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Hypoplastic aorta in a patient with familial hypercholesterolemia

Ailesel hiperkolesterolemili bir hastada hipoplastik aorta

A 20-year-old man was admitted with extensive lesions on his hands. He had cutaneous xanthomas on the back of the hands, knees and elbows (Fig. 1A). Total cholesterol, low and high density lipoprotein cholesterol (LDL-C and HDL-C) were 626 mg/dL, 536 mg/dL and 74 mg/dL respectively and familial hypercholesterolemia (FH) was diagnosed. Transthoracic echocardiography (TTE) revealed degenerative changes in the aortic valve and mild aortic regurgitation. Computed tomography (CT) showed diffuse calcium plaques in the thoracic aorta (Fig. 1B, C). Abdominal aorta was 9.6 mm from hiatus to renal artery origin, 13.2 mm distal to this segment and 15.1 mm proximal to this segment (Fig. 1D). FH is an autosomal dominant disorder. Clinically, this is manifested as tendinous xanthomata and premature atherosclerosis. Hypoplasia of the aorta is a rare entity comprising tubular hypotrophy of a large segment of the thoracic and the abdominal aorta. Patients with hypoplasia of the infrarenal aorta is increased the incidence of atherosclerosis. Although hypoplasia of the abdominal aorta accompanied by FH may seem coincidence, we showed this condition because of its relationship early atherosclerosis. TTE is the first-step modality for cardiovascular imaging in adults with heart disease. The windows of access with transthoracic echocardiography may be inadequate for all regions of interest. Therefore, the patients with FH should be evaluated the further imaging such as CT and magnetic resonance imaging for the development of early atherosclerosis.

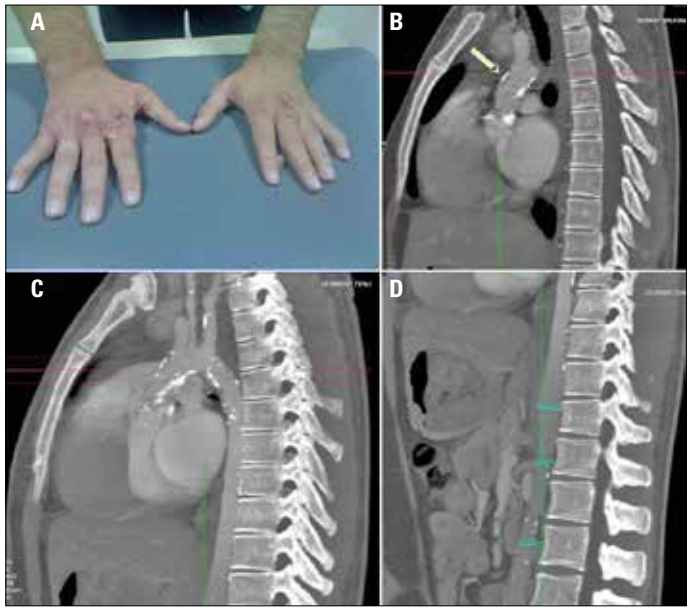

Figure 1. Xanthomas on the back of the his hands (A), computed tomography oblique sagittal images showed diffuse calcium plaques in the thoracic aorta especially in the ascending aorta (B, C), abdominal aorta was 9.6 mm from hiatus to renal artery origin, 13.2 mm distal to this segment and 15.1 mm proximal to this segment (D)

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A case of malposition of ventricular electrode through atrial septal defect

Atriyal septal defekt yoluyla uygunsuz yerleştirilen ventriküler elektrot olgusu

A 39-year-old man, who had a single-chamber pacemaker implanted for symptomatic bradycardia six years ago, was admitted because of dizziness and pre-syncope. Electrocardiogram showed sinus rhythm with right bundle brunch block and the chest X-ray demonstrated a pacemaker and its single electrode (Fig. 1). When pacemaker control was performed, the ventricular threshold was much higher than expected. Transthoracic echocardiography (TTE) revealed dilated right heart chambers, moderate tricuspid regurgitation and elevated pulmonary arterial pressure. In addition, an abnormal route of the ventricular electrode from the right atrium to the left atrium through atrial septal defect (ASD) was seen (Fig. 2A, Video 1. See corresponding video/movie images at www.anakarder.com). Transesophageal echocardiography (TEE) also demonstrated that

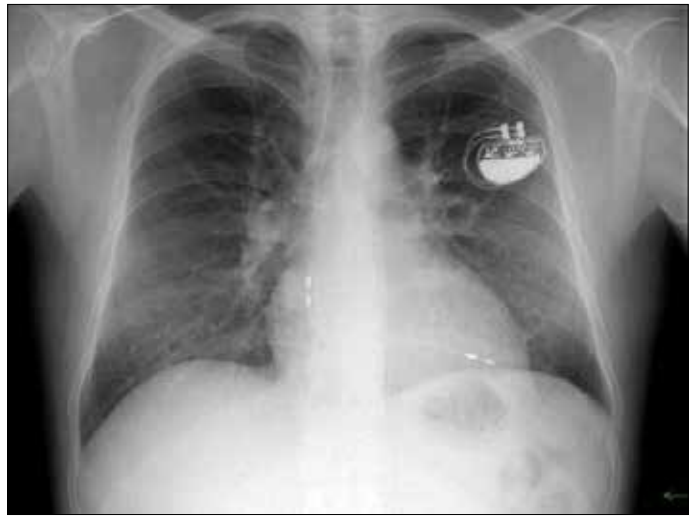

Figure 1. Chest X ray shows pacemaker and electrode