

Giant left main coronary artery aneurysm complicated with anterior myocardial infarction in Behçet's syndrome



Behçet hastalığında dev sol ana koroner arter anevrizmasına bağlı ön duvar miyokart enfarktüsü

Behçet's syndrome is chronic, systemic and inflammatory disorder and is characterized by aphthous stomatitis, genital ulcers, and ocular lesions. Vascular involvement usually affects the veins more commonly than the arteries, and coronary arterial involvement is extremely rare. A 49-year-old man presented to our institution with a prolonged retrosternal fluctuating chest pain at rest. The pain was radiating to the left arm

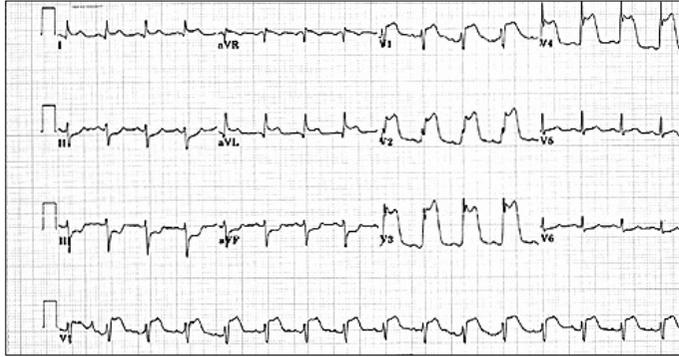


Figure 1. Electrocardiogram showing ST-segment elevation of 2 mm in leads V1-V6 and 1.0 mm in leads D1-AVL



Figure 2. Coronary angiography revealed total occlusion of the proximal LAD and 90% occlusion of the ostial Cx and IM artery and these coronary arteries originated from aneurysm of the left main coronary artery

Cx - circumflex artery, IM - intermediate artery, LAD - left anterior descending artery

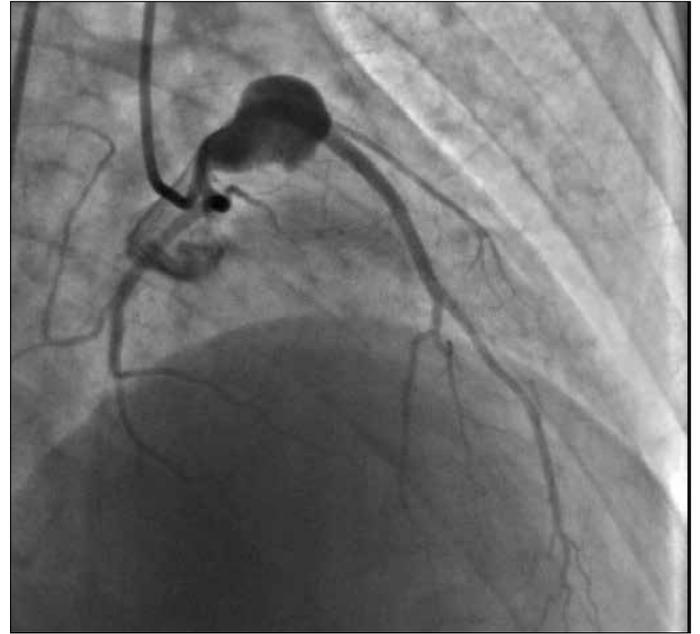


Figure 3. Left coronary angiogram showing the giant aneurysm of the left main coronary artery extending the proximal LAD

LAD - left anterior descending artery

and had started 3 h before admission. He had a history of Behçet's disease diagnosed 11 years ago and he was currently treated with colchicine and oral steroid. The patient was not overweight and had no history of hypertension, hyperlipidemia, diabetes mellitus and smoking. The initial electrocardiogram showed ST segment elevation of 2 mm in leads V1-V6 and 1.0 mm in leads D1-AVL (Fig. 1). He was diagnosed as having an acute anterior wall myocardial infarction, therefore nitroglycerin, aspirin and clopidogrel therapies were started immediately followed by early coronary angiography was performed. Coronary angiography revealed a giant left main coronary artery aneurysm extending to the left anterior descending artery (LAD) (15 mm in diameter), total thrombotic occlusion of the proximal LAD, 90% stenosis of the ostium of circumflex artery and intermediate artery (Fig. 2, 3, Video 1, 2. See corresponding video/movie images at www.anakarder.com). Because percutaneous transfemoral coronary angioplasty would have been hazardous in the present case due to the length of the aneurysm and the high risk of distal embolization, the patient was referred for emergency coronary artery bypass graft operation. Although myocardial infarction is a rare event in Behçet's disease, acute myocardial infarction has high mortality and morbidity especially in a young patient. For this reason we suggest that every Behçet's disease should be assessed with non-invasive cardiac stress test at asymptomatic period.

Video 1. Coronary angiography revealed an total occlusion of the proximal LAD and 90% occlusion of the ostial Cx and IM artery and these coronary artery originated from aneurysm of the left main coronary artery

Cx - circumflex artery, IM - intermediate artery, LAD - left anterior descending artery

Video 2. Left coronary angiogram showing the giant aneurysm of the left main coronary artery extending the proximal LAD

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Controlled removal of a dislodged stent causing myocardial ischemia 1 year after stent placement

İskemiye neden olan koroner ostiyumunda sıyrılmış stentin bir yıl sonra kontrollü olarak geri alınması

The potential complications of stent dislodgement include coronary occlusion and thrombosis, myocardial infarction and even life-threatening systemic embolization. Since dislodged stents can cause severe complications, removal of the stent should be the main goal.

A 61-year-old female presented to the clinic for exertional dyspnea and chest pain increasing for the last two months. Patient had a history of percutaneous closure of atrial septal defect (ASD) 10 days ago and stent implantation to the left circumflex artery (LCX) and right coronary artery (RCA) 1 year ago in another hospital. We reviewed the cine angiographic images during the closure of ASD and detected an unopened stent in the RCA ostium causing total occlusion. About one third of the stent was out of the coronary artery (Video 1, 2. See corresponding video/movie images at www.anakarder.com). Myocardial perfusion scintigraphy revealed ischemia in RCA regions. We took the patient to catheter laboratory for removing the unopened stent. Coronary angiography confirmed that the stent was dislodged and endothelialized. We grabbed the stent using snare and pulled out the stent gradually (Fig. 1). Aortic root imaging was performed in order to visualize the complications such as aortic dissection and was normal. No other complications developed. Since patient had ischemia in RCA



Figure 1. Endothelialized unopened stent

region we planned intervention to chronic total lesion in RCA after 1 month considering the endothelia recovery.

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Video 1, 2. Coronary angiogram shows an unopened stent in the RCA ostium. About one third of the stent was out of the coronary artery

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Three-dimensional transesophageal echocardiographic evaluation of a patent foramen ovale accompanied with interatrial septal space

Patent foramen ovale ve interatriyal septal boşluk birlikteliğinin üç boyutlu transözefajiyal ekokardiyografi ile değerlendirilmesi

Patent foramen ovale (PFO) is a common clinical finding, affecting 10 to 24% of the general population and is a result of an incomplete fusion of the interatrial septum. Double interatrial septum (IAS) is a rare anomaly in which there is a double-walled atrial septum with a persistent midline space between the two atria. It is most likely resulting from persistence of the embryologic left venous valve or an abnormal duplication of septum primum.

A 34-year-old male patient was admitted to our outpatient clinic for the cardiac source of emboli after transient ischemic attack (TIA). Arrhythmias were not documented and no thrombophilic risk factors could be identified. An electrocardiography showed a sinus rhythm. Two-dimensional transthoracic echocardiography revealed drop-out at interatrial septum. Two-dimensional transesophageal echocardiography detected a high mobile membrane adjacent and parallel to the IAS (Fig.1A and Video 1. See corresponding video/movie images at www.anakarder.com) and also showed PFO with left- to- right shunt (Fig. 1B and Video 2. See corresponding video/movie images at www.anakarder.com). Three-dimensional transesophageal echocardiography was performed and confirmed double IAS (Fig. 2A, B, asterisk and Video 3, 4. See corresponding video/movie images at www.anakarder.com).

Until now, few cases with double IAS have been reported; most of them are associated with PFO. Transient ischemic attack is seen approximately 5% of patients with PFO. Double IAS is a rare anomaly which may cause TIA. This case demonstrated PFO and double IAS in