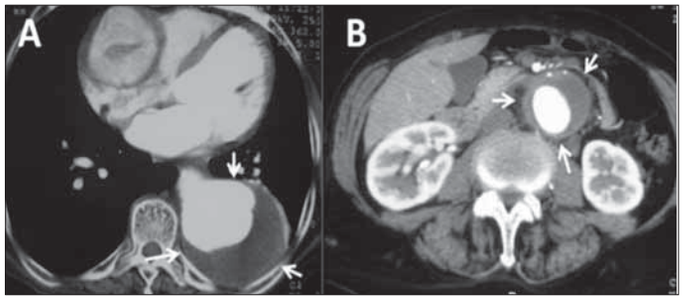


**Figure 2. Transaxial thoracoabdominal CT images of thoracic and abdominal aorta aneurysms**
CT - computed tomography

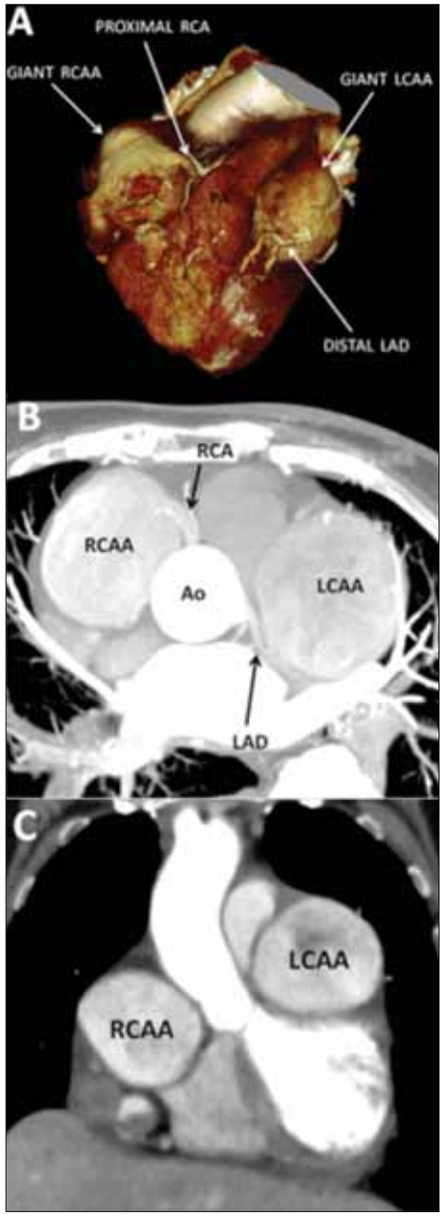


**Figure 3. Coronary MDCT images of the left and right coronary artery aneurysms**
LAD - left anterior descending artery, LCAA - left coronary artery aneurysm, MDCT - multidetector computed tomography, RCA - right coronary artery, RCAA - right coronary artery aneurysm

tion of the aortic aneurysms was favorable for percutaneous intervention, firstly, we implanted endovascular stent-grafts for the aortic aneurysms (Fig. 4a). After the recovery period, the patient underwent successful aneurysm resection and coronary artery bypass operation including end- to- end anastomosis of the two edges of the LAD (red arrow) and aorta-saphenous vein graft implantation (red arrowheads) at the distal portion of the RCA and proximal ligation (yellow arrow) (Fig. 4b). This is the first reported case of a hybrid therapy for multiple aortic aneurysms combined with giant CAA's.

Our case supports the opinion that aneurysmal disease is a systemic illness affecting multiple arterial segments including coronary arteries.


**Figure 4. a) Thoracoabdominal MDCT images after endovascular graft stent implantation. b) Cardiac MDCT image obtained after the aneurysm resection and CABG operation**
CABG - coronary artery bypass surgery, MDCT - multidetector computed tomography

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# Gaucher's disease with valvular, myocardial and aortic involvement in a patient with oculomotor apraxia

## *Okülomotor apraksili bir hastada valvüler, miyokardiyal ve aortik tutulumlu Gaucher hastalığı*

Gaucher disease (GD) is an autosomal recessive inherited defect of the lysosomal enzyme glucocerebrosidase, which leads to glucocerebroside accumulation in the reticuloendothelial system.

We report here a case of a 20-year-old woman who had been diagnosed as a type 3 GD histopathologically after liver biopsy at 10- year of age. On her current physical examination oculomotor apraxia was detected. On transthoracic echocardiography the mitral and aortic valves were abnormally thickened and calcified (Fig. 1, 2). Transmitral

gradient was 16/8 mmHg and transaortic gradient was 110/64 mmHg (Fig. 1, 2). In addition, moderate mitral and aortic regurgitations were detected on color Doppler echocardiography. Wall thickening and calcification were noted within the myocardium and the descending aorta (Fig. 3). The patient was severe symptomatic so she underwent cardiac surgery including aortic and mitral valve replacement. Intraoperative findings confirmed the diagnosis. Electron microscopy of the mitral valve revealed numerous large cells with abundant rough endoplasmic reticulum in the cytoplasm (Fig. 4). This is the reported first cases of aortic and mitral valve leaflet involvement and descendent aortic and myocardial wall involvement in the same patient with GD.

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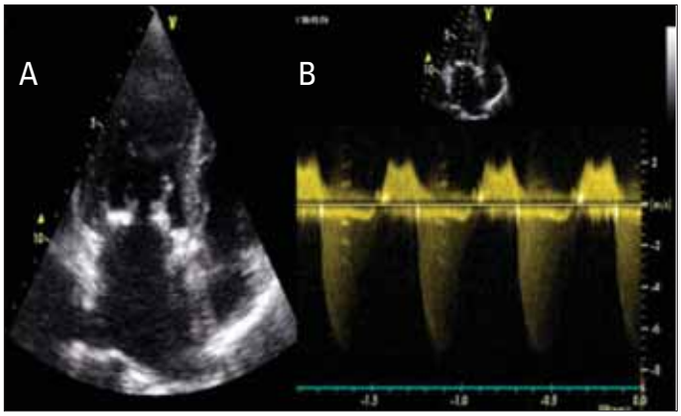


**Figure 1. a) Apical four-chamber echocardiographic view of a severely calcified mitral annulus and mitral leaflets of normal configuration b) Continuous wave Doppler imaging of a 16/8 mmHg transmitral gradient**

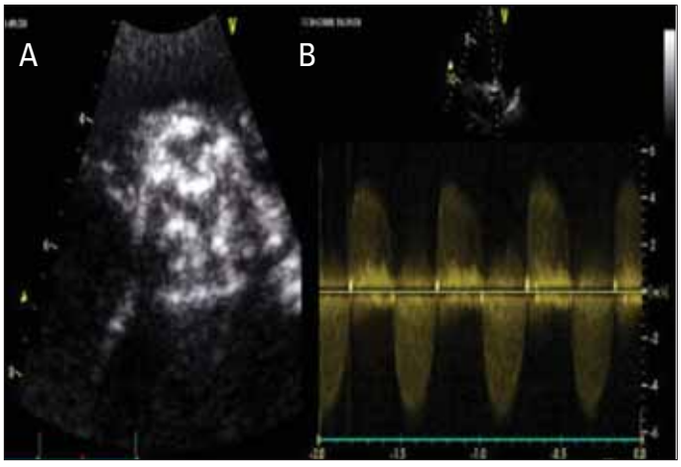


**Figure 2. a) Parasternal short-axis Echocardiographic view of severely calcific aortic leaflets and aortic annulus, and restricted aortic valve opening b) Continuous wave Doppler imaging of an 110/64 mmHg transaortic gradient**

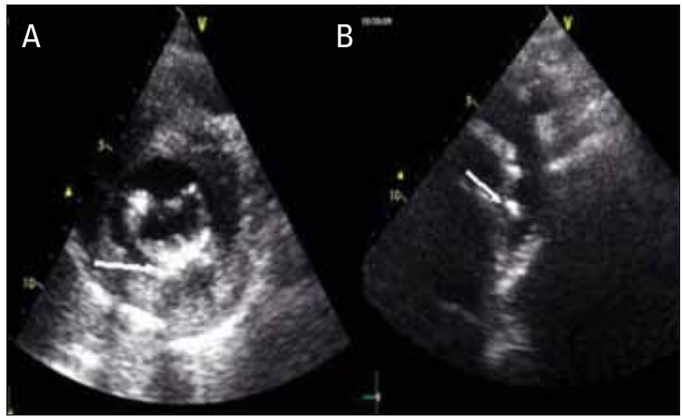


**Figure 3. a) Parasternal short-axis echocardiographic view of myocardial wall thickening and calcification b) Suprasternal echocardiographic view of a calcification on the descending aortic wall**

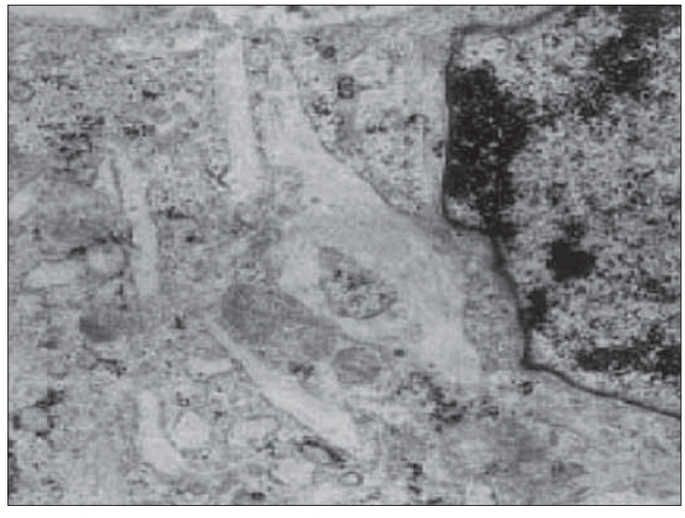

**Figure 4. Electron microscopy of the mitral valve: numerous large cells with abundant rough endoplasmic reticulum in the cytoplasm**