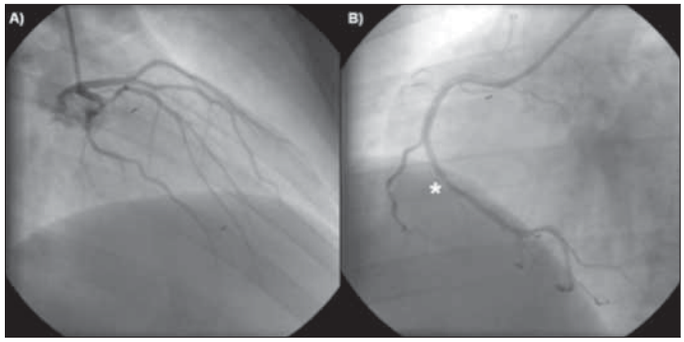

Figure 1. Coronary angiography views of non-critical lesions in the left coronary arterial system (A); and a critical stenosis of right coronary artery (asterisk), (B)

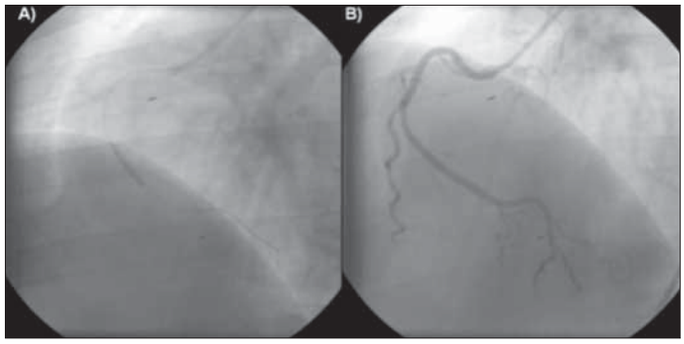

Figure 2. Critical stenosis at the mid portion of the right coronary artery was dilated by a 2.75-mm X 13-mm bare metal stent (A) with no residual stenosis (B)

therapy of the patient was optimized with clopidogrel, acetylsalicylic acid, metoprolol and ramipril. His further clinical course was uneventful; he was discharged two weeks later.

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A 23-year patency of a saphenous vein graft in a patient with diabetes mellitus

Diyabetik bir hastada 23 yıl açık kalan bir safen ven grefti

A 79- year-old man was admitted to our hospital with the complaint of progressive angina pectoris. Coronary artery bypass grafting (CABG) had been performed with the saphenous vein graft (SVG) to the left anterior descending artery (LAD) 23 years ago. He had type 2 diabetes mellitus for 18 years. Serum lipid parameters and electrocardiogram were normal. He was receiving clopidogrel because of aspirin-induced gastritis. Coronary angiography revealed the significant lesions in the circumflex coronary artery (CX), complete occlusions in the proximal regions of the LAD and the right coronary artery (RCA). The SVG showed an excellent patency (Video 1. See corresponding video/movie images at www.anakarder.com) Percutaneous coronary intervention was planned to the CX and the RCA, but the patient refused.

The predictors of graft patency are the diameter of the recipient vessel >2 mm (as our case, Fig. 1A-B), lower serum cholesterol, the use of aspirin after CABG. Clopidogrel is recommended in cases intolerant to aspirin after CABG.

A 30-year patency of a SVG in a 74-year-old adult and 22-year patencies of SVGs in two pediatric patients have been reported previously.

This presentation reveals the diabetic case having a 23-years patency of a SVG. This is the longest patency time in a diabetic patient with CABG in the literature. Considering that graft stenosis is more frequent in diabetic patients, this result is very remarkable.

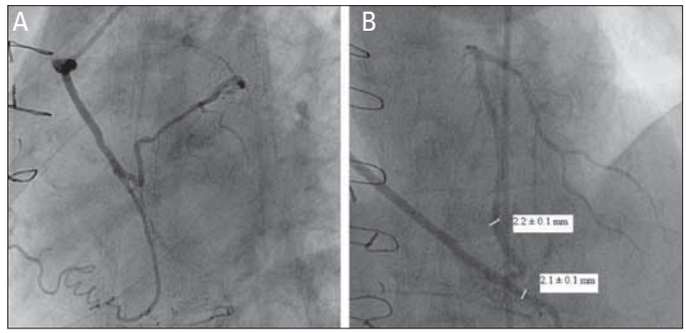

Figure 1A-B. Angiograms showing the patency of saphenous vein graft

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Coronary aneurysm and factor V Leiden mutation: A coincidence or an association?

Koroner anevrizması ve faktör V Leiden mutasyonu: Rastlantı mı yoksa ilişkili mi?

A 23-year-old male referred to our tertiary cardiology center because of chest pain, 3 ventricular fibrillation episodes in last 12 hours and troponin T elevation (1.2 µg/l). His medical history revealed recurrent deep venous thrombosis attacks on his left leg and one pulmonary embolism attack. He was a homozygous mutant on factor V Leiden

mutation analysis. The patient had no clinical or laboratory evidence of autoimmune or infectious illnesses. Early coronary angiography showed an 80% diameter stenosis and an aneurysm with a maximal diameter of 12 mm at the same site of mid-circumflex artery (Fig. 1-Panel 1, 2, 3 and Video 1. See corresponding video/movie images at www.anakarder.com). The patient was treated with a polytetrafluoroethylene (PTFE)-covered stent graft with a good angiographic result (Fig.1- Panel 4). Multi-slice spiral computerized tomography performed after 1-month of stenting did not show aneurysm (Fig. 2-3).

Coronary artery aneurysms are defined as coronary dilatations, which exceed the diameter of normal adjacent segments by 1.5 times. The main causes for coronary artery aneurysms in the Western world are atherosclerosis, congenital origin, and mycotic-embolic disease. Congenital aneurysms, which are usually situated on the right coronary artery, are generally large and are most commonly found in young patients. Left main coronary artery is the least frequently involved artery with a prevalence of 0.1%. They can rupture into the pericardial space, causing cardiac tamponade or into the right atrium. The majority of coronary aneurysms are asymptomatic. When symptoms occur, angina or infarctions are the most common presenting features.

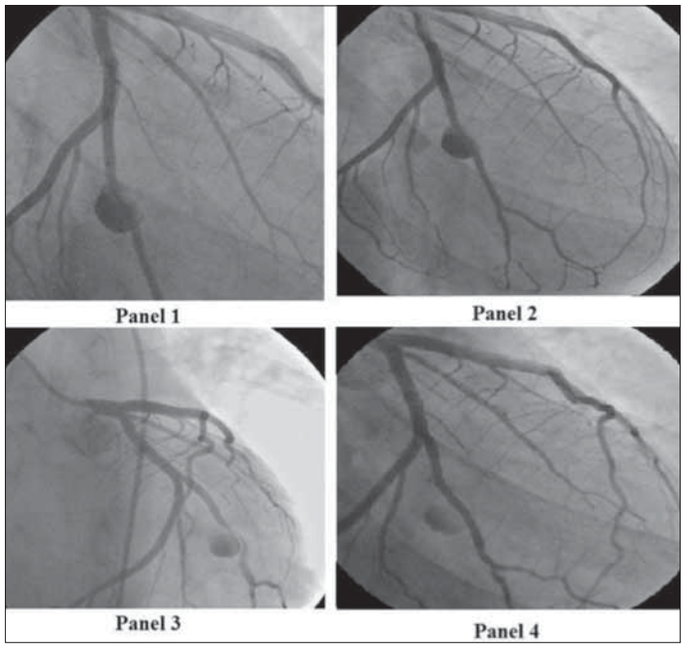

Figure 1. Panels 1-3 showing coronary angiography images of an aneurysm, panel 4: image after PTFA-covered stenting

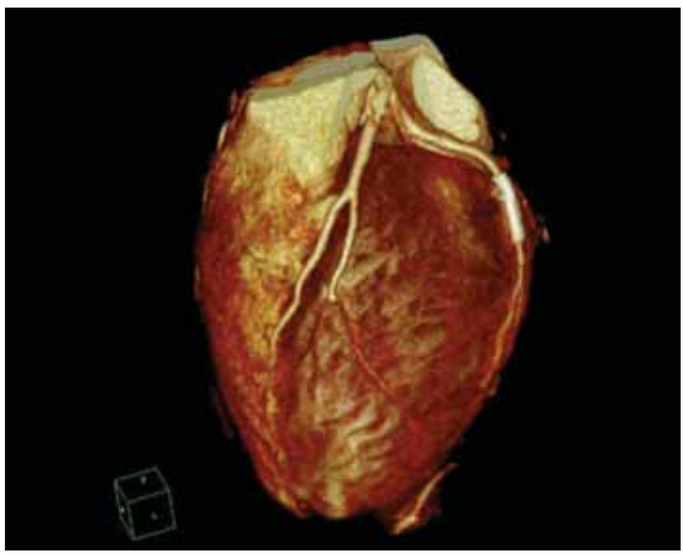

Figure 2. Computerized tomography view of a circumflex coronary artery after PTFA-covered stenting

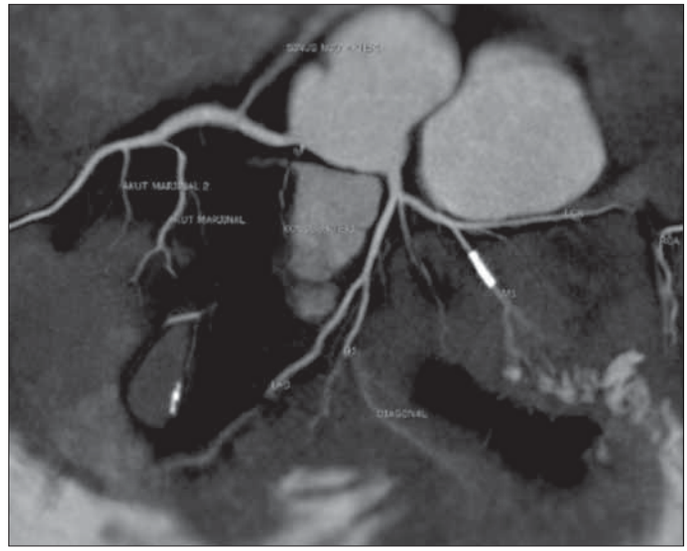

Figure 3. Computerized tomography-angiography view of circumflex coronary artery after stenting

This case is a good reminder that coronary aneurysms can be a cause for myocardial ischemia in the absence of a totally obstructive lesion. This patient has also factor V Leiden mutation and this is also interesting because to our knowledge, this coincidence or association has not been reported before in the literature.

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Pulmoner arter bifürkasyon darlığının eş zamanlı Genesis XD stent ile tedavisi

Treatment of pulmonary artery bifurcation stenosis by simultaneous implantation of Genesis XD stent

Pulmoner arter bifürkasyon darlıklarında stent yerleştirilmesinin istenilen etkiyi göstermesi açısından eşzamanlı yapılması önerilmektedir. Ancak bu işlem girişimsel kardiyolojinin en zor işlemlerinden biridir. Kliniğimizde 2010 yılı Ocak ve Ağustos ayları arasındaki sürede pulmo-