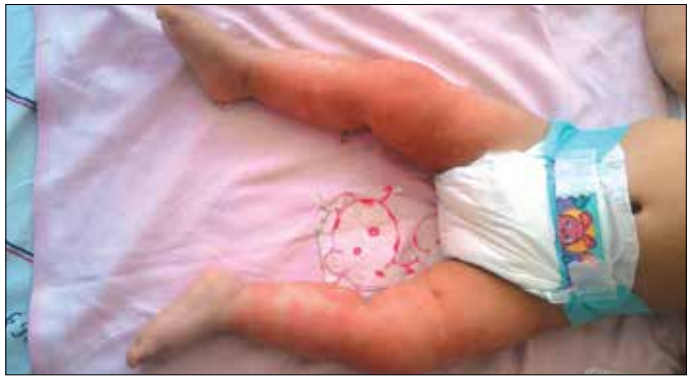

Figure 1. Erythematous rash of both lower extremities and swelling in both feet

Permissions: Permission for publishing of patient`s photos were obtained from parents

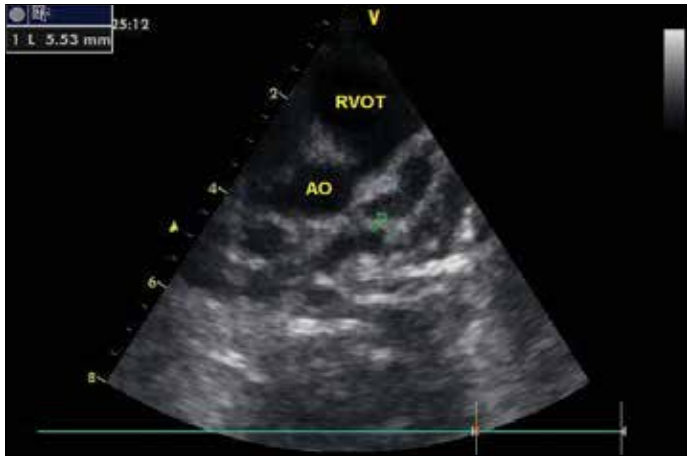

Figure 2. A 5.5 mm diameter aneurysm in LAD was observed at parasternal short-axis view in echocardiography

AO - aorta, LAD - left anterior descending artery, RVOT - right ventricular outflow tract

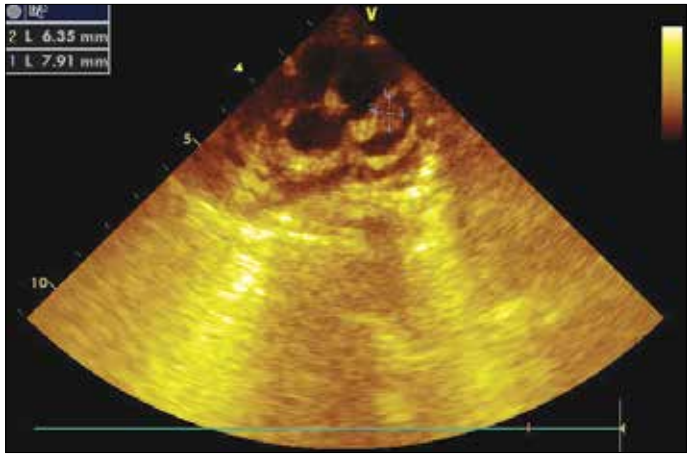

Figure 3. In the giant aneurysm 6.3x7.9 mm size thrombus was observed at parasternal short-axis view in echocardiography

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Video 1. In the giant aneurysm 6.3x7.9 mm size thrombus was observed at parasternal short-axis view in echocardiography

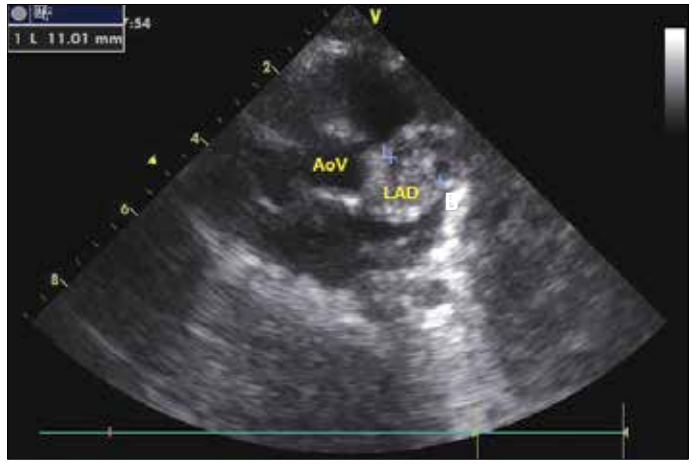

Figure 4. Echocardiography showing a thrombus obstructed the lumen in LAD

AoV - aortic valve, LAD - left anterior descending artery

Video 2. Thrombus disappeared on the fourth day of treatment in echocardiography

Video 3. Echocardiography showing a thrombus obstructed the lumen in LAD

LAD - left anterior descending artery

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Right ventricular penetration and acute cardiac tamponade caused by sewing needle in a woman under antipsychotherapeutic treatment

Antipsikiyatrik tedavi gören hastada dikiş iğnesi ile meydana gelen sağ ventrikül penetrasyonu ve kardiyak tamponad

A 25-year-old woman was admitted to the emergency service with chest pain. Her blood pressure was 90/70 mmHg, pulse rate-90 beats/min, and respiration rate-24/min. Postero-anterior chest radiography showed a linear metallic foreign body and a normally cardiothoracic ratio (Fig. 1a). Transthoracic echocardiography identified a foreign body with strong echo and no pericardial effusion. Thoracic computerized tomography demonstrated a foreign body adjacent to the surrounding pericardium of right ventricle (Fig. 1b, c).

We decided to perform an urgent surgery. After median sternotomy, pericardial incision was performed, hemorrhagic effusion was evacuated, half of the sewing needle was removed from the right ventricle and then hemorrhagic wound was repaired by direct suture technique without cardiopulmonary bypass (Fig. 2a). The remaining half of the

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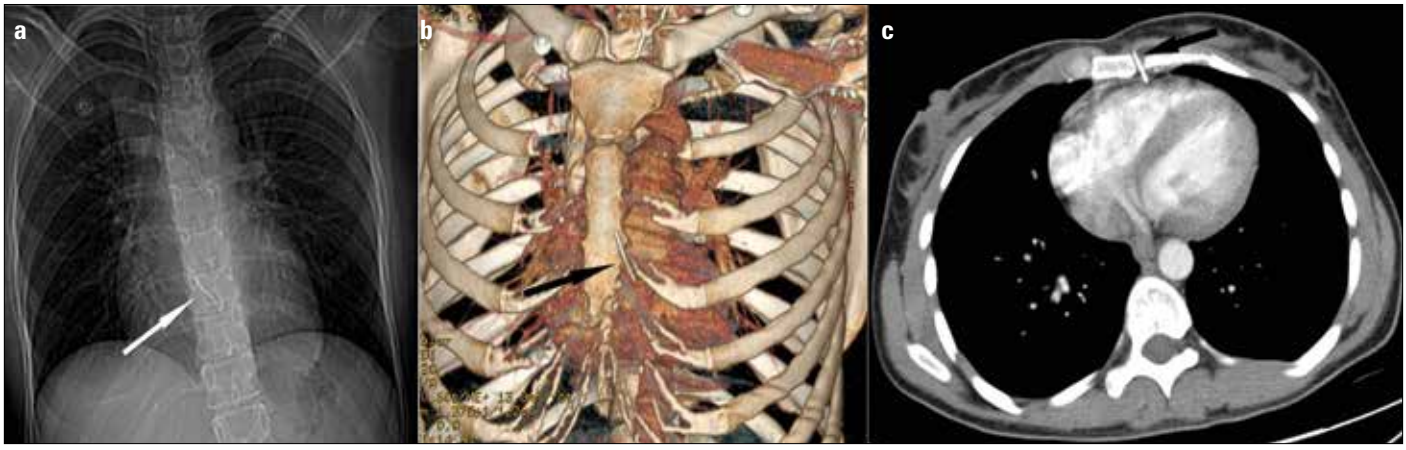

Figure 1. a) Postero-anterior chest radiography view, b) Computed tomographic angiography view, c) Foreign body on transverse cross-section view

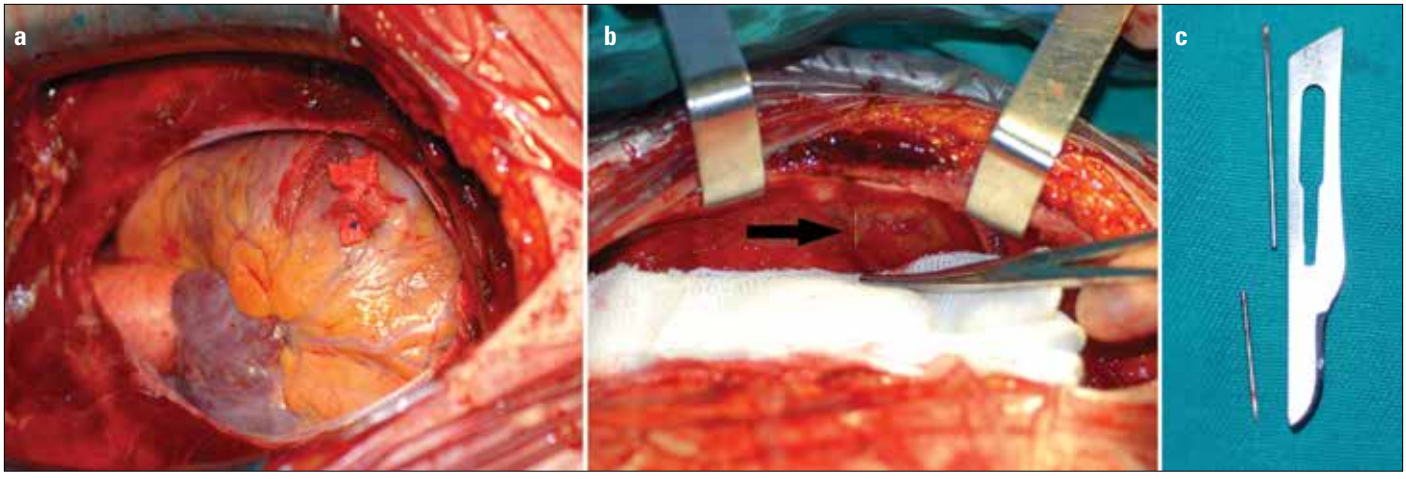

Figure 2. a) Intraoperative view of wound after repair, b) Half of sewing needle in the chest wall, c) Sewing needle

needle was removed from the chest wall (Fig. 2b, c). Postoperative course was uneventful.

It was suggested that asymptomatic foreign bodies without associated risk may be treated conservatively but if there is an injury with associated risk of infection, embolization, or erosion foreign body should be removed.

Finally, we can suggest that if the injury was associated with risk of erosion of the myocardial wall, urgent surgical intervention must be performed, even if patient was asymptomatic and pericardial tamponade was not observed.

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Acute myocardial infarction caused by severe muscular bridges of the left anterior descending artery and diagonal branch: a very unusual cause of myocardial infarction

Sol ön inen arter ve diyagonal dalın ciddi müsküler köprülerinin neden olduğu akut miyokart enfarktüsü: Miyokart enfarktüsünün oldukça nadir görülen bir nedeni

A 50-year-old man with acute anterior myocardial infarction was referred to our hospital for primary percutaneous coronary angioplasty. He had had an aortic valve replacement operation 5 years ago. He had no coronary artery disease or myocardial infarction in his medical history. Electrocardiogram obtained in emergency department during the chest pain revealed ST segment elevations and inverted T waves in precordial leads. He was taking oral anticoagulation therapy and his INR was 2.8 at hospital admission. Coronary angiography showed non-atherosclerotic coronary arteries with almost completely systolic compression (Fig 1a. arrows) and diastolic normalization of the left anterior descending coronary artery (LAD) and first diagonal branch (Fig 1b.