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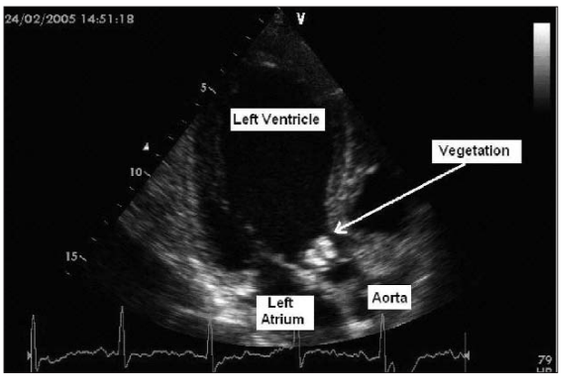

Figure 1. Transthoracic echocardiographic examination showing vegetation on aortic cusps caused by Streptococcus constellatus

The *S. milleri* group consists of three species: *S. constellatus, S. anginosus* and *S. intermedius*. This group of streptococci is part of the normal flora of the mucous membranes, but is often involved in suppurative infections especially in the presence of cirrhosis, diabetes, malignancy and immunodeficiency (2). They are also rare causes of infective endocarditis with S. anginosus predominance (3).

Although a high degree of clinical suspicion and correct interpretation of clinical findings still has paramount importance in infective endocarditis diagnosis, the possibility of rarely detected microorganism as a causative agent should be keep in mind. In our case, penicillin-gentamycin combination was unsuccessful which prompted for searching another organism. Moreover, the results of cefotaxime therapy were also unsatisfactory in the presence of persistent vegetations.

Early valve surgery with cefotaxime therapy, as in our case, may be more appropriate therapeutic approach in penicillin-resistant *S. constellatus* endocarditis cases (4, 5).

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A rare cause of dilated cardiomyopathy; Alström syndrome

Dilate kardiyomiyopatinin nadir bir nedeni; Alström sendromu

Alström syndrome (AS) is a recessively inherited genetic disorder characterized by; pigmentary retinal dystrophy, sensorineural hearing loss, obesity, non-insulin dependent diabetes mellitus. Other features reported in some but not all subjects include acanthosis nigrigans, hypogonadism, short stature, hepatic, renal and cardiac failure (1) (Table 1). The gene mutated in AS patients has recently been identified as ALMS1 (2).

We present a 21-year-old man who was referred to the hospital for routine examination before applying to military services. He had five brothers and three sisters. According to the history, one of his brothers also had almost the same features but could not be examined because of social causes. There was no history of consanguity and drug use in pregnancy. From birth, our patient suffered from progressive vision loss and nystagmus. On admission his blood pressure was 130/80mmHg, pulse rate 110/min. Weight was 55kg, height 144cm and body mass index (BMI) 26kg/m^2. He had thin hair and frontal hair loss. Eye examination showed nystagmus, bilateral posterior subcapsular cataract. Vision was at the level of perception but no projection in both eyes. His fundus examination showed pale discs and retinal pigmentary changes. He had acanthosis nigricans. Physical examination disclosed orthopnea, dyspnea, bilateral jugular venous distention and bilateral pretibial pitting edema. On auscultation, tachycardia, coarse lung sounds and bilateral rales below the scapulae were detected. He had gynecomastia, bilateral testicular atrophy and pretibial edema.

Laboratory analyses were as following; fasting blood glucose - 255mg/dl, insulin -36IU/mL, HbA1c - 11.7% (range, 4.8-6.0), creatinine - 1.5mg/dl (range, 0.6-1.2), serum glutamic-oxalacetic transaminase - 52 (range, 8-40), serum glutamic-pyruvic transaminase - 83U/L (range, 10-40), gamma-glutamyl transpherase -486 (range, 0-49U/L), alkaline phosphatase -127U/L (range, 38-94), thyroid stimulating hormone - 1.56 mcIU/mL (range, 0.27-4.2), luteinizing hormone - 30.28mıu/mL (range, 1.7-8.6), follicle stimulating hormone - 33.72 miu/mL (range, 1.5-12.4), prolactin 10.44 ng/mL (range, 4.04-15.2), testosterone - 1ng/mL (range, 2.4-9.5) 24-hour urinary albumin excretion- 250mg/24h. Electrocardiogram

Table 1. Clinical features and complications of Alström syndrome

Presentation	(*) Literature, %	Patient in the present study
Retinal degeneration	98	+
Sensorineural deafness	89	+
Diabetes	82	+
Obesity	98	-
Acanthosis nigricans	68	+
Hypergonadotropic hypogonadism	78	+
Hypothyroidism	17	-
Short stature	98	+
Hepatic dysfunction	92	+
Dilated cardiomyopathy	60	+
Renal dysfunction	49	+

*- 1. kaynaktan uyarlanmıştır.

was consistent with sinus tachycardia and echocardiography showed left ventricular dilatation with ejection fraction 30%. Viral hepatitis markers were negative. Abdominal ultrasonography was normal. Audiometric tests showed bilateral sensorineural hearing loss. We recommended diabetic diet, metformin 1000mg/day, digoxin 0.5mg/day, perindopril 5mg/day and furosemide 40mg/day. At present the patient is normoglycemic and the clinical course of cardiomyopathy resolved progressively, with ejection fraction 40% , with the treatment.

In this report, we draw attention to a very rare syndrome, Alström syndrome, which may be complicated with dilated cardiomyopathy occurred in 60 % of patients in a 182 patient series (1). It appears in infancy as an early sign of the disease or in adult age as a late appearing complication (3). In a study severe fibrosis in multiple organs has been shown in patients with AS and myocardial fibrosis ranging from moderate to severe is found in pathological investigations (1). Even if electrocardiogram results are normal, cardiac function should be evaluated carefully by echocardiography. The chances of survival are correlated with the severity of renal and cardiac failure which are the most common causes of death in this syndrome (4). Therefore, we should keep in mind AS in differential diagnosis of a patient with infantile and early onset dilated cardiomyopathy. Early diagnosis and appropriate monitoring for complications may lead to better survival of the affected individuals.

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The use of renal stents in percutaneous treatment of very large coronary arteries

Çok geniş çaplı koroner arter darlıklarında renal stent kullanımı

In current, absence of the large size coronary stents poses significant challenges to the operator. Both early and late outcomes after drug-eluting stents (DES) implantation are limited only by the available caliber of the DES (3.5 mm in the United States) and the mechanical limitations placed on current DES overexpansion (4.75 mm for Cypher, 4.25 mm for Taxus). This is also validated for bare metal stents (BMS) (3.5 to 5.0mm) and so, there is a significant need for a large size stent that addresses this clinical challenge. We considered that the renal "vascular" stents, which have larger size, might be use in percutaneous treatment of coronary lesions in large-size vessels.

Case 1 was a 65-year-old male with a history of severe chronic obstructive pulmonary disease who was transferred to our institution for coronary angiography, which revealed the significant ostial left main coronary artery lesion and proximal left anterior descending artery stenosis (Fig. 1A). Because he represented a poor operative risk due to severe pulmonary disease, it was decided to perform percutaneous cardiac intervention. Therefore, the left main artery was stented with 5.5 x12mm renal stent with postdilatation (Fig. 1B-C) and proximal left anterior descending artery was stented with 4.0x11mm bare-metal stent (Fig. 1D-E). Final angiographic appearance was normal with TIMI 3 flow (Fig. 1E). The patient was angina free at 3 months follow-up.

Case 2 was a 61 years old male patient with stable angina pectoris was referred to coronary angiography, which demonstrated significant middle left circumflex coronary artery stenosis (Fig. 2A-D). The other coronary arteries had mild atherosclerosis only. Percutaneous transluminal coronary angioplasty, with implantation of one 6.0x12mm renal stent, was successfully performed (Fig. 2E-F). The patient did well, without symptoms over the following three months.

Whereas larger stents induce more trauma to vessels and therefore more intimal hyperplasia, more edge dissections and more coronary ruptures; underexpanded stents increase both the risk of restenosis and the likelihood of stent thrombosis. Therefore, stent size must be carefully matched with reference vessel diameter, generally aiming for a 1.1:1 balloon to artery ratio. Since standard coronary angioplasty balloons or stents have generally not been available in diameters exceeding 5 mm, placing coronary stents may still remain challenging when vessels are extremely large. Consequently, angioplasty of larger arteries and grafts is commonly performed with undersized balloons or stents. The observational data support the use of adjunctive balloon postdilatation following stent deployment in the great majority of patients

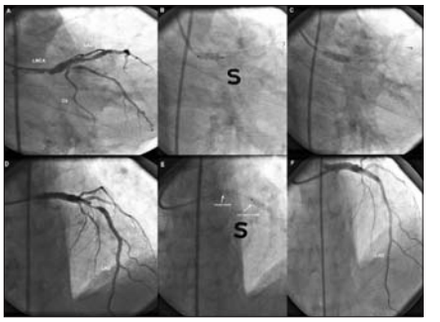

Figure 1. Angiographic images of percutaneous treatment of ostial LMCA lesion with renal stent and of proximal LAD stenosis with coronary bare metal stent

LAD- left anterior descending artery, LMCA- left main coronary artery, Cx- circumflex artery

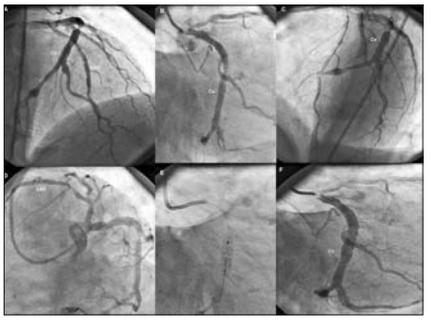

Figure 2. Angiographic images of percutaneous cardiac intervention of Cx lesion with renal stent

LAD- left anterior descending artery, Cx- circumflex artery