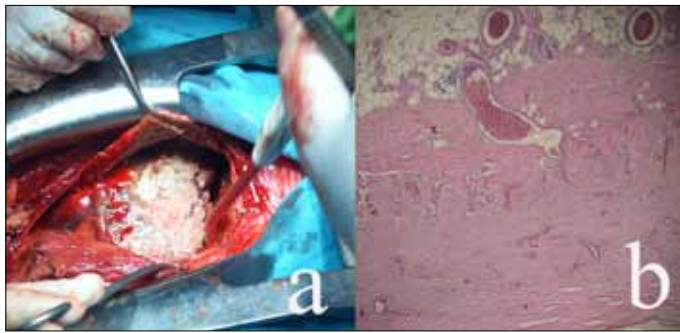


cent to the RV and RA (Fig. 4). At the surgery, cystic mass with thickened calcific fibrous tissue located anterior to right cardiac chambers was removed and hemorrhagic fluid was aspirated (Fig. 5a). The contents of the cyst included old coagulated blood. Histopathologic examination of the excised pericardial cysts revealed moderate nonspecific-noncellular inflammation, calcification and thickened connective tissue. There was no pathogen agent. The pathological diagnosis was compatible with idiopathic constrictive pericarditis (CP) (Fig. 5b). Follow-up period after surgery was uneventful.

The diagnosis of CP is often difficult to make. In fact, restrictive cardiomyopathy has similar clinical features to constrictive pericarditis. Differential diagnosis is made by diagnostic modalities such as echocardiography, computed tomography and chest X-ray. If the patient presents with cirrhosis-like symptoms, CP should be kept in mind among the differential diagnosis.



**Figure 5. a) Intraoperative view; prominent calcification of the cystic mass, b) Pathologic appearance; moderate inflammation, increased calcification, thickened connective tissue compatible with constrictive pericarditis (Hematoxylin & Eosin stained section, X40)**

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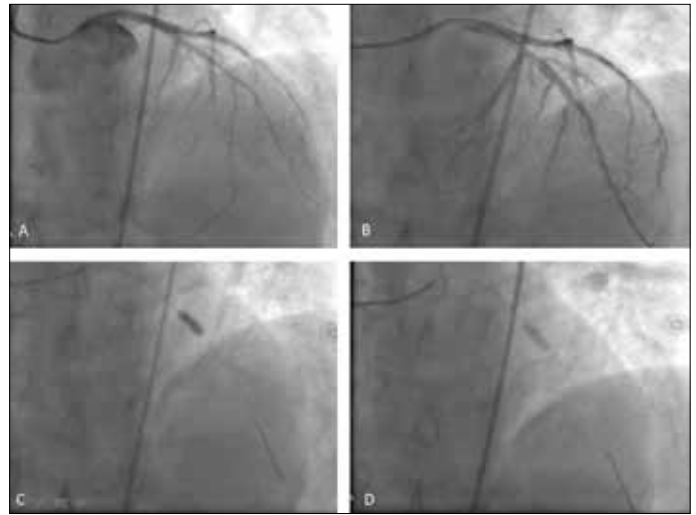
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## Ruptured covered stent in a ruptured coronary artery: A catheterization laboratory nightmare

*Rüptüre koroner arterde rüptüre olan greft stent: Bir kateter laboratuvar kabusu*

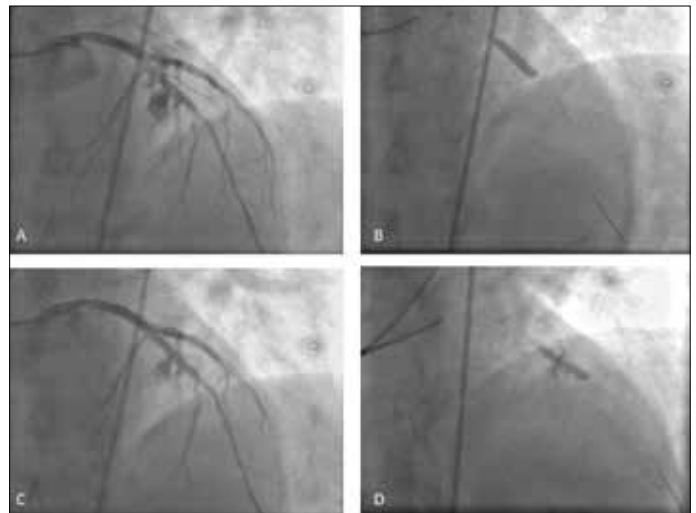
A 64-year-old male patient was admitted to our emergency department with subacute anterior myocardial infarction. Left anterior

descending artery (LAD) was occluded after the first diagonal branch (Fig. 1A). The lesion was crossed with a J-tipped soft guidewire then predilated with 2.5x12 mm balloon at 14 atmosphere pressure (atm) and 3.5x16 mm sirolimus-eluting stent (SES) at 18 atm was deployed to the lesion (Figure 1B). Post dilatation with 3.5x12 mm noncompliant balloon (NC) at 24 atm was performed due to residual stenosis (Fig. 1C). However, mid portion was not expanded optimally thus lesion was post dilated with 4.0x12 mm NC at 22 atm (Fig. 1D). Control injection revealed type-3 perforation of the LAD beneath the stent at the under-expanded area (Fig. 2A, Video 1-See corresponding video/movie images at [www.anakarder.com](http://www.anakarder.com)). Heparin anticoagulation was reversed with protamine and a 3.5x16 mm balloon was dilated proximal to the stent before the implantation of 3.5x16 mm covered stent (CS) over the perforated segment at 16 ATM (Fig. 2B). Control injection showed the passage of



**Figure 1. A- Coronary angiography view of subtotal occlusion of LAD after the first diagonal branch B) A SES was deployed to the lesion C- D) Post dilatation with NC was performed**

LAD - left anterior descending artery, NC - noncompliant balloon, SES - sirolimus-eluting stent



**Figure 2. A) Control injection revealed type-3 perforation of the LAD beneath the stent B) A CS was implanted over the perforated segment C) Control injection showed the passage of contrast material at the perforated segment to the pericardium D) The second CS was implanted to the perforated segment**

CS - covered stent, LAD - left anterior descending artery

contrast material at the perforated segment to the pericardium as if CS was not implanted (Fig. 2C, Video 2-See corresponding video/movie images at [www.anakarder.com](http://www.anakarder.com)). Probably the CS was ruptured due to a ruptured stent strut or peaks of calcified atheromatous lesion. Hence a second 3.5x16 mm CS was implanted to the perforated segment at 16 ATM (Fig. 2D). The second CS sealed the perforation completely (Fig. 3 A-B, Video 3-See corresponding video/movie images at [www.anakarder.com](http://www.anakarder.com)). Subsequent echocardiographic examination showed minimal pericardial effusion without signs of cardiac tamponade. The patient was followed with standard anticoagulant and anti-ischemic therapy and was uneventfully discharged.



**Figure 3. A-B) The second CS sealed the perforation completely**  
CS - covered stent

**Video 1.** A type-3 perforation of the LAD beneath the stent at the under-expanded area was evident in control contrast injection

**Video 2.** After the implantation of CS, control injection showed the passage of contrast material at the perforated segment to the pericardium like as CS was not implanted

**Video 3.** The second CS sealed the perforation completely  
CS - covered stent, LAD - left anterior descending artery

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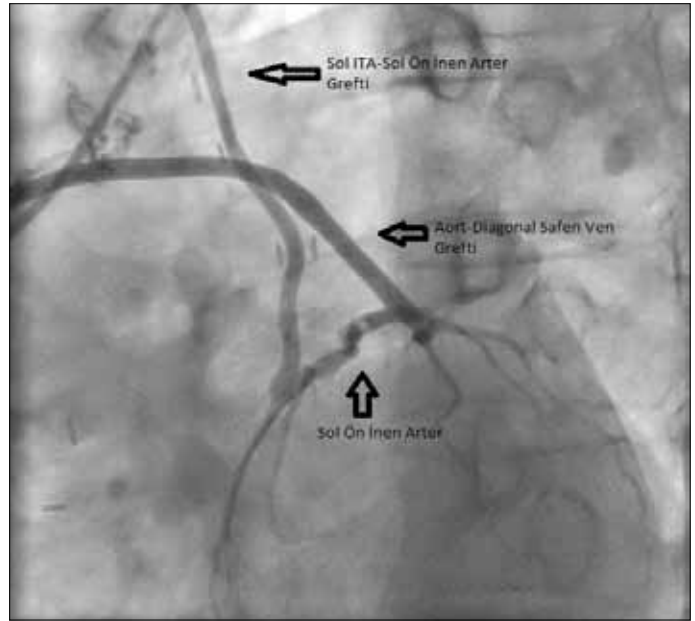
## “Spinning wheels” sendromu

### “Spinning wheels” syndrome

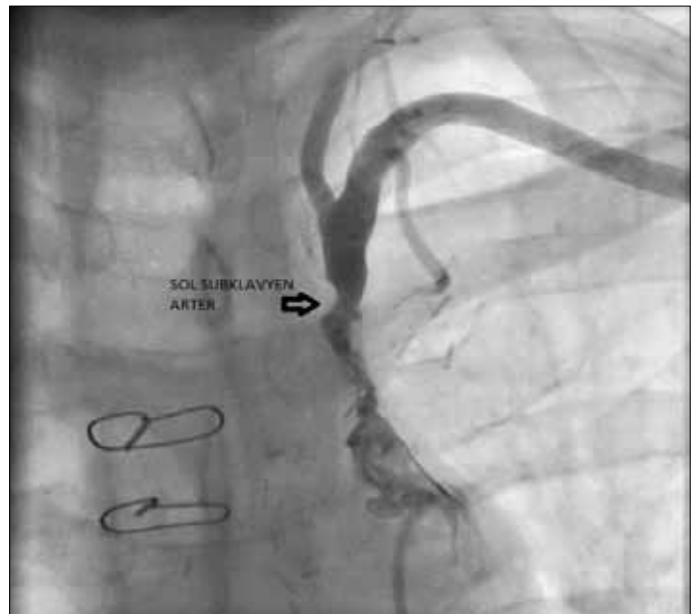


Seksen yaşında erkek hasta, 2001 yılında aterosklerotik kalp hastalığı nedeniyle koroner arter baypas greftleme (KABG) ameliyatı geçirmiş. Sol ön inen artere (SÖİA) sol internal torasik arter (İTA) kullanılarak, sağ koroner arter ve İTA'nın 1. diagonal dalına otojen safen ven kullanılarak baypas yapılmış. Hasta polikliniğimize bayılma, baş dönmesi ve sol kolunda harekette güçsüzlük olması şikâyetleri ile başvurdu.

Anjina şikayeti olmayan hastanın fizik muayenesinde iki kol arasında 40-50 mmHg sistolik tansiyon farkı ve sol radyal nabız zayıflığı belirlendi. Renkli Doppler arteryel ultrasonografi ile sol ana karotid arter bifürkasyonundan başlayıp, sol internal karotid arterde 314 santimetre/saniye akım hızına ve %70 üzeri ciddi darlığa sebep olan lezyon olduğu görüldü. Koroner anjiyografide, safen ven greftler ve sol İTA grefti açıldı. Fakat selektif olarak D1 safen ven greft görüntülediğinde, D1 safen ven greften SÖİA'nın olduğu buradan retrograd olarak İTA'dan ters akım yoluyla sol subklavyen arterin olduğu izlendi (Spinning Wheels sendromu) (Şekil 1, Video 1-Video/hareketli görüntüler [www.anakarder.com](http://www.anakarder.com)'da izlenebilir). Ayrıca selektif arteriyografide subklavyen arter başında ciddi darlık vardı (Şekil 2). Hastamızda D1 safen ven greft ile SÖİA beslediği için hastanın anjina şikayeti ve sintigrafide iskemi bulgusu yoktu.



**Şekil 1. “Spinning wheels” sendromunun anjiyografik görüntüsü**  
İTA- internal torasik arter



**Şekil 2. Sol subklavyen arter başındaki ciddi darlığın anjiyografik görüntüsü**