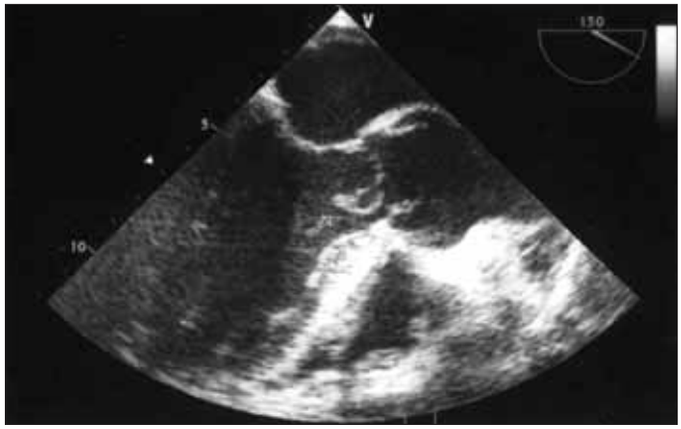

Figure 6. Transesophageal echocardiography, 150-degree, systolic frame view: An accessory mitral valve (arrow) prolapsing through the aortic valve during systole

anakarder.com). During TEE, no other congenital cardiac abnormalities found and no spontaneous echo-contrast or thrombus formation were detected. Cardiac catheterization revealed normal coronaries and LVOT gradient of 30 mmHg. In the absence of relevant obstruction of LVOT, patient is being followed up without surgical intervention and was recommended to start oral anticoagulation treatment with phenprocoumon to prevent recurrent cardioembolic events and prophylaxis for bacterial endocarditis.

Accessory mitral valve should be considered in differential diagnosis of LVOT obstruction. Transesophageal echocardiography is superior to TTE for diagnosing of sources of intracranial emboli. Accessory mitral valve without serious LVOT obstruction carries a risk of thromboembolic complication. Antiplatelet drugs should be suggested even in the absence of predisposing factor for cerebrovascular thromboembolic complication and serious LVOT obstruction.

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Porcelain left atrium

Porselen sol atriyum

Calcification of the left atrium occurs especially long years after mitral valve operations. Extensive left atrium calcification after mitral valve replacement was reported in the literature and complete calcification has been described as a "coconut atrium" or "porcelain atrium".

A 76-year-old woman who had diabetes mellitus, hypertension and the story of open mitral commissurotomy for rheumatic mitral stenosis was admitted to our department because of chest pain, dyspnea and pretibial edema. On physical examination she had arrhythmic heartbeats, 2/6 systolic murmur on the second left intercostal space, ++/++ pretibial edema, painful hepatomegaly and venous jugular distension. The electrocardiography revealed atrial fibrillation with a ventricular rate of 60 beats/min and ST depression in the inferolateral derivations. Chest radiography demonstrated an enlarged cardiac silhouette and linear calcification on the left atrial zone (Fig. 1). Echocardiogram demonstrated normal left ventricular function, moderate mitral stenosis (mean gradient was 6 mmHg), moderate aortic regurgitation and severe tricuspid regurgitation. Left atrium was dilated and the calcification covered entirely the left atrium (Fig. 2). Catheterization and coronary angiography showed normal coronary arteries, mitral stenosis (mean gradient 6 mmHg) and high systolic pulmonary artery pressure (65 mmHg). Ventriculography showed mild mitral regurgitation, extensive calcification of the left atrial zone (Fig. 3a). Aortography also showed extensive calcification of the left atrial zone (Fig. 3b) and 1-2° aortic regurgitation. The patient was discharged with suggestion of surgical operation on the mitral and tricuspid valves.

Figure 1. Chest radiography view of enlarged cardiac silhouette and linear calcification on the left atrial zone

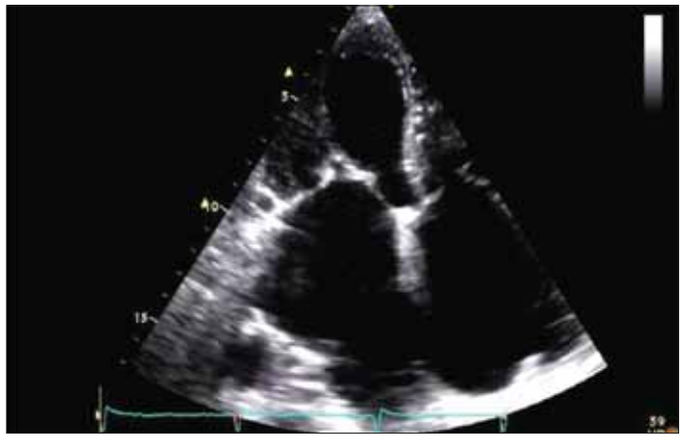

Figure 2. Echocardiography view of dilated left atrium and calcification covering entirely the left atrium

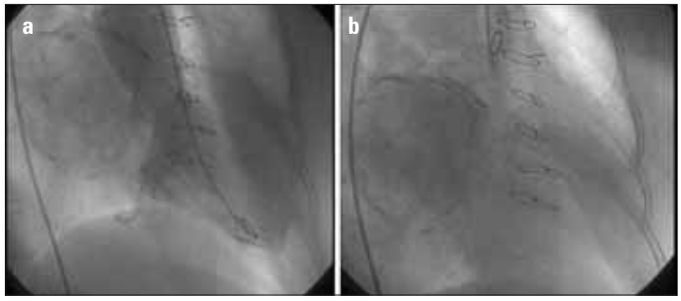

Figure 3. a) Ventriculography (RAO 35 CRA 0) and (b) aortography views of extensive calcification of the left atrial zone

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Hiatus hernia mimicking pericardial calcification

Perikardiyal kalsifikasyonu taklit eden hiatus hernisi

A 85-year-old man was admitted to our department with severe dyspnea on effort. He had no cardiac or pulmonary disease and neither anemia nor cyanosis. Electrocardiography showed normal sinus rhythm. Chest roentgenography revealed a radio-opaque image mimicking pericardial calcification and a dome-shaped air level within the heart silhouette (Fig. 1). There was no evidence of ventricular dysfunction, pericardial tamponade and pericardial calcification on two-dimensional echocardiography examination (Fig. 2, 3).

The diagnosis was a large hiatus hernia with intrathoracic stomach as confirmed by lateral chest X-ray (Fig. 4). Hiatal hernias are common, and are usually asymptomatic. Symptoms of hiatal hernia can be vague, including postprandial distress, fullness, dysphagia, nausea, vomiting, reflux and chronic anemia due to mucosal blood loss. Additionally, severe cases may present with respiratory failure in elderly patients. The therapeutic strategy of surgical repair is recommended in elderly patients with hiatus hernia complicated with respiratory impairment.

Figure 1. Posterior-anterior chest X-ray view of a large focal airspace process within the heart silhouette

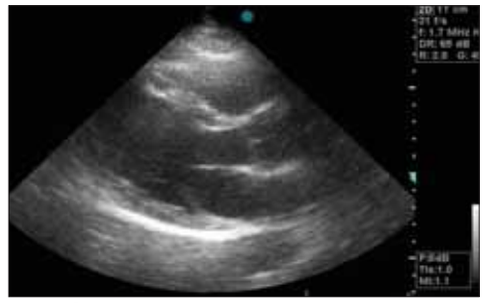

Figure 2. Apparently normal transthoracic echocardiogram - parasternal long-axis view

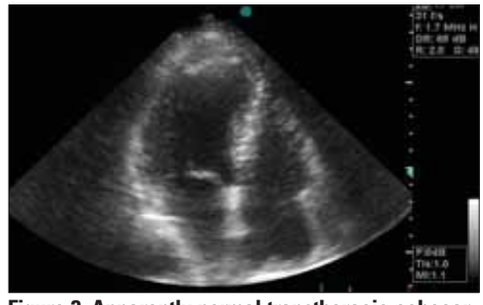

Figure 3. Apparently normal transthoracic echocardiogram - apical 4-chamber view

Figure 4. Lateral chest X-ray view of a large focal airspace process in hemithorax

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