

Massive, ring-shaped pericardial calcification of atrioventricular groove

A foreign 72-year-old man who had diabetes mellitus and hypertension was admitted to the emergency room with severe chest pain and dyspnea. Physical examination upon arrival was found to be unremarkable, with a pulse rate of 70 beats/minute and a blood pressure of 115/75 mm Hg. Initial 12-lead electrocardiogram revealed sinus rhythm with minimal ST segment elevations in leads DII, DIII, aVF, and V4-V6, without reciprocal ST segment changes. Inferior wall motion abnormalities were detected in emergency bedside two-dimensional transthoracic echocardiographic examination. The echocardiogram revealed constrictive physiology of the mitral and tricuspid valves and pericardial thickening in the atrioventricular (AV) groove. The early diastolic velocity of the lateral mitral annulus and that of the septal annulus was not reduced in tissue Doppler imaging. The patient was referred to emergency coronary angiography with the diagnosis of acute coronary syndrome. Coronary angiography (Fig. 1a, b) showed coronary artery disease (three-vessel disease) and massive calcification along the AV groove. Reconstructed images of cardiac computed tomography (Fig. 2a, b) demonstrated massive, ring-shaped calcification along the AV groove causing

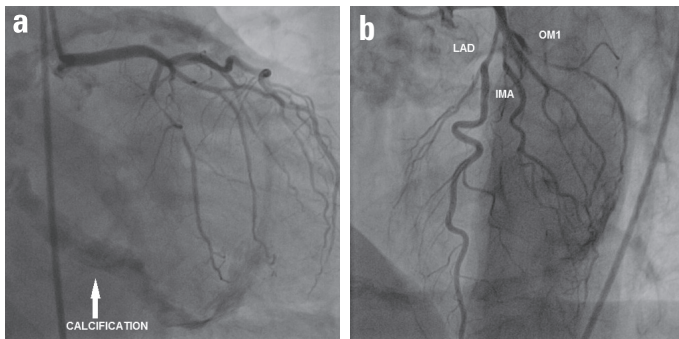


Figure 1. (a) Right anterior oblique caudal view of left system coronary angiography revealed massive, ring-shaped pericardial calcification of atrioventricular groove. (b) Left anterior oblique cranial view of left system coronary angiography showed stenosis of proximal parts of the left anterior descending, intermedium, and high obtuse margin arteries

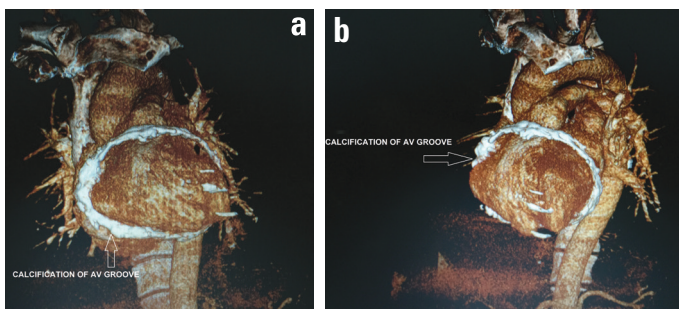


Figure 2. (a) Right-side view and (b) left-side view of the massive pericardial calcification of the atrioventricular groove in reconstructed images of cardiac computed tomography

strangulation of the heart. The patient underwent an extensive pericardial resection and coronary artery by-pass graft surgery.

Bernas Altıntaş, Derya Deniz*, Rojhat Altındağ, Barış Yaylak, Erkan Baysal, Önder Bilge
Departments of Cardiology, *Radiology, Diyarbakır Gazi Yaşargil Research and Education Hospital; Diyarbakır-Turkey

Address for Correspondence: Dr. Bernas Altıntaş
 Diyarbakır Gazi Yaşargil Eğitim ve Araştırma Hastanesi
 Kardiyoloji Bölümü, Peyas Mahallesi
 Selahaddin Eyyubi Bulvarı
 229. Sokak Hamzaoğulları Sitesi B-blok No:20
 Kayapınar, Diyarbakır-Türkiye
 E-mail: drbernas@yahoo.com.tr
 ©Copyright 2017 by Turkish Society of Cardiology - Available online
 at www.anatoljcardiol.com
 DOI:10.14744/AnatolJCardiol.2017.7986

Successful management of complications after inappropriate positioning of a hemodialysis catheter

A 61-year-old woman with a history of diabetes mellitus, hypertension, and chronic renal impairment was admitted with complaints of fever and inadequate hemodialysis. She had been undergoing catheter-based hemodialysis 3 times a week for 6 months. Chest X-ray revealed that the tip of the catheter was

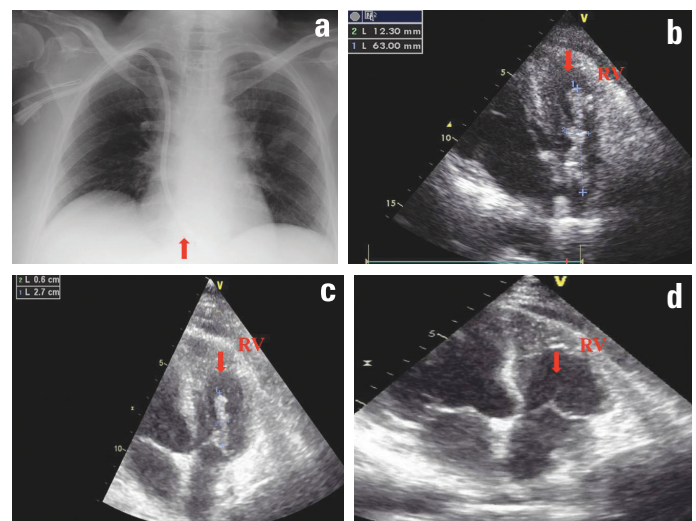


Figure 1. (a) Chest X-ray showing the catheter (arrow) extending to the right ventricle. (b) Transthoracic echocardiographic view showing the catheter and the thrombus attached to it (arrow indicates the catheter; RV - right ventricle). (c) Transthoracic echocardiographic view after surgical removal of the catheter demonstrating the thrombus attached to the tricuspid valve (arrow indicates the thrombus; RV - right ventricle, TV - tricuspid valve). (d) Transthoracic echocardiographic view after heparin infusion complete resolution of the thrombus (RV - right ventricle, TV - tricuspid valve)