A case of an atypically located cardiac hydatid cyst

Thirty five year old female patient with complaints of chest pain, numbness in the left arm and presyncopy was admitted to the cardiology clinic. There were no significant findings on cardiac examination. Electrocardiography (ECG) revealed T negativity in leads aVL, D1 and V1-5. Her blood tests were creatinine: 1.1 mg/dL, BUN: 33, Na: 144 mmoL/L, K: 4.4 mmoL/L, glucose: 110 mg/dL, pro-BNP: 117 pg/mL, fT4: 14, TSH: 2.34, AST: 16 U/L, ALT: 14 U/L, LDH: 266 U/L, CRP: 3 mg/L, sedimentation rate: 32 mm/h, hs-troponin: 6 pg/mL (<13 pg/mL), Hgb: 12.6/dL, WBC 7,400/mm^3, platelets: 296,000 mm^3. Three dimensional transthoracic and transoesophageal echocardiography of the patient revealed a cystic mass in size of 4.6 x 4.2 cm in the interventricular septum (Video 1, Fig. 1, 2).

A preliminary diagnosis of hydatid cyst was thought so indirect hemagglutination test was requested and it resulted as positive. In Cardiac MRI,

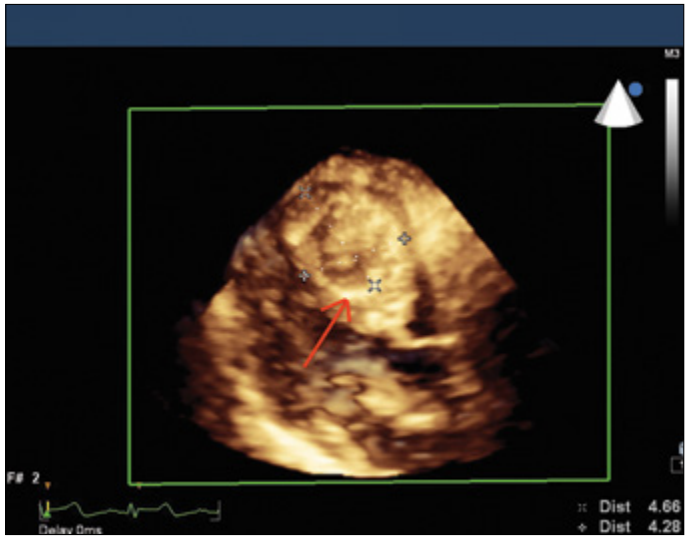

Figure 1. Parasternal long axis view of 3D transthoracic echocardiography revealed a cystic mass in size of 4.6 x 4.2 cm in the interventricular septum (Red arrow pointing cystic mass)

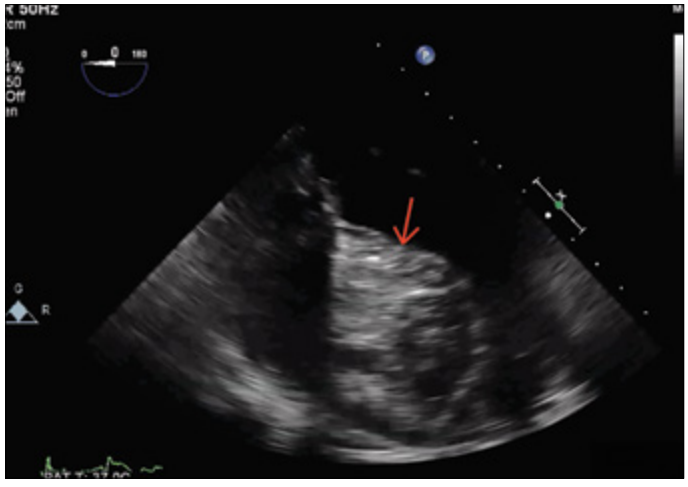

Figure 2. Mid oesophageal 0 degree view of transoesophageal echocardiography revealed a cystic mass in the interventricular septum (Red arrow pointing cystic mass)

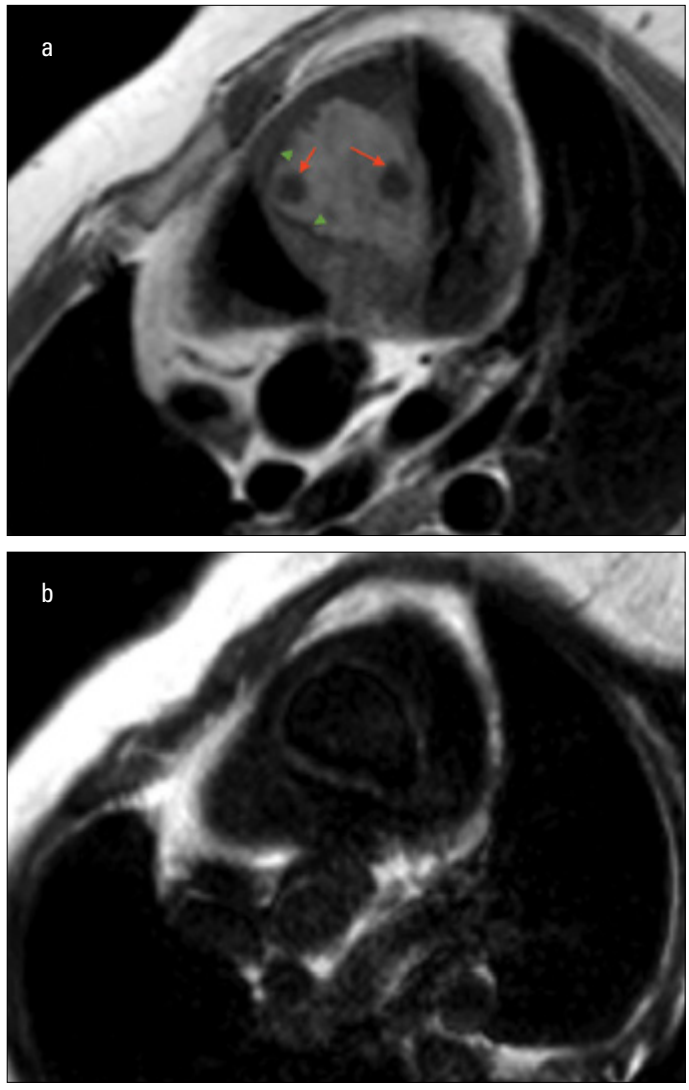

Figure 3. a, b. Cardiac MRI showed a cystic mass which was located in the interventricular septum and 5X4X3 cm in size. It was showing peripheral contrast enhancement and a few pieces of cystic spaces that had the largest 1.5 cm in size which was compatible with hydatid cysts (Red arrows pointing cystic spaces in cystic mass, green arrow heads pointing peripheral contrast enhancement)

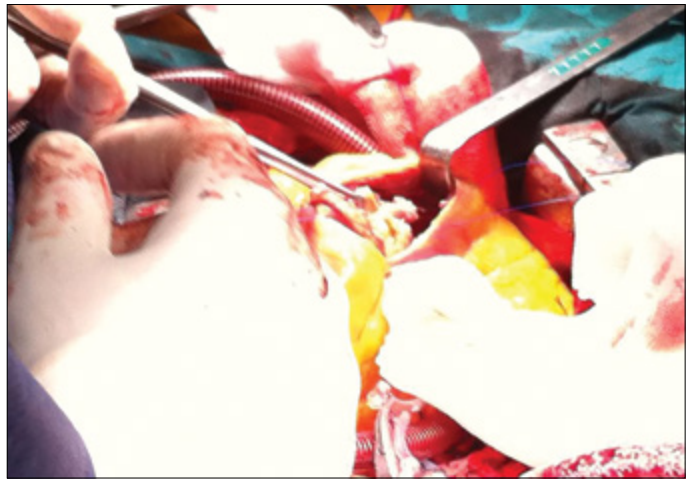

Figure 4. Peroperative view of cystic mass

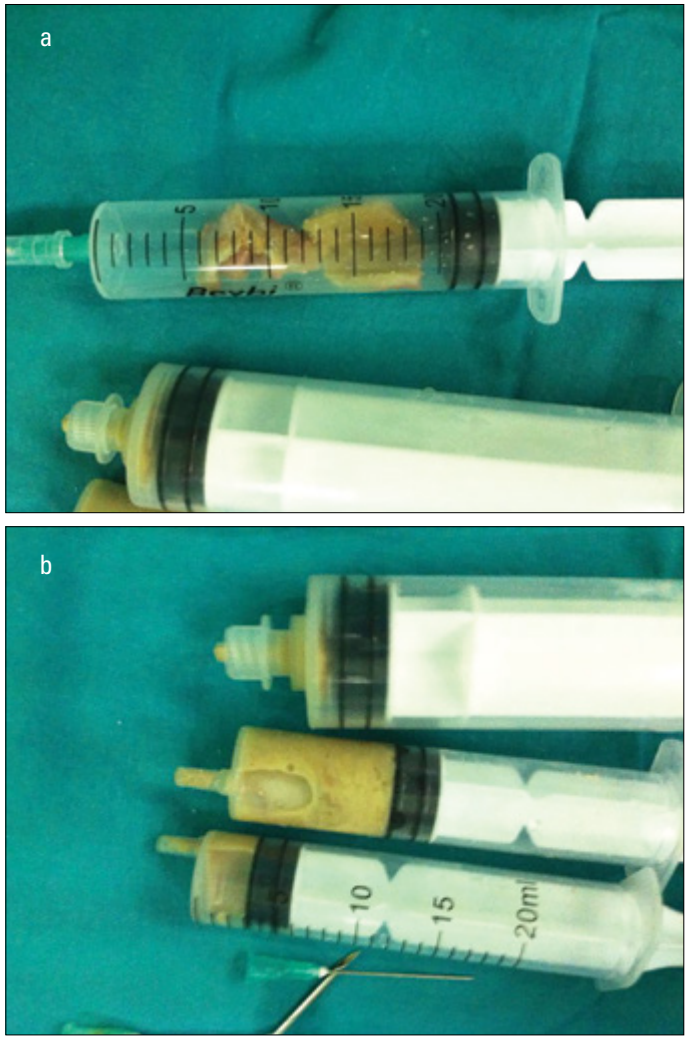

Figure 5. a, b. Resection materials in syringes were sent for pathological examination

there was a cystic mass which was located in the interventricular septum and 5 x 4 x 3 cm in size. It was showing peripheral contrast enhancement and a few pieces of cystic spaces that had the largest 1.5 cm in size which was compatible with hydatid cysts (Fig. 3, 4).

The patient was given to the operation to get surgical excision. Postoperatively, patients had no problem and as pathological examination of the material removed with surgery (Fig. 5-7), cardiac hydatid cyst diagnosis was confirmed.

Video 1. Parasternal long-axis view of transthoracic echocardiography revealed a cystic mass in the interventricular septum.

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An unpredictable complication of a transcatheter closure device and surgical treatment

The incidence of paravalvular leak (PVL) in patients who underwent mitral valve replacement is 7–17%. Hemolysis and congestive heart failure, which require an operation or intervention, are two main consequences with an incidence of 1–3%. In consequence of this reoperation is associated with high mortality and morbidity.

A 48-year-old man who underwent coronary artery bypass and mitral valve replacement surgery was evaluated. Paravalvular regurgitant jet flow adjacent to the appendix was localized with TEE imaging. Transapical transcatheter PVL closure was planned because of con-

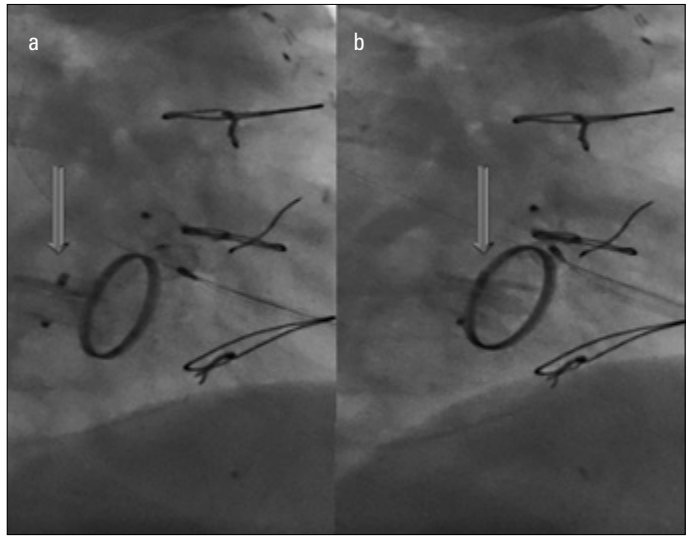

Figure 1. a, b. The forward motion of the closure device in the left atrium

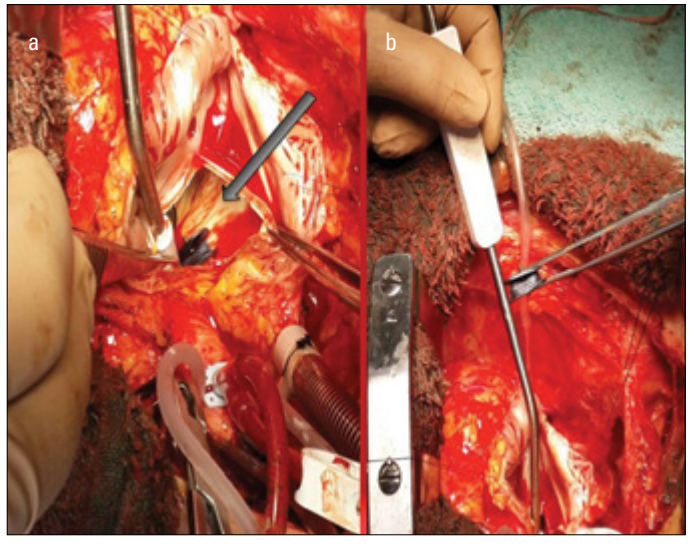

Figure 2. a, b. The position of the closure device in the left atrium during surgery