This is a surgical video of a patient with an ascending aortic aneurysm and severe aortic insufficiency (Fig. 1). On palpation of the heart, there was a significant thrill. When we recorded a video of the heart when the pericardium was opened, there was no visible abnormality (Video 1). We thought of taking a video in slow motion. On diastole, the heart was fibrillating (Video 2).

**Video 1.** Video of the beating of the heart of a patient with severe aortic insufficiency.

**Video 2.** Video of the beating of the heart in slow motion.

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**Chronic thromboembolic pulmonary hypertension versus fibrosing mediastinitis**

A 63-year-old woman with aggravating dyspnea was referred to our center. Her symptoms began three months ago and worsened throughout this period. She reported a history of breast cancer treated with mastectomy and chemoradiation.
therapy five years ago, with no recurrence noted in her subsequent follow-ups. She had also suffered from an episode of pulmonary emboli at the start of her chemotherapy. Echocardiography revealed moderate right ventricular dysfunction and an elevated systolic pulmonary artery of 85 mm Hg as well as multiple perfusion defects in the ventilation-perfusion (V/Q) scan (Fig. 1a). Hence, the patient was referred to our center for further evaluation of chronic thromboembolic pulmonary hypertension (CTEPH). Pulmonary CT angiography (CTA) revealed extensive mediastinal and bihilar fibrotic changes, which diffusely encroached pulmonary vasculature (Fig. 1b-e). Of note, co-existing small, pulmonary emboli were detected in few segmental arterial branches Figure 1b; these account for the perfusion defect noted in the initial V/Q scan.

Although fibrosing mediastinitis is primarily caused by granulomatous infections, it might be rarely observed in patients with a history of radiotherapy (1). Diffusely decreased radiotracer uptake accompanied with perfusion defects in the V/Q scan might be inspected in both fibrosing mediastinitis and CTEPH. However, despite broad mediastinal and bilateral hilar fibrosis, almost normal peripheral branch arborization in CTA is more favorable for fibrosing mediastinitis than CTEPH. This discrimination plays a crucial role in patient management and future prognosis.

Reference


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