Cor triatriatum sinister with secundum atrial septal defect in a patient with recurrent pulmonary infections

Tekrarlayan akciğer enfeksiyonları olan bir hastada sekundum atriyal septal defekt ile cor triatriatum sinister

A 25-year-old male patient was admitted to our department with effort-related dizziness and palpitation. In his medical history, he had been hospitalized several times due to recurrent pulmonary infections. A systolic murmur of grade 3/6 was heard on cardiac auscultation. Transthoracic echocardiography showed a membrane-like structure resembling a pouch dividing the left atrium into two compartments in 2-dimensional views (Fig. 1 and Video 1. See corresponding video/movie images at www.anakarder.com). Color-Doppler study showed also a color-flow across the inter-atrial septum from the left to the right side. For further anatomical diagnosis, transesophageal echocardiography was performed. An incomplete membrane-like structure and turbulent flow across the defective site were observed in the left atrium (Video 2-3. See corresponding video/movie images at www.anakarder.com). In addition, a 1.2 cm sized defect covered by this membrane and color-flow transition from the left atrium to the right atrium in this region were detected (Fig. 2 and Video 4. See corresponding video/movie images at www.anakarder.com).

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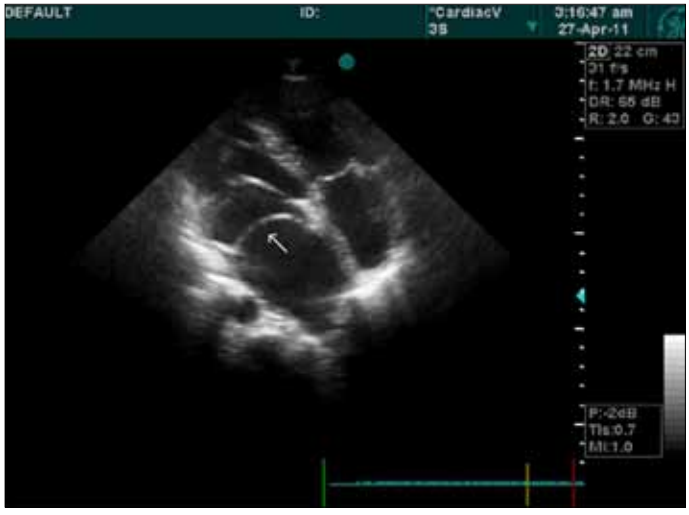

Figure 1. 2-D transthoracic echocardiography image of a membrane-like structure in the left atrium in apical four-chamber view (white arrow)

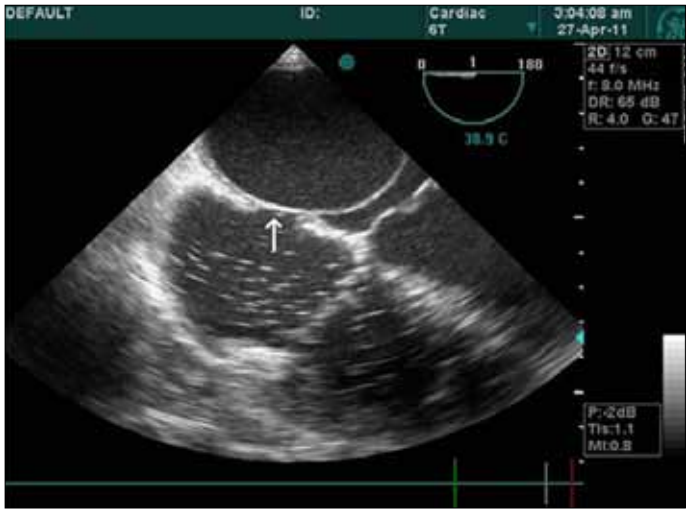

Figure 2. Transesophageal echocardiography image of an atrial septal defect covered by the membrane-like structure (white arrow)

Libman-Sacks endocarditis mimicking cardiac myxoma

Kardiyak miksomayı taklit eden Libman-Sacks endokarditi

Antiphospholipid syndrome (APS) has been defined as venous or arterial thrombosis, recurrent fetal loss, or thrombocytopenia accompanied by increased levels of anticardiolipin antibodies (ACA) and the lupus anticoagulant (LA) can be seen as primary or secondary to systemic lupus erythematosus (SLE). Libman-Sacks endocarditis, non-bacterial verrucous vegetative endocarditis, is regarded as a cardiac manifestation of both SLE and APS. Here we report a case, who had not been diagnosed SLE or APS previously, presenting with cerebrovascular event. The patient was 64-year-old woman was referred our institution after a transient ischemic attack with temporary right hemiplegia. On examination a blowing systolic murmur at the apex radiating to the left axilla was heard. Transthoracic (Fig. 1A) and transesophageal (Fig. 1B) echocardiography revealed mitral valve thickening with focal vegetations (Video 1-2. See corresponding video/movie images at www.anakarder.com). Repeated blood cultures and inflammatory markers were negative and there was no other evidence of infectious endocarditis. Erythrocyte sedimentation rate was 21 mm/h (0-25) and CRP was 0.410 mg/dL (0-0.8). The patient underwent mass excision surgery with preoperative diagno-

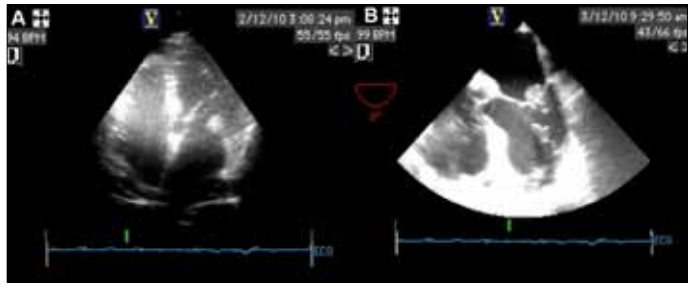

Figure 1. Transthoracic (A) and transesophageal (B) echocardiography images of vegetation on mitral posterior leaflet

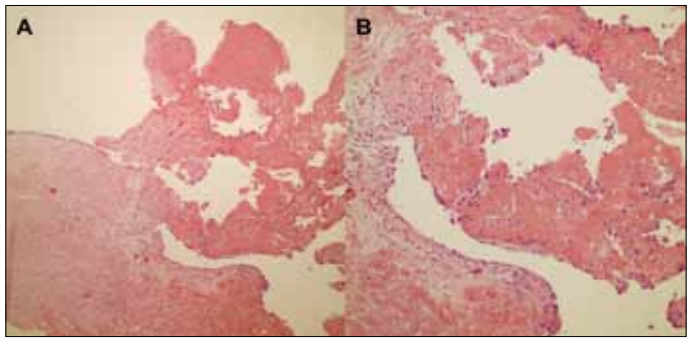

Figure 2. Microscopic histopathological image of excised mitral valve tissue, vegetation with fibrin-platelet thrombi (A. Original magnification x10, B. Original magnification x40)

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/µL, platelet 22000/µL) 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

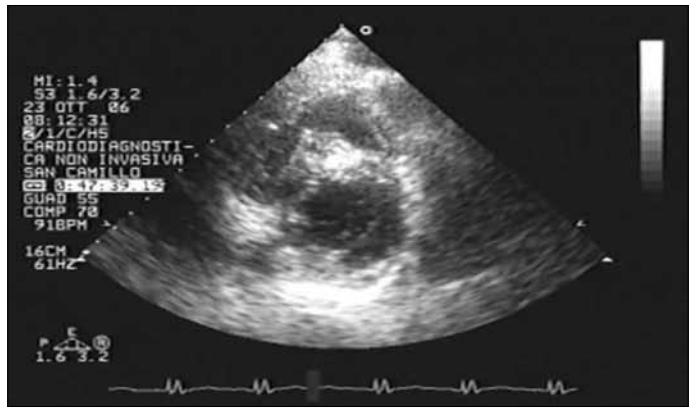

Figure 1. TTE parasternal short-axis view of a muscular band dividing the RV into two chamber and the dilatation of RV outlet part
RV - right ventricle, TTE - transthoracic echocardiography

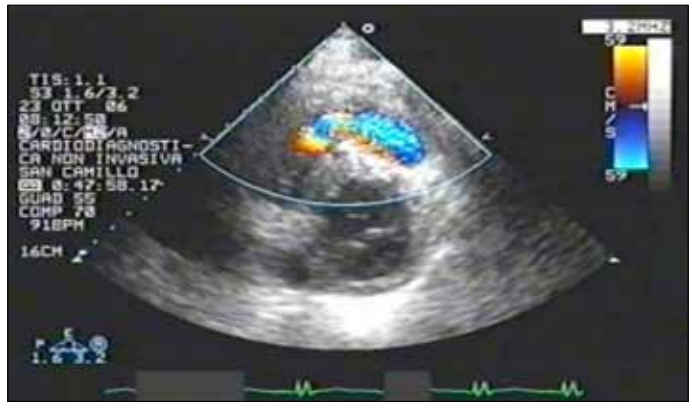

Figure 2. TTE parasternal short-axis view: the aliasing phenomena in the middle part of the right ventricle, as result of significant intraventricular gradient, is seen
TTE - transthoracic echocardiography

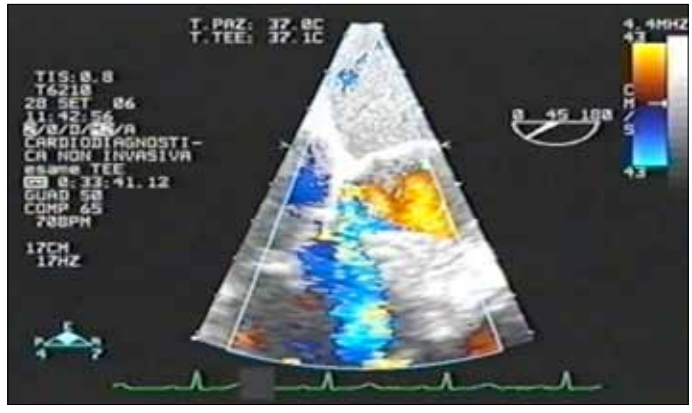

Figure 3. TEE 4-chamber view, 45°: perimembranous VSD with moderate left to right shunt is seen
TEE - transesophageal echocardiography, VSD - ventricular septal defect

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.