Anadolu Kardiyol Derg
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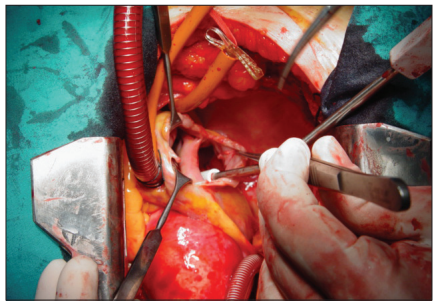

Figure 2. Operative view of right atrial mass and ascending aortic aneurysm

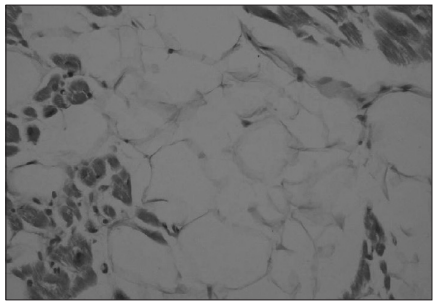

Figure 3. Histopathology showing accumulation of adipose tissue with mature adipocytes

A standard right atriotomy revealed a tumor (2.5 cm in diameter) arising from the interatrial septum and protruding into the right atrial cavity. The mass was extending superiorly and had a second attachment at the medial aspect of the superior cavo-atrial junction (Fig. 2). The tumor was completely resected due to its suitable anatomy (Video 1. See corresponding video/movie images at www.anakarder.com). The ascending aorta was completely transected above the sinotubular junction. A 28 mm Dacron graft was used to perform supracoronary ascending aortic replacement. Pathologic examination of the specimen revealed the typical pattern of lipomatous hypertrophy with large accumulation of adipose tissue (Fig. 3).

This is the first case reporting the combination of ascending aortic aneurysm and lipomatous hypertrophy.

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Abdominal aortic aneurysm with rupture into the inferior vena cava

Vena kava inferiyor'a rüptüre olan abdominal aort anevrizması

A 65-year-old man referred to our institute with an emergent situation. Physical examination revealed sinus tachycardia (130 beats/min), hypotension (90/35 mmHg), large pulsatile mass in abdomen, hemoglobin: 10.1 gr/dl. We considered abdominal aneurysm rupture and performed

Figure 1. Computerized tomography view of aorto-caval fistula

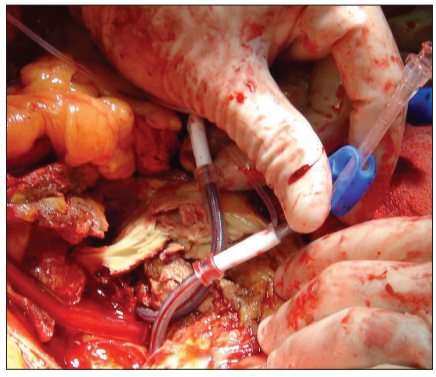

Figure 2. Intraoperative view of balloon expandable catheter

computerized tomography scanning. It showed juxta-renal abdominal aortic aneurysm (AAA) and long segment aorto-caval fistula (Fig. 1). The patient emergently was taken to operating room. Firstly, we opened abdomen and revealed big AAA (more than 10 cm), then we prepared aneurysm but we could not take it on cross-clamp inside abdomen. The incision was extended to thoracic level (9. cartilage) and we took on cross-clamp above diaphragm. When we opened aneurysm sac, suddenly and rapidly bleeding occurred, we controlled caval bleeding with balloon catheter and performed proximal aortic anastomosis with 18/9 aorta-iliac graft on renal arteries (Jotec Inc. Minnesota, USA). We took off aortic cross clamp and repaired caval injury with 2x8 cm. Dacron patch. Aorto-caval fistula is very rare complication of AAA and this pathology can be repaired with endovascular graft replacement. In this case, caval injury was in a long segment and we had to use Dacron patch for inferior vena cava. We used expandable balloon catheter for cessation of bleeding in this case. It was very useful and life saving procedure and we repaired tear of inferior vena cava without bleeding complications easily (Fig. 2).

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