lar rate (140 bpm) (Fig. 1A). A chest X-ray revealed smoothly marginated opacity in the region of the right cardiophrenic angle that partially enclosing the right border of the heart (Fig. 1B). Two-dimensional transthoracic echocardiography showed normal-sized cardiac chambers and a large echo-free space behind the right atrium (Fig. 2A, Video 1, 2. See corresponding video/movie images at www.anakarder.com). Contrast-enhanced thoracic computed tomography revealed a large fluid attenuation mass adherent to right atrium measuring 59x38x38 mm consistent with pericardial cyst (Fig. 2B). The diagnosis of a pericardial cyst was confirmed at surgery as well as pathologically. Postoperatively, the patient was in sinus rhythm again. During 2- month follow-up period, she was asymptomatic. Pericardial cysts are rarely seen benign congenital anomalies, which occur because of incomplete fusion of fetal mesenchymal lacunae forming the pericardium. For asymptomatic patients, conservative management with close follow-up periods is recommended. Surgical resection is recommended for treating related complications or symptoms.

**Video 1.** Apical 4-chamber view of echo-free space behind the right atrium

**Video 2.** Subcostal view revealing the echo-free space adjacent to right atrium

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# Transected common hepatic artery and treatment

## *Transekte ana hepatik arter ve tedavisi*

A 17-year-old trauma patient had an acute drop in blood pressure on the computed tomography scanner. The vessel cutoff sign is depicted at the origin of the common hepatic artery (CHA) on the coronal MIP reconstructed computed tomography angiography (Fig. 1). Differential includes dissection, avulsion, and embolus. He went immediately to exploratory laparotomy-the source was not identified, and all quadrants were packed.

Emergent aortogram revealed brisk extravasations from the CHA origin (Fig. 2). The CHA was selected, and the guide wire passed into an extra vascular space. A 8mm Amplazter Vascular Plug II (St. Jude Medical, St. Paul, MN) was positioned in the CHA as well as celiac artery origin (Fig. 3). Post embolization aortogram shows cessation of the bleeding (Fig. 4). His volume and pressor requirements dropped almost

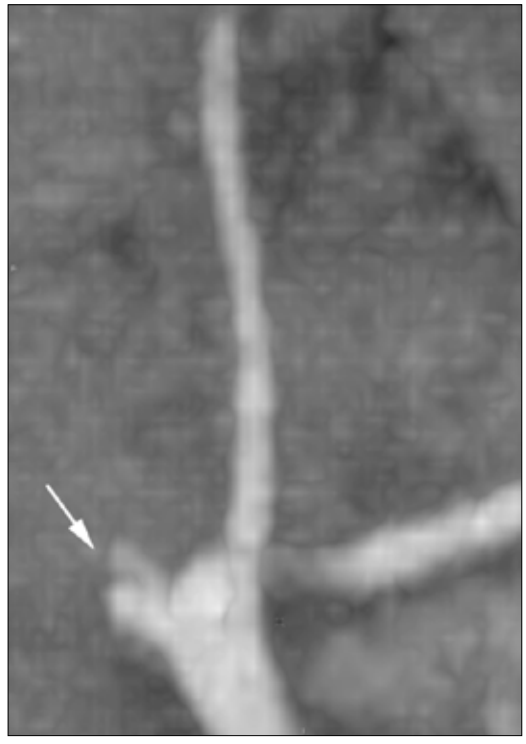

**Figure 1. Coronal MIP reconstructed image shows the vessel cutoff sign (arrow) at the origin of the common hepatic artery**

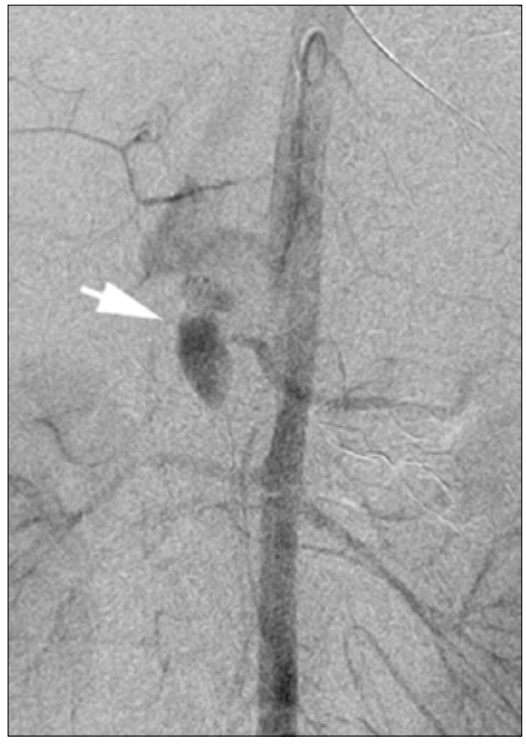

**Figure 2. Emergent aortogram revealed brisk extravasation (arrow) from the common hepatic artery origin**

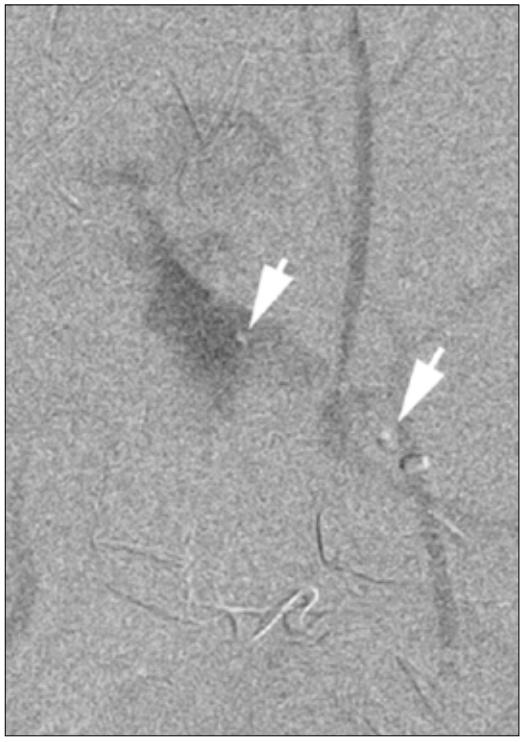

**Figure 3. Aortogram shows the Amplatzer vascular plug (arrow) that positioned in the common hepatic artery as well as celiac artery origin**

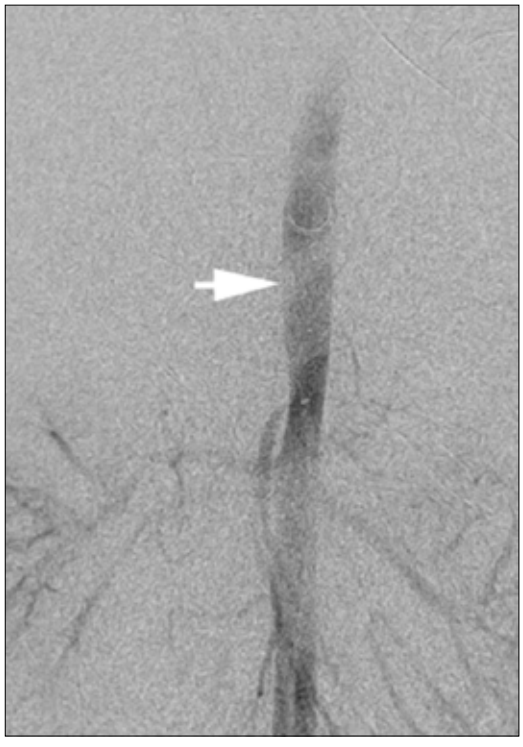

**Figure 4. Post embolization aortogram shows cessation of the bleeding (arrow)**

immediately. The patient's transaminases peaked on post-procedure day 1 and on post-procedure day 2 the patient continues to improve.

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# Long-term adverse effect of Kawasaki syndrome: Two- vessel coronary artery by pass surgery for coronary artery aneurysm in a 16-year old male patient

## *Kawasaki sendromunun uzun dönemdeki olumsuz etkisi: 16 yaşındaki erkek çocukta koroner arter anevrizması nedeniyle yapılan iki damar koroner arter baypas operasyonu*

Kawasaki disease, which is a rare systemic vasculitic syndrome with an unknown etiology, affects any type of blood vessel in the body including arteries, veins, and capillaries. It comprises about 9% of all vasculitic syndromes in childhood. The most common manifestations of disease are coronary artery vasculitis leading to coronary aneurysm (15-25%) and dilatation of aortic root. A 16- year -old male with a history of Kawasaki disease in childhood was admitted to our clinic with one year duration of CCS II exertional retrosternal chest pain and dyspnea. His physical examination revealed a blood pressure and heart rate of 130/75 mmHg and 70 bpm respectively with normal cardiac and lung auscultation. At admission, electrocardiography (ECG), telecardiography and routine biochemical laboratory findings were normal. The exercise ECG test showed 2 mm horizontal ST depression in inferolateral derivations. Coronary angiography revealed 7.16x7.71 mm aneurysm in left anterior descending (LAD) artery concomitant with 95% stenosis of the aneurysmatic segment (Fig. 1, 2) and subtotal occlusion

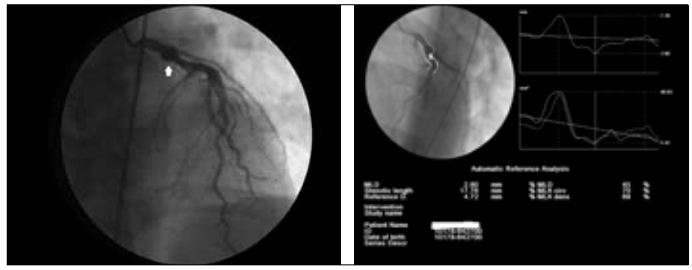

**Figure 1, 2. Coronary angiography views of a 7.16x7.71 mm aneurysm in left anterior descending artery and concomitant 95% stenosis in aneurysmatic segment**