neovascularization of the myxoma by both right coronary artery and left circumflex artery (Fig. 5, 6). Bypass surgery and mass resection was performed (Fig. 7). The postoperative course was uneventful. Histological examination confirmed the mass was a benign atrial myxoma (Fig. 8).

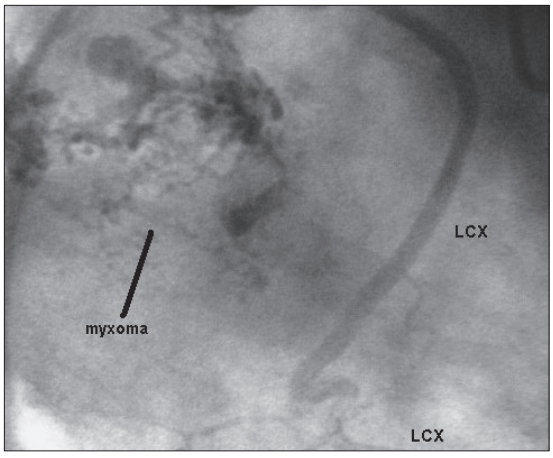

Figure 6. Coronary angiogram of the left circumflex artery (LCx) shows blood supply through myxoma

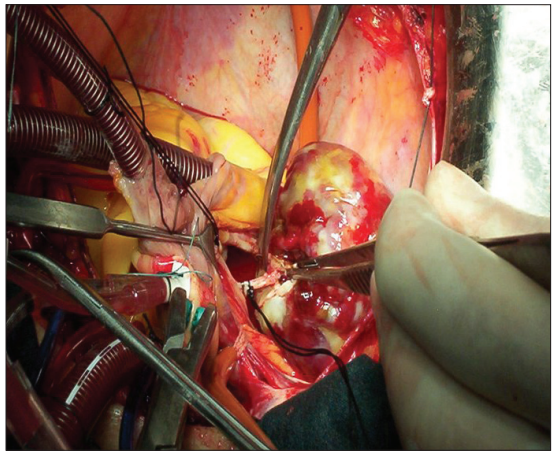

Figure 7. Intraoperative view of myxoma and its vascular structure

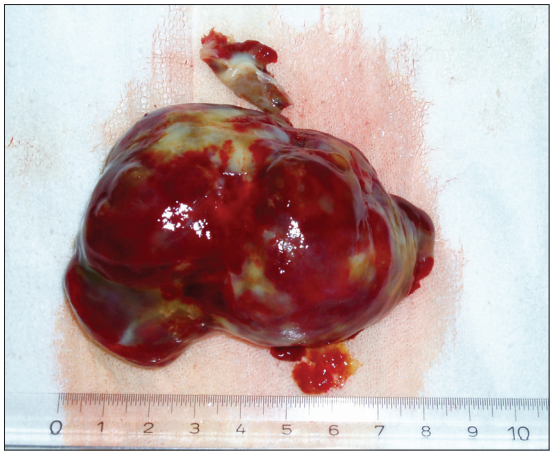

Figure 8. The large atrial myxoma after excision

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Aortico-left ventricular fistula associated with infective endocarditis

İnfektif endokardit ile birlikte görülen aort-sol ventrikül arası fistül

A 23-year-old man was admitted to an outpatient clinic for 2-month history of fever up to 38°C and weight loss. A grade IV continuous murmur with a thrill localized at the left sternal border was remarkable.

Echocardiography showed vegetations on the ventricular sides of a bicuspid aorta and the mitral valve. The ejection fraction was within normal ranges. There was a severe degree of aortic regurgitation. Apical 5-chamber view showed Doppler color flow between the ascending aorta and the left ventricular outflow tract, which was suspicious for a fistula (Video 1 and 2. See corresponding video/movie images at www.anakarder.com). Suprasternal view demonstrated an aortic coarctation with a maximum gradient of 56 mm Hg. The patient was commenced on a standard antimicrobial therapy with intravenous ampicillin and gentamycin. During further workup, magnetic resonance imaging (Fig. 1A) and the computed tomography (Fig. 1B) revealed the destructive aortic valve endocarditis complicated with an aortic fistula between the left ventricle outflow tract and the ascending aorta besides the rupture of the posterior leaflet of a bicuspid aorta (Fig.1C), (Video 3 and 4. See corresponding video/movie images at www.anakarder.com). As the blood cultures grew enterococcus, the regimen was not substituted with another antibiotherapy. He underwent Bentall procedure (Fig. 2), subsequently elective endovascular stent implantation was performed to ameliorate the coarctation. The patient was discharged after full recovery.

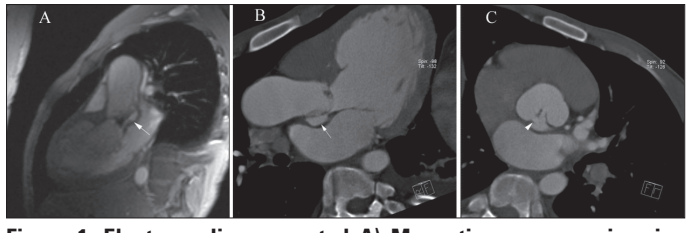

Figure 1. Electrocardiogram gated A) Magnetic resonance imaging and B) Computed tomography demonstrating the fistula and C) the rupture

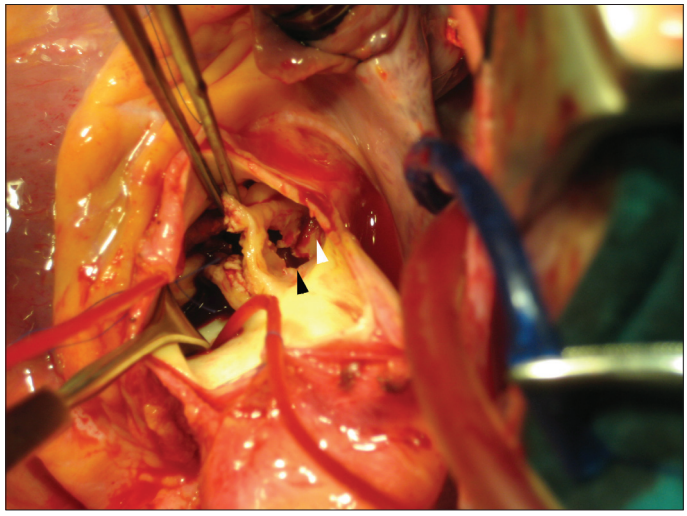

Figure 2. The tract of the fistula and the rupture on the posterior leaflet of the bicuspid aorta: intraoperative view

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Ventricular septal defect with bidirectional shunting in a patient with congenitally corrected transposition

Konjenital düzeltilmiş transpozisyonlu bir hastada bidireksiyonel şantlı ventriküler septal defekt

Congenitally corrected transposition of the great arteries (CCTGA) is a rare cardiac malformation characterized by the combination of discordant atrioventricular and ventriculoarterial connections. Most of the cases with CCTGA are diagnosed in childhood because of concomitant cardiac malformation. Relevant concomitant cardiac defects such as ventricular septal defect (VSD), atrial septal defect, tricuspid regurgitation and pulmonary stenosis were reported previously. We report an asymptomatic patient with CCTGA and coexisting VSD with bidirectional shunting.

A 22-year-old asymptomatic male in the army was seen in our department during his periodical examination. He had a grade 3/6 mesocardiac systolic murmur on cardiac auscultation. Electrocardiogram (ECG) showed normal sinus rhythm with right bundle branch block. Transthoracic echocardiography showed CCTGA with VSD with left to right shunt (Fig.1, Video 1. See corresponding video/movie images at www.anakarder.com) and moderate tricuspid and aortic regurgitation in apical four-chamber view. The pulmonary valve was moderately stenotic with a peak pressure gradient of 49 mm Hg. For identifying the direction of shunt flow in VSD contrast echocardiographic examination with agitated saline was carried out. Contrast echocardiography demonstrated positive contrast effect in the left ventricular in diastole confirming a right-to-left shunt at the ventricular septum (Video 2. See corresponding video/movie images at www.anakarder.com). According to our knowledge, our case is the first reported CCTGA with VSD with bidirectional shunting in an asymptomatic patient.

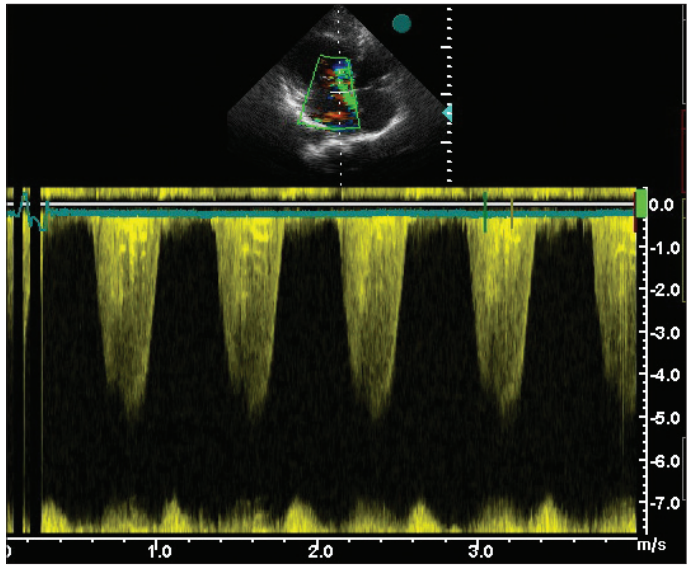

Figure 1. Transthoracic and Doppler echocardiography views of congenitally corrected transposition of the great arteries with ventricular septal defect with left to right shunt

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Huge main pulmonary arterial thrombus in a child with increased lipoprotein (a) level

Lipoprotein (a) yüksekliği olan bir çocukta pulmoner arteriyel dev trombüs

Pulmonary arterial thrombosis is an extremely rare clinical condition both in children and in adults. Lipoprotein (a) [Lp (a)] is an atherogenic