prises lymphoma, Castleman's disease, metastases and sarcomas. Paragangliomas should be considered in the differential diagnosis of strongly enhancing mass lesions at pericardial or cardiac region.

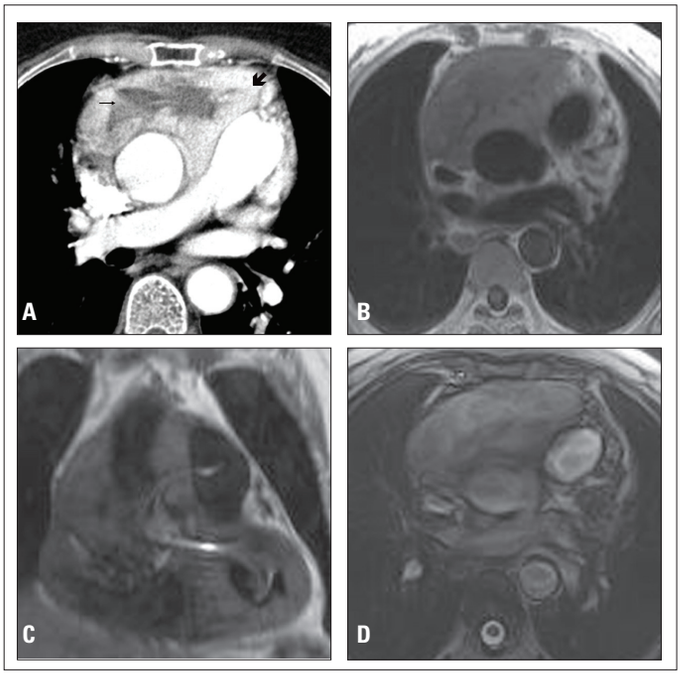

Figure 1. A) CT image of strongly-enhancing mass (thick arrow), with a necrotic central portion (thin arrow), encasing pulmonary artery and aorta. T1-weighted axial (B) and coronal (C) MR images of intrapericardial, heterogeneous mass of low signal intensity at aorticopulmonary region (D) T2-weighted axial MR image of the lesion with higher signal intensity than muscle and less signal intensity than surrounding fat tissue

CT – computerized tomography, MR – magnetic resonance

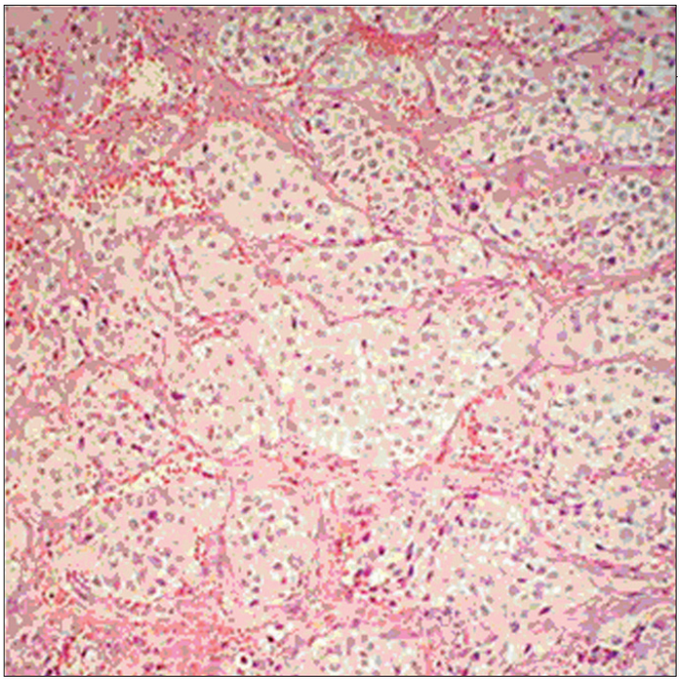

Figure 2. High-power photomicrograph demonstrates the nesting (zellballen) appearance of the paraganglioma cells (original magnification, 300; H-E stain).

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Calcified ball- like left ventricular thrombus embolized during echocardiography follow-up

Ekokardiyografi takibi sırasında embolize olan kalsifiye top şeklinde sol ventrikül trombüsü

A 48-year-old male was admitted to our cardiology department with complaints of dyspnea and palpitations for ten days. He had smoking history for 30 years as a risk factor for coronary artery disease. The patient was tachypneic and cyanotic; his blood pressure was 100/80 mmHg, pulse rate - 130 beats/min and respiratory rate was 25/min. On cardiovascular examination, a grade 2/6 systolic murmur was heard at the left sternal border. Electrocardiogram showed atrial fibrillation with anterior QS pattern. There was a mild leukocytosis and troponin level was 0.5 ng/dl. There was a cardiomegaly on telecardiography and transthoracic echocardiography demonstrated mild mitral regurgitation and global left ventricular (LV) hypokinesia with LV ejection fraction of 25%. Besides, there was a huge calcified ball-like mass (2.7 cm x 3.0 cm) in the LV apex. Urgent cardiac surgery was planned for thrombus removal. A second echocardiography follow- up was done before the cardiac surgery. During that time, he had begun to describe a severe abdominal pain and general surgeons were called for consultation. We re-evaluated the patient by echocardiography with the suspicion of embolization of the thrombus. Interestingly, there was no any thrombus in the LV cavity (Video 1. See corresponding video/movie images at www.anakarder.com). We performed mesenteric angiography. Celiac artery and its branches, and superior mesenteric artery were normal. However, inferior mesenteric artery was totally occluded by thrombus just above the bladder (Video 1. See corresponding video/movie images at www.anakarder.com). The patient was treated with heparin and aspirin for 5 days and was discharged in a good condition with prescription of coumadin, aspirin plus heart failure treatment.

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