distortion and cryptitis, with heavy mixed inflammatory cell infiltration (mostly plasma cells and eosinophils) within lamina propria.

Barium enema revealed pseudodiverticula and lead pipe sign in the transverse colon (Fig. 1). Cranial magnetic resonance imaging was normal. Electroencephalography revealed epileptic activity in temporal, parietal and occipital regions.

Cardiac catheterization showed aortic aneurysm of ascending and descending aorta (Fig. 2, Video 1. See corresponding video/movie images at www.anakarder.com). There was no pressure gradient between the ascending and descending aorta.

Oral prednisolone and sulfasalazine treatments were given for ulcerative colitis, metronidazole for perianal fissure, and sodium valproate therapy for epilepsia. Aortic graft surgery for aneurysm was planned after the inflammation control with prednisolone and sulfasalazine (5).

In conclusion we described patient who had aortic aneurysm as a rare complication of ulcerative colitis. If treatment is initiated earlier, this complication may be prevented.

**Cemşit Karakurt , Gülendam Koçak ,
Ayşe Selimoğlu*, Metehan Özen****

**From Units of Pediatric Cardiology, *Pediatric Gastroenterology and ** Pediatric Infectious Disease, Faculty of Medicine, University of İnönü, Malatya, Turkey**

## References

1. Hanaver SB. Inflammatory bowel disease. N Engl J Med 1996; 334: 841-8.
2. Kreuzpaintner G, Horstkotte D, Heyll A, Losse B, Strohmeyer G. Increased risk of bacterial endocarditis in inflammatory bowel disease. Am J Med 1992; 92: 391-5.
3. Granot E, Rottem M, Rein AJ. Carditis complicating inflammatory bowel disease in children. Case report and review of the literature. Eur J Pediatr 1988; 148: 203-5.
4. Farley JD, Thomson AB, Dasgupta MK. Pericarditis and ulcerative colitis. J Clin Gastroenterol 1986; 8: 567-8.
5. Shiono M, Hata M, Sezai A, Iida M, Negishi N, Sezai Y. Reoperation for ascending aortic aneurysm, coronary ostial aneurysm and patent Cabrol trick after Bentall operation for aortitis syndrome. Circ J 2005; 69: 861-4.

**Address for Correspondence/Yazışma Adresi:** Cemşit Karakurt, İnönü University Faculty of Medicine, Unit of Pediatric Cardiology, Malatya, Turkey
Phone: +90 422 341 06 60/5302 Fax: +90 422 341 07 28
E-mail: ckarakurt@yahoo.com

# Spontaneous dissection of left anterior descending artery and cardiac apical mass without aneurysm

## *Anevrizma olmadan sol ön inen koroner arterin spontan disseksiyonu ve kardiyak apikal kitle*

A 48-year-old man who was admitted to hospital because of syncope, transient ischemic attack, palpitations and chest pain. On physical examination, he had sight deficiency on the right eye. Electrocardiography revealed T-wave inversion in leads V1 through V6. The cardiac enzymes (creatine phosphokinase-MB and Troponin-T) were normal. Laboratory analysis was normal. Echocardiogram showed an apical mass resembling thrombus in apical region of the left ventricle (Video 1, 2. See corresponding video/movie images at www.anakarder.com). The coronary angiography (CAG) of the patient showed that the patient's left anterior descending (LAD) artery was irregular, dissected, and recanalized spontaneously following the dissection; it also revealed the presence of double lumen structure and no aneurysm any where on ventricle (Fig. 1). The other coronary arteries were normal. Brain computed tomography revealed infarction in the occipital region. It was judged by neurologists that this lesion would not hinder open heart surgery. Anticardiolipin antibodies were negative. There was no stigma of connective tissue disorder. Due to the prolonged existence of mass and continuance of the patient's complaints despite the maximal anticoagulant treatment (keeping INR 2-3), we decided to operate the patient with the techniques of standard cardiopulmonary bypass using moderate hypothermia and cardioplegia arrest. In the operation, a mass including thrombus with diameters of 20x15 mm adjacent to the papillary muscles on the left ventricular apical region was resected. Apical region was closed with felt (Fig. 2). However, we did not perform coronary artery bypass grafting (CABG) because of the absence of significant stenosis.

Histopathologic examination showed dystrophic calcified bond tissue and thrombus. He had an uneventful recovery and was discharged home six days after surgery. He was observed to be doing well in the two-month follow-up visit.

**Cevdet Uğur Koçoğulları, Hasan Kocatürk*, Hikmet Koçak**

**From Departments of Cardiovascular Surgery and *Department of Cardiology, Medical Faculty, Atatürk University, Erzurum, Turkey**

**Address for Correspondence/Yazışma Adresi:** Dr. Cevdet Uğur Koçoğulları, Dervişpaşa Mah. Dr. Mahmut Hazar Caddesi, Buse Apt.
No: 43 A Blok B, B Giriş D:4 03000 Afyon, Turkey
Phone: +90 542 235 56 03 E Mail: cevdetkoc@hotmail.com

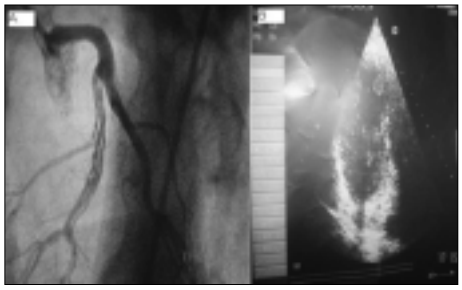

**Figure 1. A- Preoperative coronary angiography shows dissection of left anterior descending artery. B- Preoperative echocardiography shows a cardiac apical mass of left ventricle**

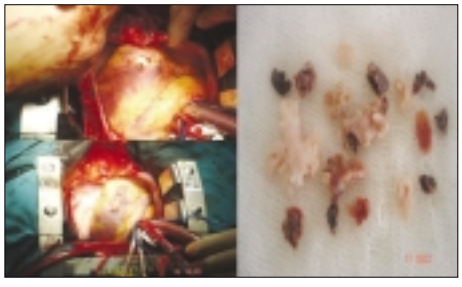

**Figure 2. Intraoperative images**