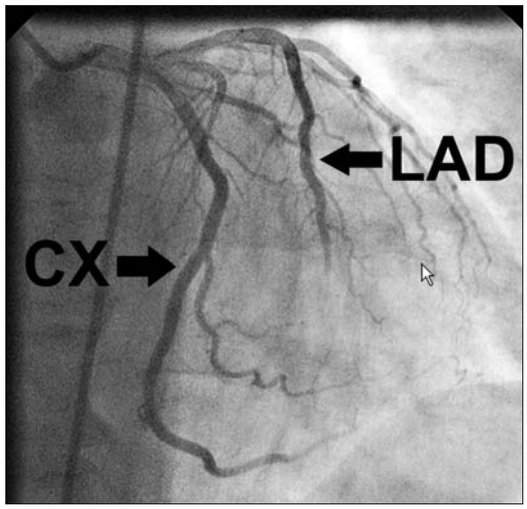

Figure 1. Angiographic demonstration of the slow coronary flow phenomenon in the left anteror descending artery. Incomplete filling of LAD is shown while CX is opacified completely.

CX - left circumflex artery, LAD- left anterior descending artery

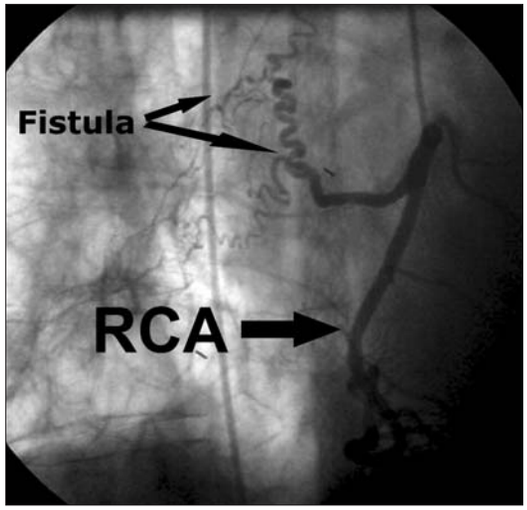

Figure 2. Right anterior oblique view showing the RCA and fistula.

RCA - right coronary artery

major vessel. Therapeutic strategies of CAF are based on symptoms and shunt size. The SCF is characterized by delayed opacification of epicardial coronary arteries in the absence of stenotic lesion. It is an important clinical entity because it may be the cause of angina at rest or during exercise and acute myocardial infarction. The association of coronary artery fistulas and slow coronary flow should be kept in mind in management of patients with these types of coronary anomalies.

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Ventriculography should be carefully monitorized

Ventrikülografi çok dikkatli izlenmelidir

A 74 years old male patient had unstable angina pectoris. On coronary angiography, he had 90% stenosis in the left main coronary artery, so he was planned to undergo urgent surgery. However, due to a suspicious, mobile mass image in his ventriculography (Video 1. See corresponding video/movie images at www.anakarder.com), echocardiography was performed. He had mild mitral insufficiency, severe tricuspid insufficiency, giant myxoma (Fig. 1-2), and ejection fraction of 40%, and a pulmonary artery pressure of 45-55mmHg on echocardiography. He underwent urgent operation with aorto-bicaval cannulation with cardiopulmonary bypass. Myxoma was seen in his left atrium (Fig. 3). The mass was excised totally with its pedicle (Fig. 4). Intraoperative mitral valve evaluation revealed severe regurgitation. Mitral valve repair and anastomoses to two coronary artery by pass (left anterior descending artery and first obtuse

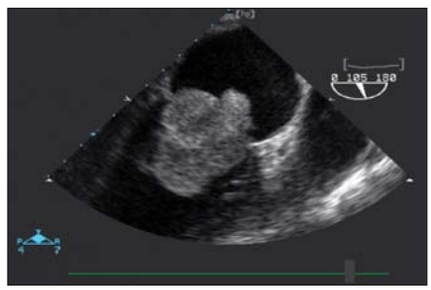

Figure 1. Echocardiography view of left atrial mass originating from left atrium with a diameter of 6x6.5 cm size, migrating to left ventricle in diastole

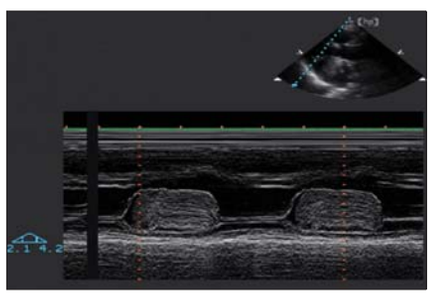

Figure 2. Myxoma between mitral valve leaflets on M-mode echocardiography

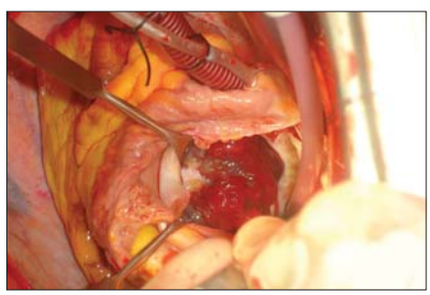

Figure 3. Intraoperative view of myxoma in left atrium

Figure 4. Excised myxoma

marginal branch of circumflex artery) were performed. Tricuspid valve was examined with saline test and severe insufficiency was seen, therefore, De-Vega annuloplasty was performed. The operation was completed without any complications and the patient was discharged on the 5th postoperative day. Pathological diagnosis was myxoma.

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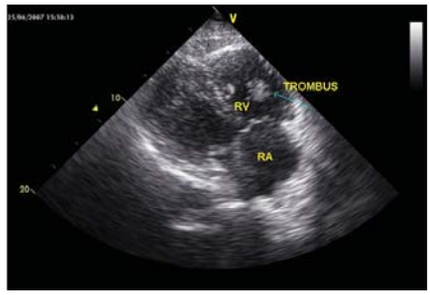
Ekokardiyografi ile sağ ventrikülde mobil trombüs tespit edilen akut pulmoner tromboemboli olgusu

A case of acute pulmonary thromboembolism with a mobile thrombus in right ventricle detected with echocardiography

Klinik olarak pulmoner tromboemboliden (PTE) şüphelenilen olguların tümünde akciğer perfüzyon sintigrafisi ve/veya pulmoner anjiografinin zamanında uygulanması mümkün olamamaktadır. Transtorasik ekokardiyografi (TTE), kalp boşluklarında trombüs tanısında oldukça önemli bir tanı yöntemidir. Acil serviste yatak başında uygulanabilen TTE yöntemi, PTE'li hastalarda erken tanı olanağı sağlayabilmektedir. Bu raporda, akut PTE kliniği gelişen bir olguda TTE ile sağ ventrikül trombüsünün gösterilmesi ve PTE tanısının doğrulanması anlatılmaktadır.

Asit etyolojisi araştırılmak üzere yatırılan morbid obez ve immobil olan 75 yaşında bayan hastada yatışının 3. gününde ani nefes darlığı, sırt ağrısı ve senkop gelişti. Hastanın genel durumu kötü, bilinç bulanık, dispneik ve takipneik idi. Kan basıncı 140/100 mmHg, nabız 100/dakika ritmik, vücut ısısı 37,4 ºC, arter kan gazı hipoksik (PO_2: 56,6), hipokapneik (PCO_2: 33) olup D-dimer 3414 mg/L olarak saptandı. Akut PTE ön tanısıyla yapılan TTE'de sağ ventrikül içinde lobüle mobil trombüs ve orta derecede pulmoner hipertansiyon (60 mmHg) tespit edildi. (Resim 1, Video 1. Video/hareketli görüntüler www.anakarder.com'da izlenebilir). Hastaya trombolitik ve antikoagülan tedavi başlandı. Genel durum bozukluğu nedeniyle trombektomi için ameliyata alınamadı. Takibinde solunum sıkıntısı artan hasta entübe edilerek mekanik ventilatöre bağlandı. Ancak akut olayın gelişimini izleyen 24 saat içinde exitus oldu.

Sağ kalp kökenli trombüslerin görülme olasılığı sol kalbe göre çok daha nadirdir ve sıklıkla mikroemboli veya masif PTE'ye yol açabildiklerinden kötü prognozludur. Bu olgularda erken tanı ve acil tedavi çok önemlidir. Bu nedenle, akut PTE şüphesi olan hastalarda, erken dönemde ekokardiyografi yapılarak PTE tanısının doğrulanması, akciğer perfüzyon sintigrafisi ve/veya pulmoner anjiyografi yapılmadan fibrinolitik tedaviye başlanması için zaman kazandırabilir.



Resim 1. Ekokardiyografide sağ ventrikül kavitesi içinde trombüsün görünümü

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Interventricular septal perforation as a rare complication of temporary transvenous pacemaker

Geçici transvenöz pacemaker'ın nadir bir komplikasyonu: İnterventriküler septal perforasyon

Interventricular septum perforation is a rare complication of pacemaker implantation, but it may cause death and may be misdiagnosed.

A 70-year-old woman was admitted to the emergency room of another hospital with complete atrioventricular (AV) block with a ventricular rate of 30 beats/min on electrocardiography (ECG). Ventricular tachycardia occurred during temporary pacemaker implantation via right subclavian vein. The patient referred to our hospital after D/C cardioversion. The ECG on admission showed right bundle branch block (RBBB) pacemaker rhythm with a rate of 68 beats/min. The pacemaker lead was not in normal position on chest X-ray.

The RBBB pattern is a useful marker of the left ventricular stimulation. The left ventricular stimulation after temporary or permanent pacemaker implantation is associated with connections formed by the coronary sinus and its branches, intracardiac defects (sinus venosus type defect, patent foramen ovale, atrial septal defect), perforation of interventricular septum and malposition due to inadvertent subclavian artery puncture. The lead position was assessed with transthoracic echocardiography.

The transthoracic echocardiography showed left ventricular hypertrophy (interventricular septum thickness of 16 mm), relaxation disturbance, pacemaker lead passing from the right atrium to the right ventricle and to the left ventricle at the interventricular plane (Fig. 1, 2). The tip of the lead was detected in the left ventricle and this was confirmed with transesophageal echocardiography (Fig. 3).