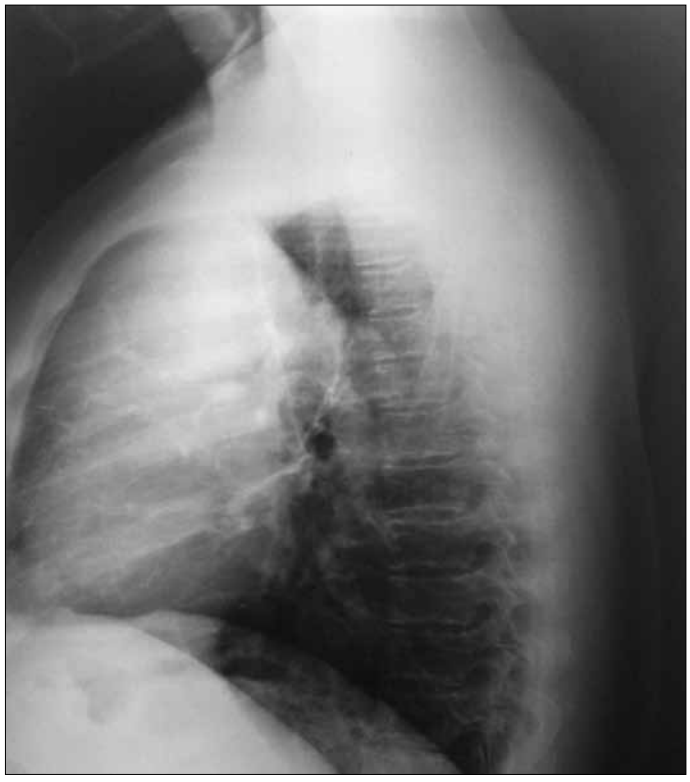

Figure 2. Left lateral chest X-ray view of abnormally dense and widened anterior mediastinum

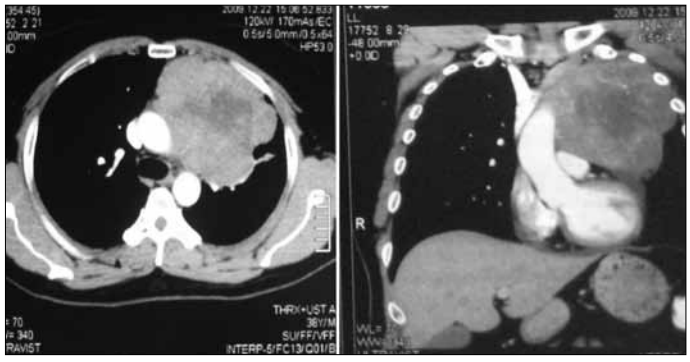

Figure 3. CT images of a heterogeneous hypodense mass in mediastinum which compresses left superior pulmonary vein

CT - computerized tomography

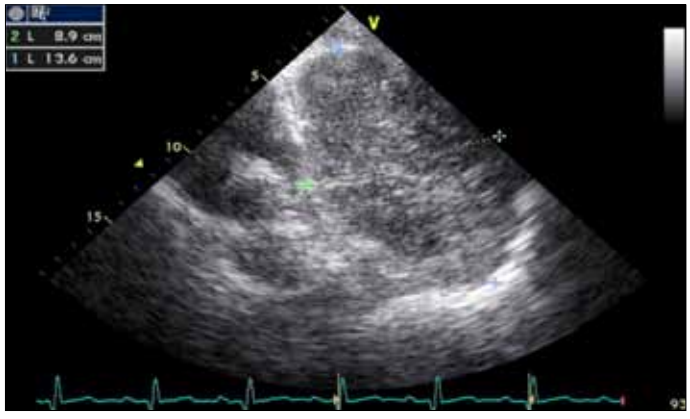

Figure 4. Transthoracic echocardiography view of a huge hyperechogenic mass

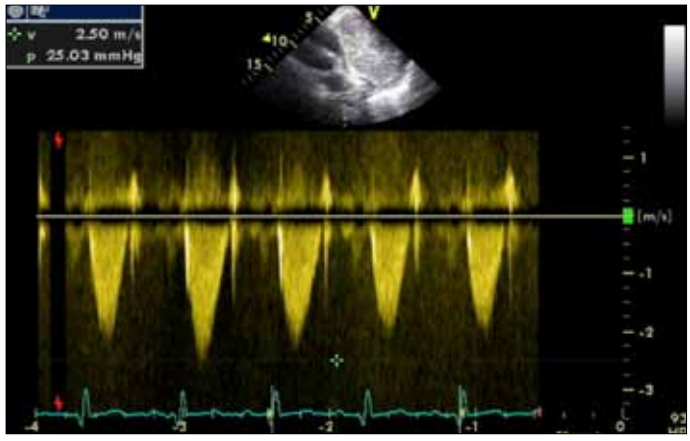

Figure 5. Continuous wave Doppler examination revealing a maximal 25 mmHg of transpulmonary gradient due to the tumoral compression

Transthoracic echocardiography demonstrated a huge mass that compressed pulmonary artery resulting in 25 mmHg transpulmonary gradient (Fig. 4, 5). Pathological evaluation showed parathormone negative, chromogranin positive stained neoplastic cells that eventually proved to be a carcinoid tumor.

Carcinoid tumors are the most common neuroendocrine tumors. They grow insidiously and usually do not cause any symptom. Our case was an extreme sample of carcinoid tumor which was extended to a massive size that caused large vessel compression, and eventually treated surgically without complication.

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Giant pulmonary artery aneurysm due to chronic pulmonary embolus associated with pulmonary hypertension

Kronik pulmoner emboliye bağlı pulmoner hipertansiyonun eşlik ettiği dev pulmoner arter anevrizması

Aneurysm of the pulmonary artery (PAA) is a rare pathology with unknown natural history. The main causes of PAA are pulmonary hypertension (PHT) secondary to pulmonary embolus or congenital heart diseases with left-to-right shunts. We report a case of giant PAA due to chronic pulmonary embolus associated with PHT in an elderly patient.

An 83-year old male with a known history of multiple episodes of deep venous thrombosis, chronic pulmonary embolism associated with PHT and chronic atrial fibrillation in last five years was admitted with NYHA-3 exertional dyspnea. The physical examination revealed orthopnea, jugular venous distention, ascites and bilateral pretibial edema. Electrocardiography revea-

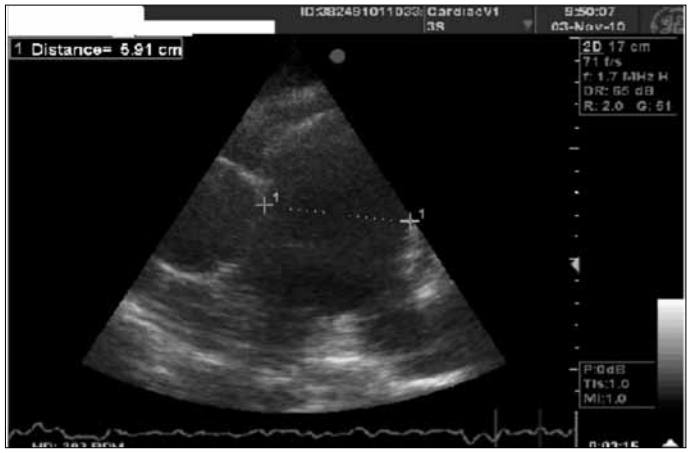

Figure 1 Transthoracic echocardiography view of an aneursym of pulmonary artery together with aneurysm of ascending aorta, pericardial effusion and right ventricular dilatation

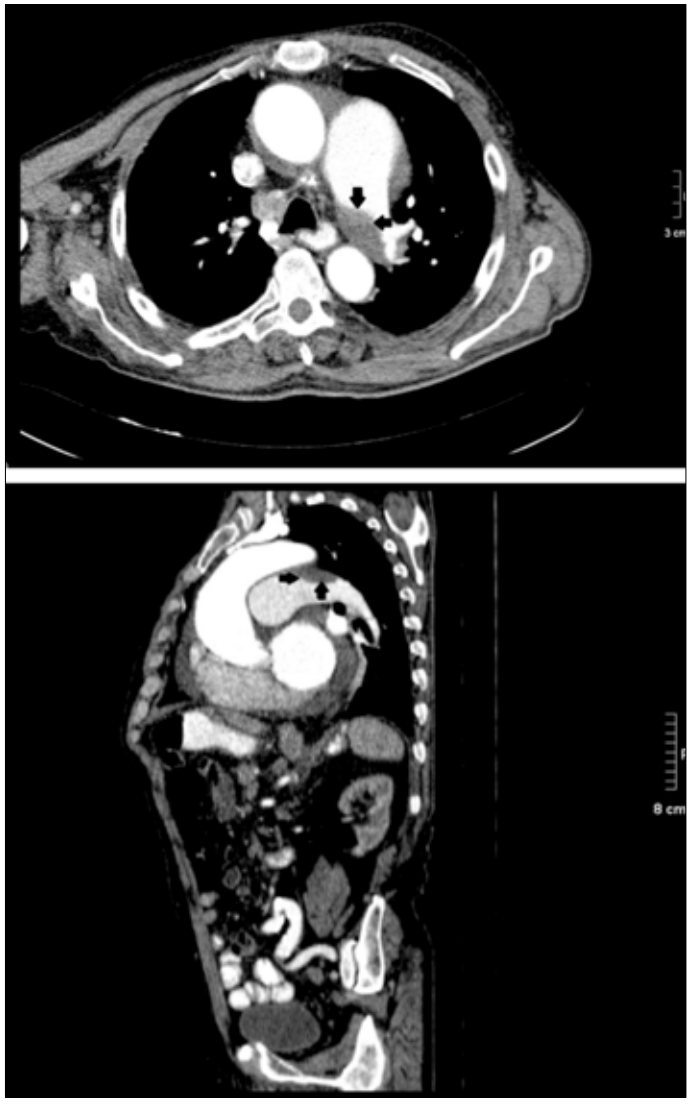

Figure 2 A-B. Multislice CT demonstrated main pulmonary artery of 6.1 cm, left pulmonary artery of 3.3 cm and right pulmonary artery of 3.6 cm. There was a massive (1.3 cm) thrombus in the lumen of the aneurysmatic left pulmonary artery
CT - computerized tomography

led atrial fibrillation and right ventricular strain pattern. Transthoracic echocardiography showed PAA together with aneurysm of ascending aorta, pericardial effusion and right ventricular dilatation (Fig. 1). Multislice computerized tomography demonstrated main, left and right pulmonary arteries with diameters of 6.1 cm, 3.3 cm, and 3.6 cm respectively. There was a massive (1.3 cm) thrombus in the lumen of the aneurysmatic left pulmonary artery (Fig. 2A-B). The medical treatment of patient consisted of warfarin 5 mg/day, metoprolol 50 mg/day and furosemid 40 mg/day. The functional capacity of patient showed improvement after treatment and two- year follow-up was uneventful. In our case, pulmonary dilatation developed due to the pressure overload on pulmonary circulation caused by PHT. There is no definitive therapeutic approach for PAA. However, low-pressure aneurysms without PHT are usually treated medically; aggressive surgical management is recommended for patient with high risk of dissection or laceration of high-pressure PAA with underlying PHT.

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Resolution of obstructive prosthetic valve thrombosis after coronary embolism

Koroner emboli sonrası düzelen tıkayıcı protez kapak trombüsü

Coronary embolism is an uncommon but serious complication of prosthetic valve thrombosis. During the course of prosthetic valves, myocardial infarction (MI) due to coronary embolism can be seen as a presentation or during treatment of valve thrombosis.

A 35-year-old man, with a history of bileaflet mechanical aortic and mitral prosthetic valve replacement 12 years ago, presented with dyspnea. He has not taken warfarin for six months. The patient's INR was measured as 1.3. Transthoracic echocardiographic examination

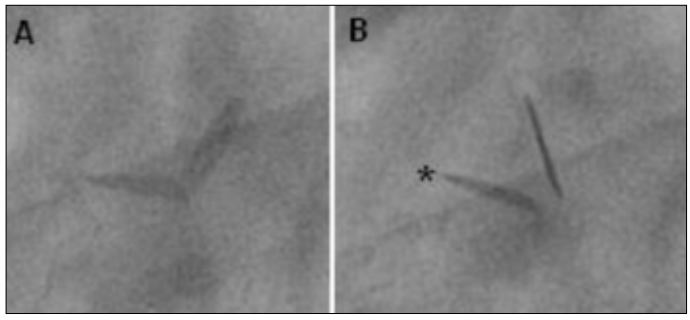

Figure 1. Aortic prosthetic valve, one leaflet (asterisk) is stuck (A-diastole, B-systole)