy was referred with the diagnosis of mass on the tricuspid valve. He was a child of consanguineous parents. He had chest pain and dyspnea on exertion. On physical examination, there was a systolic, grade II/VI murmur on the left lower part of sternum. He did not have fever, rheumatic complaints, arachnodactyly or elasticity of joints. Acute phase reactants were within normal limits. Electrocardiography and chest X-ray were normal. Echocardiography revealed thick myxomatous transformation and prolapse of tricuspid valve (Fig. 1. Video 1. See corresponding video/movie images at www.anakarder.com), prolapse of aortic (Fig. 2), pulmonary (Fig. 3) and mitral valves (Fig. 4. Video 2. See corresponding video/movie images at www.anakarder.com). There were moderate regurgitation of aortic, mitral and tricuspid valves and mild regurgitation of the pulmonary valve. Rare

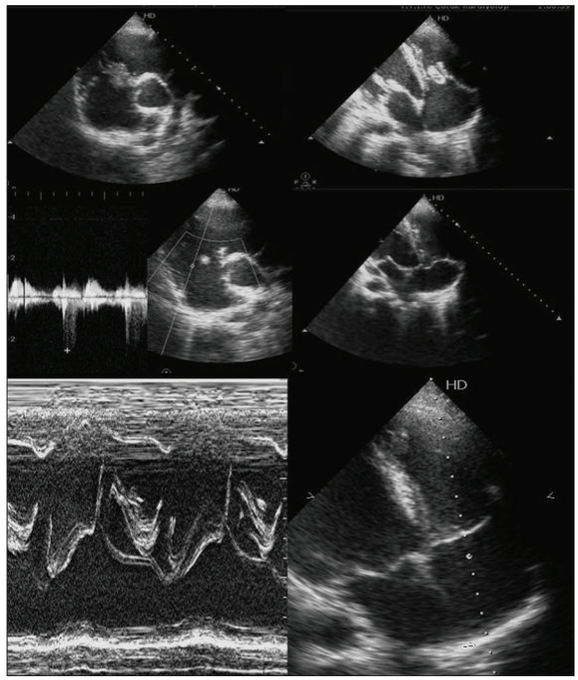

Figure 1. Four-chamber, parasternal short-axis, and M-mode transthoracic echocardiographic views of myxomatous structure and prolapse of tricuspid valve. The continuous wave Doppler examination shows mild tricuspid regurgitation

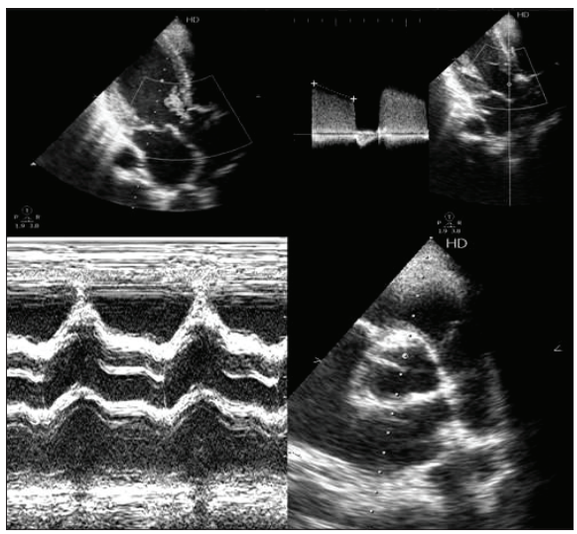

Figure 2. Four-chamber, parasternal short-axis, and M-mode transthoracic echocardiographic views of thickened aortic valve with mild prolapse and continuous wave Doppler recording of mild aortic regurgitation