

est point in the proximal part of the fistula. However control angiogram showed residual flow in the fistula and we used 6 Fr right Judkins catheter to push forward AVP device inside of the 8 Fr left Judkins catheter. Eventually, a 14 and 16 mm AVP devices were deployed just below to circumflex branches.

Repeat angiogram showed complete closure of the defect as well as improved filling of the coronary branches (Fig. 2B, Video 2). The patient had an uneventful hospital course. At 3-month follow-up, the patient is asymptomatic and doing well.

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Video 1. Selective coronary angiogram in right caudal view shows dilated circumflex artery with an aneurysm and fistula draining into the coronary sinus. Note the poor opacification of the left coronary system, suggestive of coronary steal

Video 2. Check angiogram shows no residual shunt, with good opacification of coronary arteries and the AMPLATZER™ Vascular Plugs I devices in situ

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Available Online Date: 09.06.2014

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 DOI:10.5152/akd.2014.5641

Giant right coronary artery aneurysm with atherosclerotic disease

Coronary artery aneurysm (CAA) is defined as dilatation of the coronary artery that is more than 1.5 times the diameter of normal adjacent segments. A coronary artery with a diameter more than 2 cm is

termed as 'giant aneurysm'. In adults, CAA is predominantly atherosclerotic in origin; however, other causes include Kawasaki disease, autoimmune disease, trauma, infection, dissection, congenital malformation and angioplasty.

A 63-years-old man was admitted to our hospital with chest pain. On physical examination, blood pressure was 145/90 mm Hg and pulse rate 70 beats/min. The rest of the physical examination was unremarkable. The 12-lead electrocardiogram showed Q waves in V1-4 leads. Transthoracic echocardiography demonstrated left ventricular ejection fraction of 40%, dilated left heart chambers and, an extra-cardiac mass was noted adjacent to the right atrium (Fig. 1). The patient was then referred for cardiac computed tomography (CT) angiography for further evaluation. A prospective ECG-gated contrast-enhanced CT angiogram was obtained on 64-slice multi-detector CT (MDCT). A giant atherosclerotic right coronary artery (RCA) aneurysm located and involving the proximal segments was confirmed. The aneurysm had a diameter of 32x22 mm (Fig. 2).

Diagnostic coronary angiography showed an aneurysm arising from the proximal segment of the RCA. There was total occlusion of the ostial left anterior descending artery and 70 % stenosis of the proximal circumflex artery (Fig. 3, Video 1-2).

Coronary artery bypass graft surgery for three vessels and coronary artery aneurysm ligation were performed (Fig. 4). The follow up period for one month was uneventful.

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Video 1. Right coronary angiogram showing the giant aneurysm of the proximal RCA

Video 2. Left coronary angiogram showing total occlusion of the ostial LAD artery and 70% stenosis of the proximal Cx artery

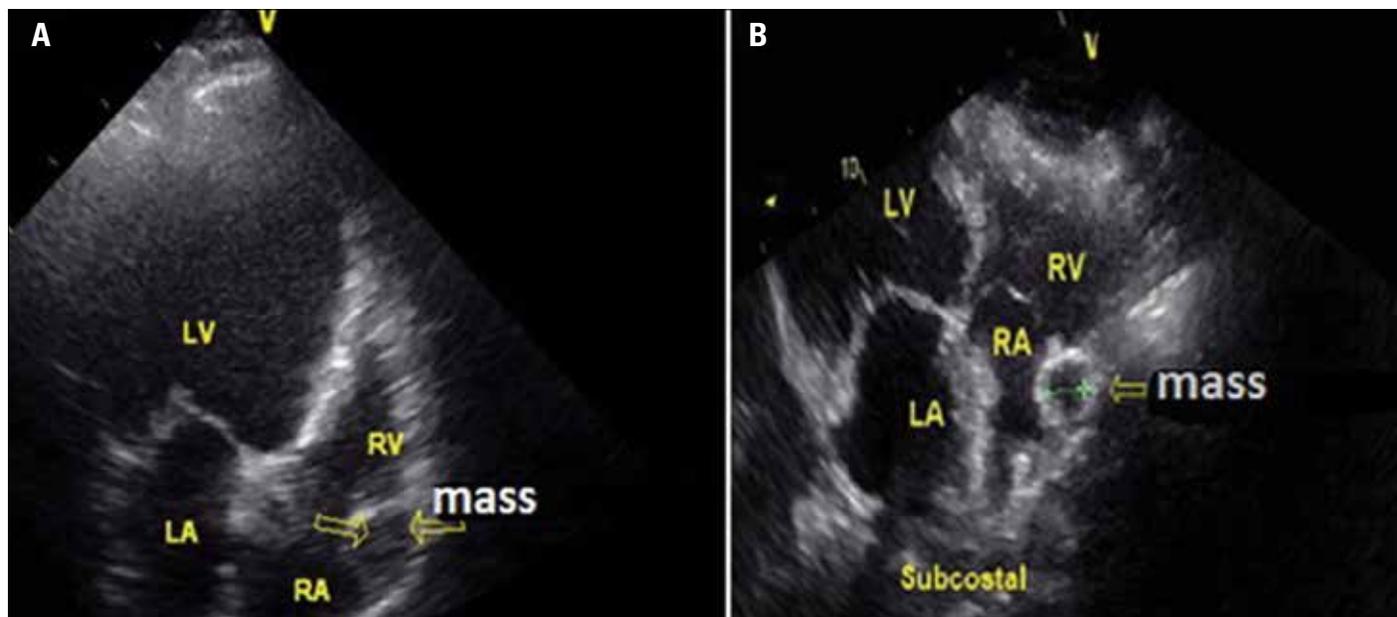


Figure 1. Echocardiogram; apical and subcostal four-chamber views showing an echogenic mass compressing the right atrium

LA - left atrium; LV - left ventricle; RA - right atrium; RV - right ventricle

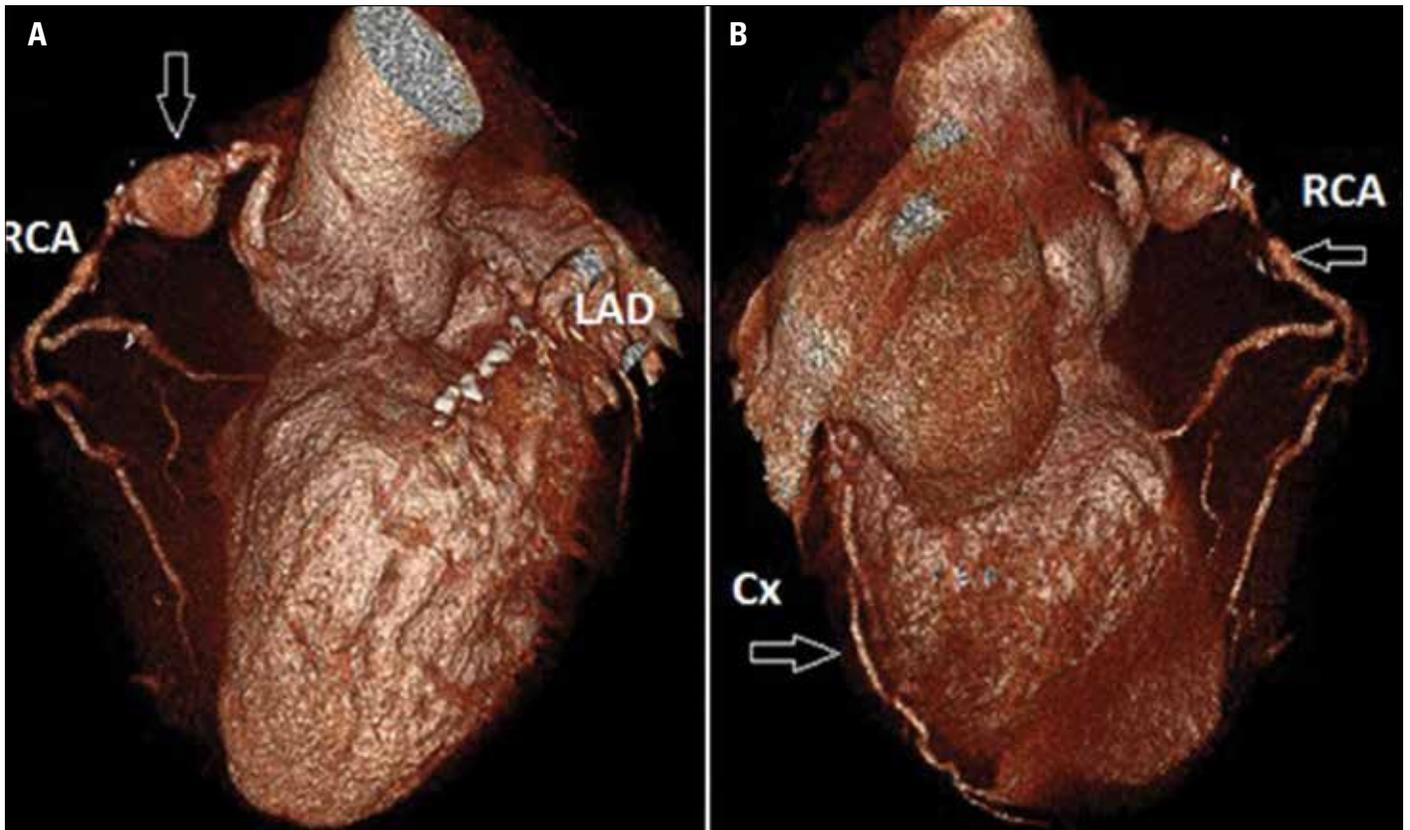


Figure 2. Echocardiogram-gated contrast-enhanced computed tomography. **A-**Three-dimensional volume-rendered reformats showing the giant RCA aneurysm and total occlusion of the ostial LAD artery. **B-**Critical stenosis of distal aneurysm and Cx artery
Cx - circumflex; LAD - left anterior descending; RCA - right coronary artery

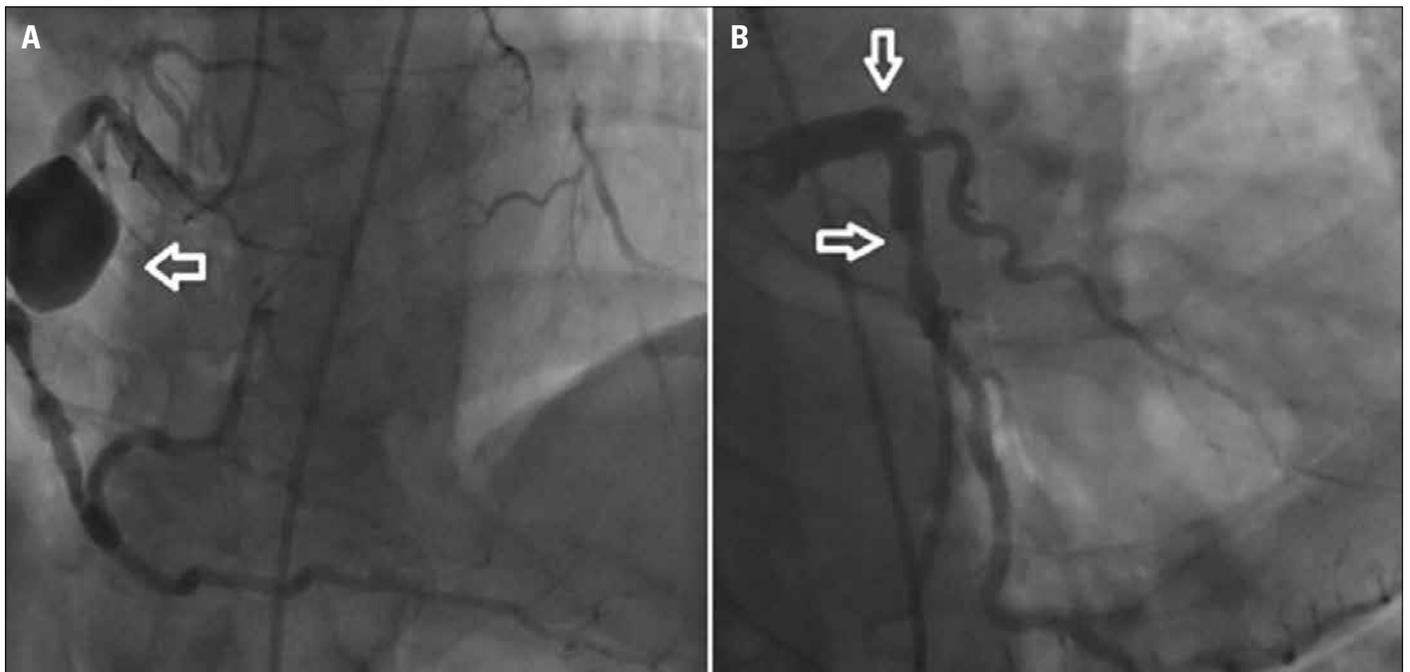


Figure 3. **A-**Right coronary angiogram showing the giant aneurysm of the proximal RCA, **B-** Left coronary angiogram showing total occlusion of the ostial LAD artery and 70% stenosis of the proximal Cx artery

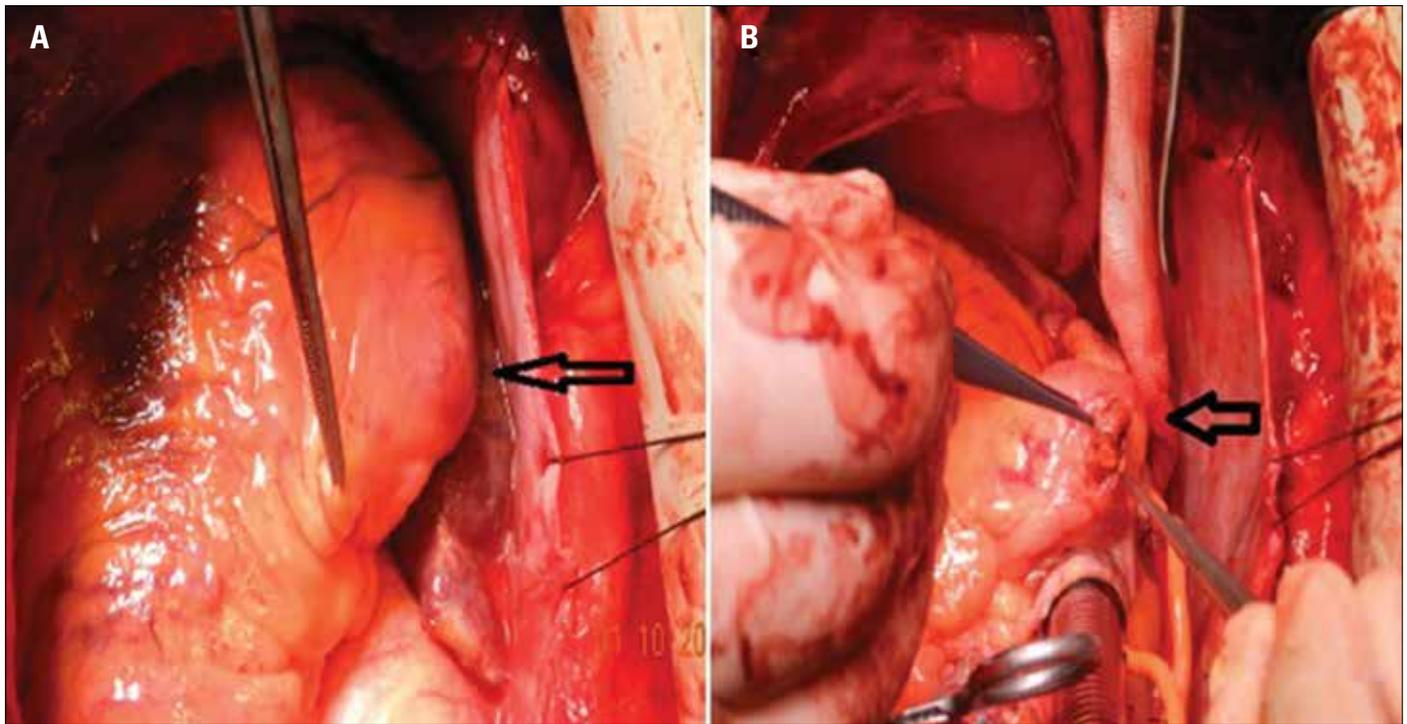


Figure 4. Intraoperative photo showing the giant RCA aneurysm images before and after the incision

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Available Online Date: 09.06.2014

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DOI:10.5152/akd.2014.5367

Double aortic arch associated with tracheal and esophageal compression in an adult

A 44-year-old female admitted to cardiology clinic with complaints of heartburn and chest pain. Past medical history displays hypertension, and she is on medical therapy. Physical examination, laboratory, electrocardiography, echocardiography and spirometer were normal. Chest roentgenogram demonstrated suspicious opacification over aortic arch (Fig. 1A). CT showed; double aortic arch in the form of complete vascular ring around trachea and esophagus. Both the trachea and esophagus were compressed by vascular ring (Video 1, Fig. 1B-E). Esophagogram shows extrinsic impression on left-side of barium-filled esophagus from left-sided arch (Fig. 1F). Therapeutic strategy balanced between risks of cardiovascular abnormality and risks due to surgery. Surgery wasn't performed due to; patient refused operation, vascular

ring isn't associated with serious complications and good general condition and prognosis of patient. Hereby conservative approach adopted.

Aortic vascular anomalies should be considered in patients with respiratory distress, nutritional problems, and pulmonary infections. Also, identification is important for prevention of chronic and irreversible complications.

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Video 1. 3-dimensional CT video demonstrated double aortic arch. Right arch is higher than left and both arches had similar diameters. Left subclavian and common carotid arteries originated individually from the left aortic arch, moreover right subclavian and common carotid arteries originated individually from right aortic arch

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Available Online Date: 09.06.2014

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DOI:10.5152/akd.2014.5487