Paravalvüler apse, infektif endokarditin (İE) önemli bir komplikasyonu olup, persistan enfeksiyon, iletim anomalileri, fistül oluşumu, kalp yetersizliğinin kötüleşmesi, ölüm ile beraberdir ve aortik kapakta mitral kapağa göre daha sık izlenir. Yeni oluşan iletim defekti ve ateş varsa ayırıcı tanıda İE mutlaka düşünülmelidir. Bu hastalarda günlük EKG takibi hastalığın takibinde oldukça önemlidir. Transözofajiyal ekokardiyografi imkânı olmayan merkezlerde TTE bu komplikasyonun hızlı tanısında oldukça önem kazanmaktadır.

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A case of left ventricular diverticulum diagnosed by left ventriculography

Sol ventrikülografide tespit edilen bir sol ventrikül divertikülü olgusu

A 21-year-old man admitted with dyspnea on exertion (NYHA Class II) and palpitation. On physical examination, 3/6 pansystolic murmur was heard at the apical area. Subsequently performed transthoracic echocardiography revealed severe rheumatic mitral regurgitation with normal left ventricular systolic functions. Since then, the patient underwent coronary angiography and left ventriculography before mitral valve replacement surgery. On left ventriculography, a contractile left ventricular diverticulum arising from the left ventricular posterobasal region was observed (Fig. 1, Video 1. See corresponding video/movie images at www.anakarder.com).

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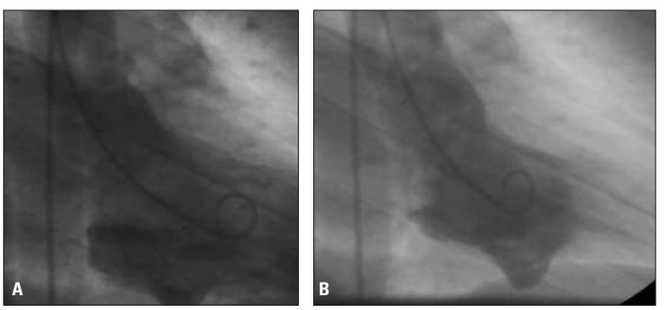

Figure 1. Right anterior oblique left ventriculography view showing a contractile diverticulum arising from posterobasal region at end-diastole (A) and end-systole (B)

A pseudoaneurysm of the saphenous vein graft to the posterior descending coronary artery

Posteriyor desandan koroner artere bağlanan bir safen ven greft psödoanevrizma olgusu

A 75-year-old man was admitted with of exertional angina (NYHA Class-II) and dyspnea. Fifteen years ago he had undergone triple vessel coronary artery bypass surgery. Six months ago, plain old balloon angioplasty (POBA) was performed in the distal segment of the saphenous vein graft (SVG) to the posterior descending coronary artery because of severe diameter stenosis. During coronary angiography we observed that a pseudoaneurysm of the distal segment of SVG (with the dimensions of 15X7 mm) and severe stenosis just before the aneurysmatic segment probably resulting from injury of the earlier POBA (Fig. 1).

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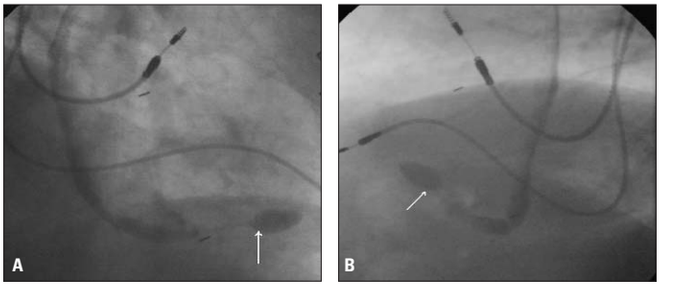

Figure 1. Right anterior oblique (A) and left lateral (B) coronary angiography views demonstrating a pseudoaneurysm of the saphenous vein graft to the posterior descending coronary artery and severe stenosis just before the aneurysmatic segment. Arrow denotes pseudoaneursym

Successful stent implantation to bilateral renal artery stenosis in a case with diffuse atherosclerotic involvement

Diffüz aterosklerotik tutulum tespit edilen bir olguda bilateral renal arter darlığına başarılı stent implantasyonu

A 75-year-old woman was referred to emergency service with near syncope and chest pain. The patient had uncontrolled systemic arterial hypertension for 15 years. During initial physical examination, pulse rate

was 45/minute, arterial blood pressure was 270/100 mmHg and systolic murmur (2/6 at the right side of umbilicus) was present. Electrocardiography revealed complete atrioventricular block with a ventricular rate of 45/minute.

Coronary angiography documented 75% narrowing at left anterior descending coronary artery (LAD) and 70% narrowing at first diagonal branch. After VVI mode pacemaker implantation, balloon angioplasty was performed to the diagonal artery and stent was implanted to the LAD.

Renal angiography documented 85% narrowing at proximal of right renal artery (RRA) and 70% narrowing at proximal of left renal artery (LRA) (Fig. 1). Using a guiding catheter and a guidewire, the stenosis at LRA was passed. A stent was implanted (5/15mm) at 10 atm without pre-dilatation (Fig. 2, Video 1. See corresponding video/movie images at www.anakarder.com). Later, same catheter was placed to RRA. After pre-dilatation using a balloon catheter (5.0x20 mm), a balloon-expandable renal stent (6.0/14 mm) was implanted at 12 atm without residual stenosis (Fig. 3, 4, Video 2, 3. See corresponding video/movie images at www.anakarder.com). A few days after renal artery stenting, blood pressure gradually improved and antihypertensive medications were decreased. Duplex carotid ultrasonography revealed a 60% narrowing at proximal part of left internal carotid artery.

Figure 1. Right renal artery angiography view of 85% narrowing in proximal region of left renal artery (arrow)

Figure 2. Nonselective renal artery angiography view of 70% narrowing in proximal region of left renal artery (arrow)

Figure 3. Angiography view of left renal artery after stenting

Figure 4. Angiography view of right renal artery after stenting

Percutaneous intervention can be safely used in a patient with coronary artery disease and renal artery stenosis. We emphasized that it should be never forgotten that atherosclerosis is a diffuse and multisystem disease.

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Antiaggregant and anticoagulant therapy of free-floating thrombus in left atrium

Sol atriyumda serbest dolaşan trombüsün antiagregan ve antikoagülan ajanlarla tedavisi

A 43-year-old female patient presented with dyspnea and palpitation. Electrocardiogram showed atrial fibrillation. Echocardiography showed a large left atrial thrombus with moving to left ventricle. A transesophageal echocardiogram (TEE) showed the large thrombus in left atrial appendix with floating and erratically moving in left atrium (Fig. 1). It was moving freely from the upper part of left atrium to the lower part and protruding to left ventricle through the mitral valve (Fig. 2). There was no another abnormal finding by echocardiography. The diagnosis was lone atrial fibrillation with large thrombus in the left atrium. There was a particular concern about embolisation given the highly mobile appearance of the thrombus. The patient denied the surgery. Treatment with continuous infusion of heparin (aPTT ratio>2.5) and coumadin (5mg/day) in addition to aspirin (100mg) and clopidogrel (75mg/day) were started. Bisoprolol