

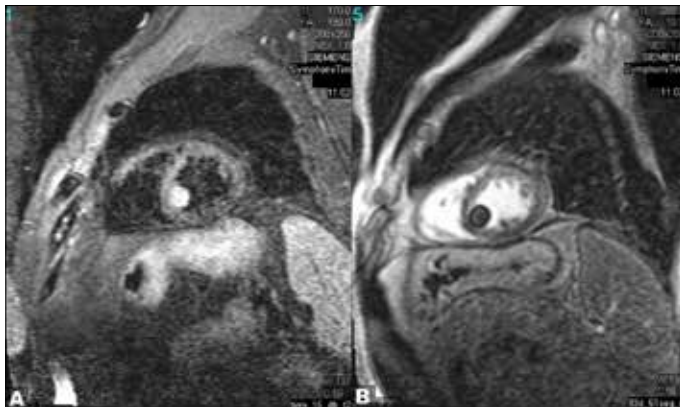
narrow-QRS complex tachycardia with a rate of 190 bpm (Fig. 1). Sinus rhythm was achieved after i.v. administration of verapamil which showed 0.5-1 mm ST segment elevation in septal leads (V1-V3). Chest X-ray revealed normal findings. Transthoracic echocardiography revealed left ventricular (LV) ejection fraction of 65%, LV end-diastolic diameter of 45 mm and cystic appearance at mid segment of the interventricular septum with 19x15 mm in diameter (Fig. 2, Video 1. See corresponding video/movie images at [www.anakarder.com](http://www.anakarder.com)). Cardiac magnetic resonance imaging demonstrated a cystic lesion, 20x13 mm in size, in the left ventricular side of interventricular septum, protruding into the lumen. The cystic lesion was hypointense on T1A sequences and hyperintense on T1 and T2A images, but was not suppressed on fat suppression sequences, which was compatible with cardiac hydatid cyst (Fig. 3). Cranial, thoracic and abdominal tomographic imaging showed no lesions of hydatid cyst. Preoperative coronary angiography revealed normal coronary arteries. Leukocyte count was 8400/mm<sup>3</sup> (1.2% eosinophils). However, serological findings with indirect hemagglutination test were negative for echinococcal disease. Albendazole was initiated preoperatively for three weeks. The patient was operated with right



**Figure 1. Electrocardiogram showing narrow QRS complex tachycardia (180 bpm)**



**Figure 2. Transthoracic echocardiography showing cystic appearance within the interventricular septum at parasternal long-axis (A), parasternal short-axis (B) and apical 4-chamber (C) views**



**Figure 3. Cardiac magnetic resonance scans showing cystic lesion within the interventricular septum. The cyst is hyperintense on T1- and T2A-weighted black blood images, not suppressed in fat suppression sequences. Cystic dense content is hyperintense (A) on T2A sequence and hypo intense on T1A sequence (B)**

ventriculotomy and cyst excision was performed with no complication. Pathological examination also confirmed the diagnosis of hydatid cyst. The patient was well at 3rd month control without any palpitation. Echocardiography revealed no defect or lesion at the interventricular septum. Additionally, 24-h Holter monitoring revealed sinus rhythm without any conduction blocks or dysrhythmia.

**Video 1.** Apical 4-chamber view of the cystic lesion within the interventricular septum

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**Available Online Date/Çevrimiçi Yayın Tarihi:** 22.06.2012

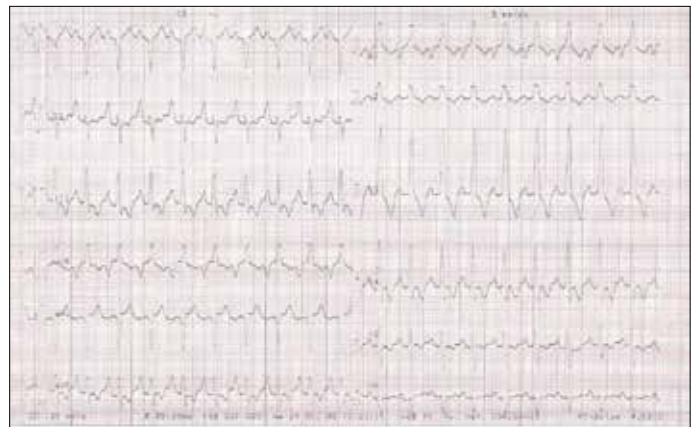
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doi:10.5152/akd.2012.178

## A patient with severe congenital pulmonary stenosis and severe right ventricular hypertrophy

### *Ciddi sağ ventrikül hipertrofisi ve ciddi konjenital pulmoner darlığı olan bir hasta*

A 20-year-old male patient was admitted to hospital with the complaints of frequent syncope on exertion, shortness of breath and chest pain. His weight and height were 55 kg and 147 cm, respectively. General appearance showed increased lumbar lordosis. Both the blood pressure and pulse were normal. There was 3-4/6° systolic murmur in pulmonary area with a strong heave in left lower sternal area. Electrocardiogram showed a huge P-pulmonale and right ventricular hypertrophy with secondary ST-T changes, and right axis deviation (Fig. 1). Transthoracic echocardiography

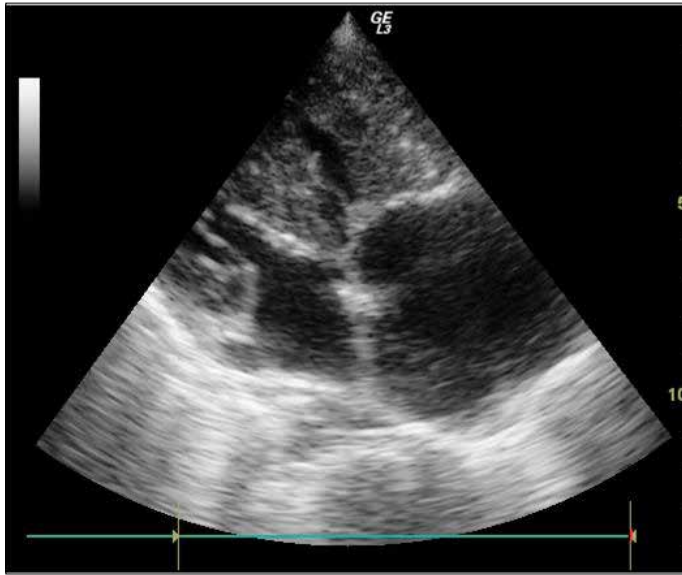


**Figure 1. A 12-derivation electrocardiogram of the patient**

revealed massive right ventricular hypertrophy (Video. 1, 2. See corresponding video/movie images at [www.anakarder.com](http://www.anakarder.com)), obliterating right ventricular cavity with the maximum gradient of 178 mmHg across the pulmonary valve (Fig. 2, 3). He did not accept any interventional or surgical treatment.

**Video 1.** Parasternal short-axis echocardiographic views of the right ventricular hypertrophy

**Video 2.** Parasternal long-axis echocardiographic views of the right ventricular hypertrophy



**Figure 2.** Modified apical four-chamber view of right ventricular hypertrophy

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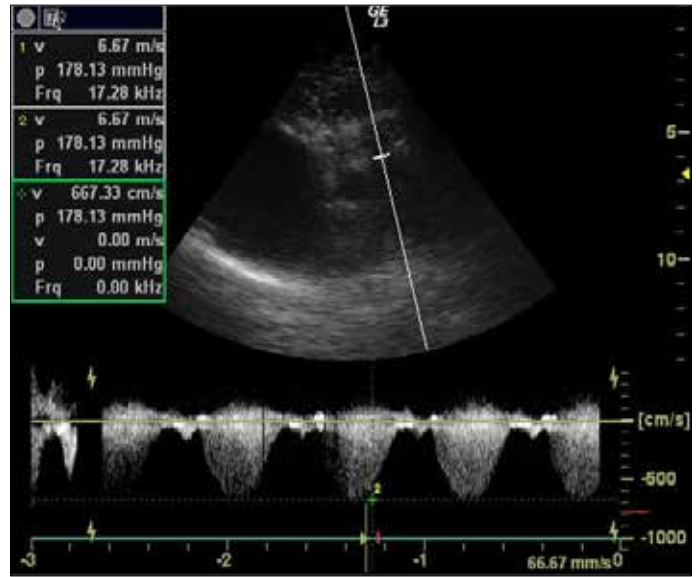
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**Available Online Date/Çevrimiçi Yayın Tarihi:** 22.06.2012

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**Figure 3.** Parasternal short-axis view of pulmonary artery velocity and gradient